A Common Goal: The U.S. Federal Trade Commission's Healthcare Enforcement Program and Its Implications for ACOs
Keynote Address
Commissioner Julie Brill
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The history of healthcare delivery in the United States has been one of constant evolution. Employee health benefits grew as a way to avoid wage caps imposed by the government during World War II, helped by a 1943 IRS ruling that employers' contributions to group health insurance policies were tax-free.[1] Over 20 years later, in 1966, the federal

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As the form and delivery of healthcare has shifted over the past 100 years, so have U.S. antitrust agencies evolved to adapt to the changing economy. When the FTC opened its doors in 1914, we were far more likely to be investigating steel and oil mergers. While those industries

Fortunately, antitrust is flexible—and we en

Indeed, when it comes to mergers in the healthcare sector, the vast majority do not attract the attention of antitrust agencies. The FTC challenges the very small number of mergers that result in higher rates and reduced incentives to compete on clinical quality or patient satisfaction. When we do, we sometimes hear criticism from those who suggest that antitrust enforcement is contrary to the goals of the Affordable Care Act, or contrary to providers' goals to improve clinical care. As our recent enforcement matters demonstrate, this is simply not true.

In several of our recent enforcement actions, the courts have found that the ACA's goals and antitrust are not at cross-purposes. For instance, in *FTC v. St. Luke's*, the district court blocked St. Luke's Health System, a hospital and physician network, from further combining with Saltzer Medical Group, Idaho's largest independent, multi-specialty physician practice group. The FTC argued that the acquisition would result in an anticompetitive combination of the two largest providers of adult primary care physician services in the Nampa, Idaho area.[13]

The district court agreed, finding it "highly likely" that health care costs would rise as the merged firm "obtains a dominant market position," allowing the firm to negotiate higher rates

These cases underscore that the FTC has moved forward to challenge mergers only where the anticompetitive effects are strong, and where there were other, less problematic ways of achieving any claimed benefits.

The antitrust agencies recognize the need to adapt as new types of transactions appear on the horizon. While the FTC's provider challenges have traditionally focused on competing healthcare providers, and we have not yet brought a vertical provider challenge, we will continue to be on the lookout for other types of healthcare transactions that may raise antitrust concerns. For example, we would evaluate whether a hospital's purchase of a large, multi-specialty physician group would foreclose referrals to a remaining third-party hospital in the geographic area, calling into question the ability of that rival hospital to survive.

The FTC's antitrust inquiry would also evaluate whether a health plan's combination with a dominant hospital would foreclose other plans from contracting with that essential provider. We would ask what individuals would do to obtain care, should their chosen health plan suddenly lose access to their local hospital, and whether that dominant hospital would be able to charge supracompetitive rates as a result.

And we will continue to apply the tenets of antitrust economics to emerging payment models. We sometimes hear from merging providers that the FTC should not be concerned with potentially problematic transactions because the shift to value-based provision of health care means that provider competition is not relevant. We recognize that there are incremental changes away from fee-for-service payments to value-based payment methods, as Zeke Emanual outlined in a recent speech at the FTC-DOJ "Examining Health Care Competition" Workshop.[19] Antitrust is flexible enough to incorporate such adaptations into our analysis of these transactions. Wherever bargaining exists between health plans and providers, and wherever bargaining leverage is still driven—in whole or in part—by competing alternatives in the market, there will still be an important role for antitrust merger enforcement.

Implications of FTC's Enforcement Program for ACOs and Next Steps

ACOs are a growing part of the healthcare landscape. In February 2015, Centers for Medicare & Medicaid Services ("CMS") representatives revealed the number of ACOs—Pioneer, Shared Savings, and Commercial—has expanded. To date, providers have established 405 ACOs, including 89 new Shared Savings ACOs in 2015. These represent 7.2 million assigned beneficiaries in 47 states, plus DC and Puerto Rico. Moreover, CMS expects continued growth in Shared Savings Program ACOs in 2016 and beyond.[20]

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We will, when invited, offer guidance on promoting competition in healthcare to other federal agencies and state legislatures. In a recent FTC staff comment to the Office of the National Coordinator for Health Information Technology ("ONC"), for example, we offered guidance on how to promote competition by increasing the adoption of interoperable health IT systems, which can provide substantial consumer benefits.[28] Heightened interoperability enhances providers' ability to share patient information without a merger or other financial integration.

We will continue our scalpel-like approach to antitrust enforcement, which only targets those few combinations that raise serious compe