

**PROMOTING HEALTHY COMPETITION IN HEALTH CARE MARKETS:  
ANTITRUST, THE ACA, AND ACOS**

**Keynote Address by Julie Brill  
Commissioner, Federal Trade Commission**

**Before the**

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Catalyst For Payment Reform  
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Good afternoon, and thanks to Bob Leibenluft, Suzanne Delbanco, and Catalyst For Payment Reform for inviting me to address you today. I am delighted to be part of today's National Summit. The Catalyst for Payment Reform and the FTC share an interest in looking closely at issues surrounding provider market power. At the FTC, we are determined to use antitrust enforcement to maintain competition in the health care sector to help promote high quality, cost-effective care. The antitrust laws are vital to maintaining competitive health care markets, never more so than now.

We are especially grateful for the valuable role that employers like many of you have played in promoting competition in health care markets. Through your amicus briefs, your comments on our policy proposals, and your participation in our workshops, you have helped us and our sister competition agency, the Antitrust Division of the U.S. Department of Justice, understand the real world harms from anticompetitive conduct to help us get our analysis right. I look forward to continuing to work together.

I and my colleagues at the FTC share your view about the importance of competition in health care markets, the subject of today's conference. There is a wealth of empirical evidence on the harmful effects of high concentration among health care providers. Numerous studies have found that the existence of provider market power results in higher prices, lower quality, and less innovation.<sup>1</sup>

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<sup>1</sup> See, e.g., Martin Gaynor et al., *Death by Market Power: Reform, Competition and Patient Outcomes In the National Health Service* (April 2012), available at: [http://www.andrew.cmu.edu/user/mgaynor/Assets/Death\\_by\\_Market\\_Power.pdf](http://www.andrew.cmu.edu/user/mgaynor/Assets/Death_by_Market_Power.pdf); Clark C. Havighurst and Barak Richman, *The Provider-Monopoly Power Problem in Health Care*, 89 Oregon L. Rev. 847 (2011); Robert Berenson, Paul Ginsburg, & Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, Health Affairs (April 2010); William B. Vogt and Robert Town, *How Has Provider Consolidation Affected the Price and Quality of Hospital Care?*, Synthesis Project No. 9, Robert Wood Johnson Foundation (Feb. 2006). Prices for inpatient hospital services in particular have risen dramatically. A new study published in the *American Journal of Managed Care* in March of this year found that from 2008 to 2010, inpatient hospital prices increased 8.2 percent per year, with wide variation in price levels. Jeff Lemieux, MA & Teresa Mulligan, MHS, *Trends in Inpatient Hospital Prices, 2008-2010*, 19(3) AM. J. MANAG. CARE, e106 (2013). Data show that increasing provider consolidation is one contributor to rising hospital prices. See The Robert Wood Johnson Foundation, *The Synthesis*

So I'm pleased to have the opportunity to discuss the FTC's work to promote competition in health care. Most interestingly for many of you, I'd like to talk about our work in the context of the Patient Protection and Affordable Care Act (ACA),<sup>2</sup> and describe how the FTC's work to promote competition in health care markets supports the goals of the ACA.

The ACA was designed, in part, to address the escalating costs of health care in the U.S. I don't think anyone disputes the fact that health care costs in the U.S. are too high. It has been reported that health care costs have risen over three times faster than wages over the last decade.<sup>3</sup> The U.S. spends more per capita on health care than any other developed country, and the growth in our public and private health expenditures outpaces growth in comparable countries.<sup>4</sup> Despite this higher level of health care spending, studies show that the U.S. does not achieve higher health care quality.<sup>5</sup>

The ACA seeks to improve the quality and reduce the costs of health care services in the U.S. in a number of ways, some relating to health care financing, and some relating to health care delivery. With respect to health care financing, the ACA provides for the creation of state-based health insurance marketplaces (sometimes called exchanges).<sup>6</sup> While health care financing and insurance is not part of the FTC's primary field of competition expertise,<sup>7</sup> I will note that the exchanges should offer individuals and small employers a range of competing health insurance products that might otherwise be unavailable or unaffordable. This will enable consumers to be more responsive to the cost and quality of provider networks. The exchanges should also encourage greater competition in local insurance markets, driving premiums down for consumers.<sup>8</sup>

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Project: New Insights From Research Results, Policy Brief No. 9, June 2012, *available at*:

[http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf73261](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261);

*see also* James C. Robinson, Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology, 17(6) AM. J. MANAG. CARE, e241 (2011), *available at*:

<https://www.blueshieldca.com/sites/make-care-affordable/documents/Hospital-market-concentration-pricing-profitability.pdf>.

<sup>2</sup> Patient Protection and Affordable Care Act, Pub. L. No. 11-48, 124 Stat. 119 (2010) (Affordable Care Act).

<sup>3</sup> Health Care Cost Institute, 2011 Health Care Cost and Utilization Report, Sept. 25, 2011, *available at*: <http://www.healthcostinstitute.org/>.

<sup>4</sup> Snapshots: Health Care Spending in the United States & Selected OECD Countries, The Henry J. Kaiser Family Foundation, *available at*: <http://kff.org/health-costs/issue-brief/snapshots-health-care-spending-in-the-united-states-selected-oecd-countries/>.

<sup>5</sup> *Id.*

<sup>6</sup> Affordable Care Act, *supra* note 2, Section 1322.

<sup>7</sup> On the consumer protection side, the FTC will continue to protect consumers against fraud or deception in health care markets. This includes enforcement and consumer education efforts to combat fraud and deception relating to the health insurance marketplaces or other ACA programs.

<sup>8</sup> Dafny, Leemore, Duggan, Mark, and Ramanarayanan, Subramaniam, "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," *American Economic Review*, 102 (2): 1161-85, *available at*: <http://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.102.2.1161>.

With respect to health care delivery, the ACA's Medicare Shared Savings Program encourages groups of providers to form Accountable Care Organizations (ACOs) to work together to coordinate care for Medicare fee-for-service beneficiaries.<sup>9</sup> An ACO participating in the Medicare Shared Savings Plan may share in some portion of any savings they create if the ACO meets certain criteria set out by the Secretary of HHS, including quality performance standards.

The ACA and its ACO initiative address concerns that the current health care fee-for-service payment system creates incentives for overuse. In addition, when doctors fail to coordinate treatment plans for a patient, they may order duplicative tests and medications. This increases health care costs and can even result in worse patient outcomes.

As the FTC goes about its normal business of examining potentially problematic mergers among providers, agreements not to compete in their dealings with health plans, and other potentially troubling activity, we are starting to see some providers point to the ACO program as a justification for such conduct. The parties and their counsel complain that the federal government is "speaking out of both sides of its mouth," with the Medicare program encouraging providers to come together and create organizations that will enable greater collaboration, while the antitrust agencies challenge them.

These contentions are creative, but misguided. Indeed, the goals of the ACA and antitrust enforcement are aligned and compatible.

The federal health care regulators and the FTC and Antitrust Division of the Department of Justice have a shared commitment to the development of lawful and procompetitive ACOs. The Centers for Medicare and Medicaid Services (CMS) always intended that the antitrust agencies would monitor the potential for anticompetitive harm associated with ACOs. There was extensive cooperation among CMS, the Department of Health and Human Services, the Antitrust Division of the Department of Justice, and the FTC as the antitrust agencies developed a policy statement on ACOs,<sup>10</sup> while the health care agencies crafted regulations to implement the Medicare Shared Savings Program.<sup>11</sup> The final program rule stipulates that CMS will rely

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<sup>9</sup> Affordable Care Act, *supra* note 2, at 395 (Section 3022). ACOs have also formed outside the context of the Medicare Shared Savings Program to bring similar care coordination efforts to commercially-insured patients. See David Muhlestein, "Continued Growth of Public and Private Accountable Care Organizations," Health Affairs Blog (Feb. 19, 2013), available at: <http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/> (Muhlestein Health Affairs Blog)(noting that while there are more than 250 Medicare Shared Savings Program ACOs, there are a total of 428 ACOs in 49 states, including private sector, non-Medicare ACOs).

<sup>10</sup> Fed. Trade Comm'n and U.S. Dep't of Justice: Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026, 67030-31 (Oct. 28, 2011)(FTC/DOJ ACO Policy Statement).

<sup>11</sup> See Susan S. DeSanti, *ACO Antitrust Guidelines: Coordination Among Federal Agencies*, The Antitrust Source (December 2011) at 1.

on the antitrust agencies to use “their existing enforcement processes for evaluating concerns raised about an ACO’s formation or conduct and [to file] antitrust complaints when appropriate.”<sup>12</sup> Importantly, CMS can exclude from the Shared Savings Program any ACO that violates the antitrust laws, and CMS has promised to “coordinate closely with the Antitrust Agencies throughout the application process and the operation of the Shared Savings Program to ensure that the implementation of the program does not have a detrimental impact upon competition.”<sup>13</sup>

Secretary of Health and Human Services Kathleen Sebelius recently reaffirmed her understanding of the important role to be played by competition oversight. In a recent interview, she addressed the harms that can flow from monopolies and said: “To counter the possibility of monopoly, federal agencies must be vigilant . . . ‘Having that constant oversight is really appropriate.’”<sup>14</sup>

Indeed, far from being a barrier to procompetitive collaboration envisioned in the ACA, antitrust aligns naturally with the goals of ACOs. By serving as a watchdog against anticompetitive conduct, antitrust promotes market behavior that creates efficiencies and benefits consumers. Antitrust law permits providers to engage in a wide array of legitimate collaborative activities, including ACO arrangements, as well as many mergers and consolidations, so long as the conduct is likely to promote consumer welfare through lower cost or improved quality. Thus agreements among competitors that limit some aspect of their rivalry are permissible where the restraint at issue is “reasonably necessary” to produce procompetitive benefits to the market that outweigh any loss of competition among the participants.<sup>15</sup> This is not a new concept for

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<sup>12</sup> Dep’t of Health & Human Servs., Centers for Medicare & Medicaid Servs., Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 42 C.F.R. § 425 (2011), 76 Fed. Reg. 67,826 (Nov. 2, 2011)(CMS Final Rule).

<sup>13</sup> *Id.* at 67,842.

<sup>14</sup> Interview by Sharon Begley with Kathleen Sebelius, Secretary, U.S. Dep’t of Health and Human Services, in Boston, Mass. (Apr. 8, 2013), *available at*: <http://theforum.sph.harvard.edu/events/conversation-kathleen-sebelius>.

<sup>15</sup> For a more detailed discussion of the antitrust analysis of such arrangements, *see, e.g.*, Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition to Michael E. Joseph, Esq., McAfee & Taft, concerning Norman PHO, dated Feb. 13, 2013, *available at*: <http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf> (Norman PHO); Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition to Christi J. Braun, Esq., Ober, Kaler, Grimes & Shriver, concerning TriState Health Partners, Inc., dated April 13, 2009, *available at*: <http://www.ftc.gov/opa/2009/04/tristate.shtm>; Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition to John J. Miles, Esq., Ober, Kaler, Grimes & Shriver, concerning Follow-Up to 2002 MedSouth, Inc. Staff Advisory Opinion, dated June 18, 2007, *available at*: <http://www.ftc.gov/bc/adops/070618medsouth.pdf>; Letter from Markus H. Meier, Assistant Director, Bureau of Competition to Christi J. Braun, Esq., and John J. Miles, Esq., Ober, Kaler, Grimes & Shriver, concerning Greater Rochester Independent Practice Association, Inc., dated September 17, 2007, *available at*: <http://www.ftc.gov/opa/2007/09/clinicalintegration.shtm>; Letter from David R. Pender, Acting Assistant Director, Health Care Division, Bureau of Competition to Clifton E. Johnson, Esq., and William H. Thompson, Esq., Hall, Render, Killian, Heath & Lyman, concerning Suburban Health Organization, dated March 28, 2006, *available at*: <http://www.ftc.gov/opa/2006/03/shor31.shtm>.

antitrust regulators – we embraced it as far back as 1996.<sup>16</sup> With regard to aggregations of market power – whether through mergers or otherwise – antitrust law uses a scalpel, not a sledgehammer, and carefully analyzes each case to bar only those that on balance threaten to harm consumers.<sup>17</sup>

The argument that the ACA encourages providers to “consolidate” whereas the antitrust laws require that providers “compete” is mistaken. The ACA requires providers to create entities that *coordinate* the provision of patient care services. The ACA neither requires nor encourages providers to merge or otherwise consolidate. ACOs may be formed through contractual arrangements that are well short of a merger, such as a joint venture. Provider groups, like any other business entity, must successfully develop lawful business and competitive strategies. For some providers, that means forming contractual joint venture or ACO arrangements, for others it means mergers or consolidations, and still others may choose to pursue different strategies or “go it alone.” Neither the statute nor the implementing regulations express any preference for consolidation of competing entities.<sup>18</sup>

The data demonstrate that ACOs are flourishing. A report from earlier this year found that 428 ACOs are operating in 49 states, including more than 250 ACOs established under Medicare programs, and hundreds of additional ACO-type organizations formed outside of Medicare.<sup>19</sup> These numbers will undoubtedly continue to grow. Moreover, to the extent that any newly forming ACO is concerned about potential antitrust exposure, the FTC/DOJ ACO Policy Statement establishes a process for them to seek expedited antitrust guidance.<sup>20</sup> As of April 2013, only two provider groups had availed themselves of this option.<sup>21</sup> Taken together, these facts belie claims that antitrust concerns have been a barrier to the development of ACOs.

Indeed, it is my view that appropriate antitrust enforcement will help ensure that ACOs fulfill the goal of the ACA by promoting better outcomes and lowering costs. The fact of the matter is that it is often much easier for providers to “collaborate” on setting their prices than it is to figure out how to improve quality, enhance patient satisfaction, and make care more cost-effective. Without the incentive to “build a better mousetrap” in order to compete more

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<sup>16</sup> U.S. Dep’t of Justice and Fed. Trade Comm’n, Statements of Enforcement Policy in Health Care (Aug. 1996), available at: <http://www.ftc.gov/bc/healthcare/industryguide/policy/hlth3s.pdf>.

<sup>17</sup> See U.S. Dep’t of Justice and Fed. Trade Comm’n, Horizontal Merger Guidelines (2010), available at: <http://www.ftc.gov/os/2010/08/100819hmg.pdf>.

<sup>18</sup> Indeed, as CMS stated in its final rules: “we do not believe that mergers and acquisitions by ACO providers and suppliers are the only way for an entity to become an ACO. The statute permits ACO participants that form an ACO to use a variety of collaborative organizational structures, including collaborations short of merger. . . . We reject the proposition that an entity under single control, that is an entity formed through a merger, would be more likely to achieve the three-part aim [of the Shared Savings Program].” CMS Final Rule *supra* note 12, at 67843.

<sup>19</sup> See Muhlestein Health Affairs Blog, *supra* note 9.

<sup>20</sup> FTC/DOJ Policy Statement, *supra* note 10.

<sup>21</sup> Fed. Trade Comm’n & Dep’t. Justice Working Group Issues Summary of Activities Since October 2011 Release of ACO Antitrust Enforcement Policy (Apr. 10, 2013), available at: <http://www.ftc.gov/bc/healthcare/aco/mssp-summary.pdf>.

effectively, there is little to prod dominant providers to do the hard work needed to achieve better, more cost-effective care for patients. Antitrust enforcement is thus a critical element to realizing the goals of ACOs.

Take, for example, what happened in Grand Junction, Colorado. Media reports have highlighted the benefits from collaboration among Grand Junction physicians, who have been working together to reduce unnecessary medical procedures and invest in a community-wide electronic record system to share office notes, test results, and hospital data for patients.<sup>22</sup> Researchers have found that Grand Junction's patients are healthier than those in most areas of the United States, and Grand Junction's costs for Medicare spending are among the lowest in the United States – about 30 percent below the national average.<sup>23</sup>

But it wasn't always like that in Grand Junction. Back in the mid-1990s, the FTC had evidence that physician prices in Grand Junction were as much as 30 percent *higher* for private payers than elsewhere in the state.<sup>24</sup> The FTC's investigation indicated that almost all of the doctors in the Grand Junction area had agreed that a single organization – the Mesa County Physicians Independent Practice Association (Mesa IPA) – would bargain with health insurance plans on behalf of the entire group. We believed this meant that health plans had to pay the doctors whatever fees the Mesa doctor association demanded, because the health plans had practically nowhere else to turn for physician services in the county. The FTC also charged that the Mesa IPA doctors' agreement prevented innovative health plans from entering the Grand Junction area.<sup>25</sup>

Facing the potential of enforcement action, the Mesa IPA agreed to end the anticompetitive pricing practices and settle the FTC's charges.<sup>26</sup> The FTC worked with the physicians to create a settlement that allowed the doctors to form legitimate collaborations involving the use of a community-wide electronic health records system, common practice protocols, and physician peer review. Without the FTC's action, doctors in Grand Junction may well have failed to collaborate on ways to improve quality and reduce costs, and instead may have only collaborated on prices, which would have led to lower quality, more expensive care than we see today.

Advocate Health Partners in Chicago is another case in point. In the late 1990s we began an investigation of several physician organizations representing more than 2,900 Chicago-area

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<sup>22</sup> See, e.g., Scott Horsley's report on *Morning Edition*, Aug. 14, 2009; Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us about Health Care*, *The New Yorker* (June 1, 2009) at 9, available at: [http://www.newyorkers.com/reporting/2009/06/01/090601fa\\_fact\\_gawande?currentPage=all](http://www.newyorkers.com/reporting/2009/06/01/090601fa_fact_gawande?currentPage=all).

<sup>23</sup> *Id.*, citing Dartmouth Atlas of Health Care and Jim Weinstein.

<sup>24</sup> *In the Matter of Mesa County Physicians Independent Practice Association, Inc.*, Docket No. 9284 (Complaint), dated May 12, 1997, available at: <http://www.ftc.gov/os/1997/05/mesacoun.htm>.

<sup>25</sup> *Id.*

<sup>26</sup> *In the Matter of Mesa County Physicians Independent Practice Association, Inc.*, Docket No. 9284 (Consent Agreement), dated February 19, 1998, available at: <http://www.ftc.gov/os/1998/02/d09284.agr.htm>.

independent physicians for alleged price fixing and refusal to deal with health plans except on collectively determined terms. We found that Advocate Health Partners and the other organizations had negotiated group contracts with fees 20 to 30 percent higher than one health plan's individual physician contracts. The physician groups settled the charges, entering into an order that bars anticompetitive pricing practices and refusals to deal, and allows the doctors to collaborate when doing so could lead to cost savings and better health care for patients.<sup>27</sup> Advocate Health Partners earnestly undertook reforms consistent with our order. Today, Advocate Health Partners is cited as an exemplary provider organization delivering high-quality, cost-effective care.<sup>28</sup>

FTC staff gave this same message earlier this year to physicians in Norman, Oklahoma, who sought our advice concerning their proposal to develop a clinically integrated, centrally managed physician hospital organization (PHO) as a way to improve quality of care and reduce costs. FTC staff concluded that the proposed PHO created the potential for a high degree of interdependence and cooperation among the participating physicians, and therefore would have the potential to generate significant efficiencies in the provision of physician services.<sup>29</sup> Hopefully the Norman PHO will have results similar to the reports about Mesa IPA and Advocate Health Partners.

Now let me touch on our recent enforcement actions where the primary focus was on the accumulation of market power by providers.<sup>30</sup> It is critical that our enforcement actions in this area get it right, because once market power is created it is hard to undo. Most of our enforcement activity involving provider market power has involved hospital mergers, where we have a very active and successful program. Since 2011, we have investigated and challenged four mergers,<sup>31</sup> while at the same time allowing dozens more to proceed without a challenge.

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<sup>27</sup> *In the Matter of Advocate Health Partners, et al*, FTC File No. 031-0021 (Consent Agreement), dated Dec. 29, 2006, available at: <http://www.ftc.gov/os/caselist/0310021/061229agree0310021.pdf>.

<sup>28</sup> See, e.g., Annie Lowry, 'Accountable Care' Helping Hospitals Keep Medical Costs Down, *New York Times* (April 24, 2013), available at: [http://www.nytimes.com/2013/04/24/business/accountable-care-helping-hospitals-keep-medical-costs-down.html?pagewanted=all&\\_r=0](http://www.nytimes.com/2013/04/24/business/accountable-care-helping-hospitals-keep-medical-costs-down.html?pagewanted=all&_r=0).

<sup>29</sup> Norman PHO, *supra* note 15. FTC staff determined that they would not recommend that the FTC challenge any proposed joint contracting activities by the Norman PHO, so long as the physicians implement the program as planned.

<sup>30</sup> Other enforcement activities in the health care provider area did not have a primary focus on market power issues, but rather allegations of cartel behavior by physician groups – we have brought dozens of physician price fixing cases over the last 20 years. See Enforcement Actions in Industry/Sector: Health Care – Professional Services (FY1996-FY2013), available at: <http://www.ftc.gov/bc/caselist/industry/cases/healthcare/HealthCareProfessionals.pdf>.

<sup>31</sup> *In the Matter of ProMedica Health System, Inc.*, Docket No. 9346 (Commission Opinion), dated March 28, 2012, available at: <http://www.ftc.gov/os/adjpro/d9346/120328promedicabrillopinion.pdf>; *Federal Trade Commission v. Phoebe Putney Health System, Inc., et al.*, No. 11-1160, slip op. (U.S. Feb. 19, 2013), available at: [http://www.supremecourt.gov/opinions/12pdf/11-1160\\_1824.pdf](http://www.supremecourt.gov/opinions/12pdf/11-1160_1824.pdf); *In the Matter of OSF Healthcare System*, Docket No. 9349 (Complaint), dated Nov. 18, 2013, available at: <http://www.ftc.gov/os/adjpro/d9349/111118rockfordcmpt.pdf>; *In the Matter of Reading Health System and Surgical Institute of Reading*, Docket No. 9353 (Complaint), dated Nov. 16, 2012, available at: <http://www.ftc.gov/os/adjpro/d9353/121116readingsurgicalcmpt.pdf>.

More recently we have had increased enforcement activity raising issues relating to market power when a hospital acquires physician practices. In those cases the anticompetitive problem stems from a large share of specialists in a particular practice area joining a single hospital, giving that hospital market power in that specialty area.<sup>32</sup> This can happen with or without the formation of an ACO.

In addition to hearing that our enforcement efforts run counter to the goals of the ACA – a notion I have hopefully dispelled – in many of these cases we hear claims that we do not fully consider quality improvements or medical technology when analyzing these transactions. Let me assure you that we take these arguments seriously and look closely at all evidence. Parties must provide good documentary evidence to support their arguments about quality improvement. Vague promises and aspirations that an acquisition will reduce costs and improve care are not sufficient.

Of course, there are limits on what antitrust enforcement can accomplish with respect to market power. Transactions that are below a certain dollar value level can be consummated before we have a chance to investigate. Once the assets are integrated, it can be hard to unscramble them, and anticompetitive harm can happen immediately. All this confirms the importance of your role in helping us prevent anticompetitive aggregations of market power by health care providers. I hope you will continue to let us know what is happening on the ground in your communities; our Bureau of Competition Health Care Division staff are always happy to hear from you. With your continued assistance, active enforcement of the antitrust laws can continue to play its critical role in realizing the benefits that Congress sought in promoting the creation of ACOs, and fostering competition in health care markets more generally.

Thank you.

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<sup>32</sup> See Federal Trade Commission and State of Idaho v. St. Luke's Health System, Ltd, and Saltzer Medical Group, Case No. 1:12-cv-00560-BLW-REB, Complaint For Permanent Injunction, dated March 12, 2013, *available at*: <http://www.ftc.gov/os/caselist/1210069/index.shtm>; In the Matter of Renown Health, FTC File No. 111 0101 (Consent Agreement), dated Aug. 6, 2012, *available at*: <http://www.ftc.gov/os/caselist/1110101/121204renownhealthdo.pdf>; Statement by FTC Bureau of Competition Director Richard Feinstein, concerning Providence Health & Services' Abandonment of its Plan to Acquire Spokane Cardiology and Heart Clinics Northwest, dated April 8, 2011, *available at*: <http://www.ftc.gov/opa/2011/04/providence.shtm>.