

Antitrust Enforcement in Health Care: Proscription, not Prescription

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It is a time of unprecedented change in the way health care services are provided and paid for in this country. These changes have prompted participants at all levels to reevaluate how health care is delivered and financed. As with other sectors of our economy that have experienced dramatic change, industry participants are reacting by developing new models, learning from their experiences, and adopting best practices. The agenda for this conference reflects the energy and innovation that are occurring in all facets of the health care industry, including, in particular, the creation and expansion of Accountable Care Organizations (ACOs).

It is hardly surprising that existing health care providers are reacting to market changes by adopting innovative methods of delivering their services. The FTC has seen this phenomenon in many of the industries we investigate. Sometimes we are told that antitrust has no role in rapidly evolving industries, but we disagree. Effective antitrust enforcement is as important in a time of dynamic change as in periods of stability, if not more so. The Commission's enforcement efforts help ensure that new and potentially more efficient ways of delivering and financing health care services can develop and compete, while preventing accumulations of market power that will injure consumers through reduced competition. By preventing anticompetitive mergers, as well as alliances and conduct that thwart competition, antitrust enforcement saves money that consumers, employers, and governments would otherwise spend on health care. In addition to these cost savings, preserving competition can help spur innovation that improves care and expands access.

The FTC's unique blend of enforcement, advocacy, and research makes us well-positioned to promote a competitive healthcare marketplace in the midst of change, something we believe is crucial to the success of on-going health care reform efforts. Yet while we can and do advocate for certain laws and policies, the FTC is primarily a law enforcement agency, not a regulatory body. The bulk of our resources dedicated to the competition mission are necessarily devoted to challenging anticompetitive transactions and conduct. We cannot design a collaboration or joint venture in ways that further what we think is best for competition; we take what is before us and decide whether it violates the antitrust laws. Only if it does can we seek a remedy to address the competitive harm.

It is critical to recognize that the integration of care provided to patients is fully compatible with core antitrust principles. Even before issuance of the joint FTC and DOJ *Health Care Statements* in the 1990s, but especially since, antitrust enforcers have made clear that there is no tension between rigorous antitrust enforcement and bona fide efforts to coordinate care, so

* The views expressed in this speech are my own and not necessarily those of the Commission or any Commissioner.

long as those efforts do not result in the accumulation of market power.¹ For instance, in a number of advisory opinions, FTC staff has concluded that arrangements to improve quality and control costs through clinical integration are unlikely to violate the antitrust laws.² The passage of the Affordable Care Act (ACA) has not altered the antitrust standard that would apply to similar collaborations designed to reduce costs and improve the quality of health care.³ Importantly, as Commissioner Brill recently noted, the ACA does not require providers to merge or consolidate and recognizes that ACOs may be formed through contractual arrangements that are well short of a merger.⁴

Collaboration designed to promote beneficial integrated care can benefit consumers. On the other hand, collaboration that eliminates or reduces price competition or allows providers to gain increased bargaining leverage with payers raises significant antitrust concerns. Antitrust concerns can arise if integration involves a substantial portion of the competing providers of any particular service or specialty, whether that market is a cluster of hospital services or a single specialty, like cardiac care.

In every investigation of health care provider transactions, we carefully consider evidence that the transaction will benefit consumers through improved quality, new services and/or decreased costs. We expect and encourage parties to provide us with concrete evidence to support their quality claims. We work closely with experts in the field to assess the arguments made by providers about improvements to quality of care.

¹ U.S. Dep't. of Justice & Fed. Trade Comm'n, Statements of Enforcement Policy in Health Care (1996), *available at* http://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf.

² *See, e.g.*, Letter from Markus H. Meier, Assistant Director, Bureau of Competition, Federal Trade Commission to Michael E. Joseph, McAfee & Taft (Feb. 13, 2013), *available at* http://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr_0.pdf; Letter from Markus H. Meier, Assistant Director, Bureau of Competition, Federal Trade Commission to Christi J. Braun, Ober, Kaler, Grimes & Shriver 8 (April 13, 2009), *available at* <http://www.ftc.gov/os/closings/staff/090413tristatealetter.pdf>; Letter from Markus H. Meier, Assistant Director, Bureau of Competition, Federal Trade Commission to Christi J. Braun & John J. Miles, Ober, Kaler, Grimes & Shriver 7 (Sept. 17, 2007), *available at* http://www.ftc.gov/sites/default/files/documents/public_statements/ftc-staff-will-not-recommend-antitrust-challenge-proposal-provide-member-physicians-services-through/070921finalgripamcd.pdf. In evaluating health care collaborations that claim likely efficiencies from clinical integration, FTC staff have focused on the programs' structural capabilities, systems, and processes for achieving such efficiencies, and the motivations and incentives for the participants to embrace the programs' goals.

³ *See* Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule, 76 Fed. Reg., 67,802, 67,841 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf> (“[C]ompetition in the marketplace benefits Medicare and the Shared Savings Program because it promotes quality of care for Medicare beneficiaries and protects beneficiary access to care . . . Competition among ACOs can accelerate advancements in quality and efficiency. All of these benefits to Medicare patients would be reduced or eliminated if we were to allow ACOs to participate in the Shared Savings Program when their formation and participation would create market power.”)

⁴ Remarks of Commissioner Julie Brill at 2014 Hal White Antitrust Conference, Competition in Health Care Markets, (June 9, 2014), *available at* http://www.ftc.gov/system/files/documents/public_statements/314861/140609halwhite.pdf.

We also recognize that providers want antitrust guidance to help them navigate the complex issues that arise in making business decisions in this evolving environment. In response, the Commission has undertaken a broad initiative to inform participants in health care markets about competition principles. Indeed, perhaps in no area of enforcement has the FTC provided as much detailed guidance as it has in health care. Consider the list: statements of enforcement policy such as the *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program* (ACO Policy Statement);⁵ seminal hearing and reports;⁶ extensive advisory opinions on a wide variety of topics;⁷ congressional testimony; speeches; amicus briefs detailing the application of antitrust law to health care conduct; press releases; blog posts; and advocacy in the area of state and local regulation.⁸ Just last month, the FTC convened a two-day public workshop to discuss cutting-edge issues in health care delivery such as telemedicine, advancements in health care technology, measuring and assessing health care quality, and price transparency of health care services.⁹

When we initiate litigation, we strive to be transparent about our reasons and the factual underpinnings of our cases. Beyond this formal, written guidance, our experts in health care competition appear at public events and respond to requests for informal guidance throughout the year. Market participants may not always agree with what we have to say, but our track record in providing guidance is difficult to dispute.

Today, I want to explain the FTC's approach to enforcement in health care markets. I will begin with an overview of how we examine ACOs and other collaborations. I will then explain the type of enforcement actions we bring to prevent collaborations that create or enhance market power. Next, I will turn to two defenses we often hear -- that a collaboration will result in efficiencies or is necessary because the acquired entity is struggling financially. Finally, I will discuss remedies and explain why we prefer structural rather than conduct remedies.

⁵ Fed. Trade Comm'n & Dep't of Justice, *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, 76 Fed. Reg. 67026 (Oct. 28, 2011) [hereinafter "ACO Policy Statement"].

⁶ Fed. Trade Commission and Dep't of Justice, *Improving Health Care: A Dose of Competition* (2004), *available at* <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>.

⁷ Health Care Division, Bureau of Competition, *Topic and Yearly Indices of Health Care Antitrust Advisory Opinions by Commission and Staff* (Mar. 2013), *available at* <http://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/indexadop.pdf>.

⁸ Materials related to the Commission's competition health care work is compiled online at <http://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care>.

⁹ *Examining Health Care Competition*, materials *available at* <http://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition>.

The Antitrust Treatment of ACOs and Other Health Care Collaborations

The antitrust laws treat collaborations among health care providers that are bona fide efforts to create legitimate, efficiency-enhancing joint ventures¹⁰ differently from the way they treat price fixing schemes. As stated in the joint FTC and DOJ ACO Policy Statement:

The antitrust laws treat naked price-fixing and market allocation agreements among competitors as per se illegal. Joint price agreements among competing health care providers are evaluated under the rule of reason, however, if the providers are financially or clinically integrated and the agreement is reasonably necessary to accomplish the procompetitive benefits of the integration.¹¹

The Commission asks several threshold questions when reviewing provider collaborations. Does the proposed arrangement offer the potential for pro-consumer cost savings or quality improvements in the provision of health care services? Is there bona fide integration or is this simply a mechanism to enhance leverage with payers through joint negotiation? Even if there is bona fide integration, are any price or other agreements among participants regarding the terms on which they will deal with health care insurers reasonably necessary to achieve the benefits of the collaboration? If the answer to these questions is “yes,” then the collaboration is not considered a per se illegal agreement, but rather is evaluated under a rule of reason standard, which assesses whether the likely effect of the collaboration will be to benefit or harm competition and consumers.

The rule of reason analysis applied to provider collaborations generally follows the same framework contained in the *Horizontal Merger Guidelines*:¹² defining relevant product and geographic markets, identifying market participants, calculating market shares and concentration, considering the likelihood of expansion by existing players or entry by new players and determining whether efficiencies will likely result. Because the collaboration does not result in the full integration of a merger, additional factors will be considered, including whether the individual members may continue to compete independently, and what other alternatives are available to customers of the joint venture. We also look at the purpose of the agreement, but I want to caution that even the best intentions will prove insufficient if the combination is likely to have anticompetitive consequences. Ultimately, we make a determination as to whether a particular agreement, on balance, benefits consumers or is likely to diminish quality, reduce output, or increase price.

Our analysis of ACOs is similar to our analysis of joint ventures in any market. As explained in our ACO Policy Statement, the FTC and DOJ will apply a rule of reason analysis to any ACO that (i) meets eligibility standards for, and participates in, the Shared Savings Program

¹⁰ Terms such as joint venture and collaboration are used interchangeably throughout this speech. These terms do not refer to any particular corporate structure.

¹¹ ACO Policy Statement, *supra* note 5, at 67030-31.

¹² Dep't. of Justice & Fed. Trade Comm'n, 2010 Horizontal Merger Guidelines [hereinafter HMG], *available at* <http://www.ftc.gov/os/2010/08/100819hmg.pdf>.

(SSP) established by the Centers for Medicare and Medicaid Services and (ii) uses the same governance and leadership structures and clinical and administrative processes it uses in the SSP to serve patients in commercial markets. The antitrust agencies determined that the eligibility standards are broadly consistent with the indicia of clinical integration identified in prior antitrust advisory opinions dealing with clinical integration by health care providers,¹³ and are likely to signal bona fide arrangements intended to improve quality and reduce costs of medical care provided by the group. Coupled with CMS monitoring in terms of cost, utilization, and quality, the FTC and DOJ determined that it was appropriate to treat joint negotiations with private payers by ACOs meeting SSP standards as reasonably necessary to the ACOs' primary purpose of improving health care delivery, and therefore afford them rule of reason treatment. Newly-formed ACOs can also request voluntary expedited review to obtain additional antitrust guidance.

To further clarify likely antitrust treatment for any ACO that also provides care to commercially insured patients, the agencies set out a safety zone for certain ACOs that are highly unlikely to raise significant competitive concerns. The safety zone is based on a key issue in antitrust analysis: market shares. As in other industries, market shares can be useful as a screening device for identifying those provider combinations that are unlikely to raise competitive concerns. And because health care is provided to patients near where they live and work, market shares are calculated for local geographic markets.¹⁴ In addition, the availability of the safety zone may differ for those ACOs that permit providers to participate on a non-exclusive basis, for those operating in a rural area, and for those that include a dominant provider. Even when an ACO does not fall within a safety zone, the agencies may nevertheless determine that the creation of that ACO is nonetheless procompetitive and lawful. This will occur where the ACO is not likely to impede the functioning of a competitive market. For example, an ACO that falls outside the safety zone may not raise competitive concerns where meaningful alternatives exist for patients and payers when considering network options. These meaningful alternatives may exist where there are competing providers not affiliated with the ACO, or where providers participating in the ACO are non-exclusive and able to contract directly with payers and/or participate in other ACOs. Moreover, even if an ACO does raise potential anticompetitive concerns, those concerns may be outweighed by the ACO's likely procompetitive efficiencies, and therefore be deemed lawful.

On the other hand, certain ACO design features or behavior may raise red flags for the antitrust agencies, especially for ACOs coupled with high market shares or other indicia of market power: (1) preventing payers from steering patients to certain providers; (2) tying sales of the ACO's services to the private payer's purchase of other services from providers outside the ACO; (3) requiring exclusivity that discourages providers from contracting with payers outside the ACO; and (4) restricting a payer's ability to make available to enrollees information on cost, quality, efficiency, and performance. These types of conduct, in combination with high market shares, may prevent private payers from obtaining lower prices and better quality service for their enrollees. Additionally, regardless of market share, the sharing of competitively sensitive

¹³ See letters *supra* note 2.

¹⁴ As the ACO Policy Statement notes, the geographic areas used to calculate ACO shares may not necessarily constitute a relevant geographic market for antitrust purposes. ACO Policy Statement, *supra* note 5, at 67028.

information among ACO participants that threatens or leads to price fixing or other collusion for competing services provided outside the ACO raises significant antitrust concerns.

Based on information available from CMS, there are about 250 or 300 Medicare Shared Savings Program ACOs, and several hundred more commercial-only ACOs. Only two ACOs have requested antitrust review of their operations.¹⁵ To date, the FTC has not opposed the formation of an ACO, or taken any enforcement action against an ACO. Nor have we received complaints that might warrant further inquiry. As a result, we are confident that antitrust concerns are not preventing the formation of beneficial ACOs. The FTC continues to work closely with CMS and DOJ to offer guidance and monitor the market for developments.

The Commission's enforcement actions against other provider collaborations provide further detail on how we analyze collaborations among health care providers.

Merger enforcement to prevent collaborations that create or enhance market power

Much has been written about the ongoing wave of provider consolidation in health care markets. A growing body of literature suggests that providers with significant market power can negotiate higher-than-competitive payment rates.¹⁶ In a recent article, Professor Martin Gaynor, the current Director of the Bureau of Economics, points to economic research that shows that higher concentration in hospital markets leads to significantly higher prices.¹⁷ Studies have shown price increases as high as 40% as a result of a system acquiring a competing hospital.¹⁸ Professor Gaynor contends that because the United States has a market-based health care system, it is critical that health care markets are sufficiently competitive that firms have incentives to innovate and act as an effective vehicle for reform initiatives. He explains that as an antitrust enforcer, the FTC has an important role to play in preserving competition in markets where it exists today:

The challenge of finding effective policies for dealing with highly concentrated markets underscores the importance of active antitrust enforcement. Preventing harmful consolidation ex ante is far more

¹⁵ Fed. Trade Comm'n & U.S. Dept. of Justice, ACO Working Group Summary of Activities Following Issuance of the Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (Apr. 10, 2013) 2, *available at* <http://www.ftc.gov/sites/default/files/attachments/accountable-care-organizations/mssp-summary.pdf>.

¹⁶ *See, e.g.*, Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power* (Center for Studying Health System Change, Research Brief No. 16, 2010), *available at* <http://www.hschange.com/CONTENT/1162/>.

¹⁷ Martin Gaynor, *Competition Policy in Health Care Markets: Navigating the Enforcement and Policy Maze*, 33 HEALTH AFF. 1088 (June 2014).

¹⁸ *See, e.g.*, Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, INT'L J.L ECON. OF BUS., 65-82 (2011).

effective at promoting efficiency and protecting consumers than is trying to deal with the consequences *ex post*, once it has occurred.¹⁹

In light of concerns about the potential anticompetitive consequences of provider consolidation, the FTC has acted to stop mergers where the evidence shows that they are likely to lead to higher prices or reduced quality. Beginning with the *Evanston* case in 2007, the FTC has successfully challenged three hospital mergers,²⁰ and a number of transactions have been abandoned after the FTC threatened a challenge.²¹ Not surprisingly, many of our enforcement actions have concerned markets with a small number of providers. Areas where the number of providers decreases from 4-to-3, 3-to-2 and especially 2-to-1 are the most vulnerable to anticompetitive effects.

The Commission's recent Sixth Circuit victory in *ProMedica* concerns the type of hospital transaction that creates antitrust problems. In the first appellate review in over 15 years of an FTC enforcement action against a hospital transaction, the Sixth Circuit upheld the Commission's decision to undo ProMedica Health System's acquisition of its rival, St. Luke's hospital.²² The proposed merger would have given ProMedica, already the largest hospital system in the Toledo, Ohio area, more than half the market for general acute care hospital services and over 80% of the market for inpatient obstetrics services. The Sixth Circuit noted that in the Toledo market, a hospital's market share correlated closely with price, reflecting market power, but that price, at least in the case of ProMedica, did not correlate with higher quality. The court concluded that the high combined market share, and St. Luke's location in the affluent southwestern Toledo suburbs, would have made ProMedica a "must have" for area insurers and left them with virtually no ability to walk away from the merged firm. Party documents supported this conclusion, including many indicating that St. Luke's management saw the acquisition leading to higher prices by increasing its "negotiating clout" over insurers.

The combination of physician practices was at issue in the Commission's and the State of Idaho's successful challenge to the acquisition by St. Luke's Health System of Saltzer Medical

¹⁹ Gaynor, *supra* note 17, at 3.

²⁰ Opinion of the Comm'n, *In the Matter of Evanston Northwestern Healthcare Corp.*, Docket No. 9315, Aug. 6, 2007, *available at* <http://www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf>; *ProMedica Health Sys. v. FTC*, 749 F.3d 559, 2014 WL 1584835, at 5 (6th Cir. Apr. 22, 2014); *Fed. Trade Comm'n v. OSF Healthcare System & Rockford Health Sys.*, No. 3:11-cv-50344 (N.D. Ill. 2012), *available at* www.ftc.gov/sites/default/files/documents/cases/2012/04/120505rockfordmemo.pdf.

²¹ *In the Matter of Inova Health System Foundation and Prince William Health System, Inc.*, Docket No. 9326, (Order Dismissing Complaint), 2008, *available at* www.ftc.gov/sites/default/files/documents/cases/2008/06/080617orderdismisscmpt.pdf; *In the Matter of Reading Health System and Surgical Institute of Reading*, Docket No. 9353 (Order Dismissing Complaint), 2012, *available at* <http://www.ftc.gov/sites/default/files/documents/cases/2012/12/121207readingsircmpt.pdf>; Statement of Bureau of Competition Director Richard Feinstein on announcement by Capella Healthcare that it will abandon its plan to acquire Mercy Hot Springs, (June 27, 2013), *available at* <http://www.ftc.gov/news-events/press-releases/2013/06/statement-ftc-competition-director-richard-feinstein-todays>.

²² *ProMedica Health System, Inc. v. FTC*, No. 12-3583 (6th Cir. Apr. 22, 2014). ProMedica filed for rehearing and en banc review on June 3, 2014.

Group in Nampa, Idaho.²³ St. Luke's, the state's dominant health system, had a large number of employed primary care physicians from prior acquisitions, including eight primary care physicians in Nampa. St. Luke's acquired 16 primary care physicians practicing in Nampa from Saltzer. The Commission alleged that St. Luke's 80% post-acquisition market share gave it the ability to demand higher rates for adult primary care physician services in Nampa, Idaho's second-largest city. Although those prior acquisitions involving Nampa-area physicians gave St. Luke's greater bargaining power, payers had been able to resist at least some of St. Luke's demands because of the presence of an alternative provider, Saltzer. We alleged, and the Court agreed, that St. Luke's acquisition of Saltzer eliminated that remaining competitive option and would have led to higher prices for physicians services.²⁴

While the private plaintiffs challenged the transaction under a vertical theory,²⁵ that is, based on the combination of providers at different levels, providing complementary, not competing, products and services, the Commission's challenge was based strictly on a horizontal theory. Indeed, antitrust challenges by the federal antitrust agencies based on vertical theories of harm are rare.²⁶ That said, a vertical provider transaction could raise concerns, e.g., if a hospital acquired so many physicians in a particular specialty that a competing hospital would be unable to provide that service because it lacks access to the needed physicians. The viability of such a theory would depend, in part, on entry: could the foreclosed hospital obtain the services of physicians not presently in the market? Further, in a vertical transaction, we would ask not only whether another hospital would be harmed, but whether competition as a whole would be harmed from the foreclosure. While we are attentive to the possibility of a transaction leading to vertical foreclosure, we have not yet challenged a purely vertical merger involving a hospital and a physician practice.

²³ *FTC and State of Ohio v. St. Luke's Health Sys., Ltd.*, Case No. 1:13-CV-00116-BLW (D. Idaho Jan. 24, 2014).

²⁴ *St. Luke's Health Sys., Ltd.*, 1:13-CV-00116-BLW, Memorandum Decision and Order 3 (Jan. 24, 2014). (On March 4, 2014, St. Luke's and Saltzer appealed the court's order to unwind the existing relationship and requested a stay pending the appeal.) A similar concern arose in the Commission's action against the consummated acquisition of outpatient clinics in Roanoke, Virginia. *In the Matter of Carilion Clinic*, Dkt. 9338 (complaint Jul. 24, 2009), available at <http://www.ftc.gov/enforcement/cases-proceedings/0810259/carilion-clinic-corporation-matter>. Carilion Clinic provided a broad set of outpatient services. It acquired two outpatient clinics in Roanoke, VA. These were physician-owned outpatient centers, developed in part to compete against Carilion for the provision of outpatient services. The FTC alleged that it would reduce the number of competitors in outpatient imaging and surgery services from three to two and allow Carilion to exercise market power. The parties settled the complaint by divesting the previously acquired clinics.

²⁵ The court found it unnecessary to address that issue. "The Court need not resolve the issues raised by the private plaintiffs because the Acquisition is being unwound due to its effects in the Nampa market for primary care physician services." *St. Luke's Health Sys., Ltd.*, 1:13-CV-00116-BLW, Findings of Fact & Conclusions of Law 50 (Jan. 24, 2014).

²⁶ In the past 30 years, the FTC has sometimes relied on a vertical theory of harm in health care matters, in each case involving concerns about pricing of prescription pharmaceuticals. *See, e.g., In the Matter of Fresenius Medical Care*, Dkt. C-4236 (Oct. 20, 2008) (merger between owner of dialysis clinics and supplier of key intravenous iron drug would give merged firm ability to drive up drug price); *In the Matter of Merck & Co.*, 127 F.T.C. 156 (1999) (acquisition of pharmacy benefits manager would give drug maker ability to favor its drugs in the PBM formulary); *In the Matter of Eli Lilly*, 120 F.T.C. 243 (1985) (same).

I should note that management contracts whereby one hospital manages another hospital with which it also competes may raise concerns similar to horizontal acquisitions. These arrangements can be procompetitive if they create cost savings, quality improvements or other efficiencies. They could also be problematic, if a single entity negotiates price on behalf of both hospitals, or if the arrangement involves two of only a few competing hospitals in a market and enhances the likelihood of anticompetitive conduct. Although we have not challenged such conduct to date, we would take appropriate action if we find that such arrangements are likely to diminish competition.

Nevertheless, while we have been very concerned about certain collaborations, the Commission challenges very few provider collaborations. Over the last decade, we have challenged less than 1% of hospital deals, and we brought those challenges only after rigorous analysis of market conditions showed that the acquisition was likely to substantially lessen competition.²⁷ Similarly, we have brought only three challenges to physician combinations,²⁸ though we continue to investigate such transactions on a regular basis as well.

For every transaction that we challenge, there are many more that we determine do not warrant a challenge. In most cases, we do not make public our decisions not to take action against a particular arrangement because of confidentiality concerns. We recognize, however, that it is helpful for the public to understand the facts and reasoning that led us to close an investigation. Where possible, the Commission issues closing statements to explain the basis for its decision.²⁹ We also use opportunities, such as this speech, to explain our decision-making.

Often, the competitive analysis reveals that the transaction would eliminate only limited competition. For example, staff originally had concerns about a proposed merger of a large medical center and a community hospital 40 miles away, based on initial indications that the hospitals competed and the combined entity would have a high market share for inpatient hospital services in the relevant geographic area. However, a several-month investigation, which included interviews with payers, employers, other hospitals, and community members, led us to conclude that the hospitals did not, in fact, engage in significant head-to-head competition.

²⁷ From 2002 to 2012, the Commission challenged six hospital mergers out of 970 total hospital transactions, less than one percent. See Presentation by Greg Koonsman, CFA, Senior Partner, VMG Health, “Analyzing the Health System Market”, at 24 (Oct. 24, 2013), available at <http://www.vmghealth.com/Downloads/BeckerASCKoonsman2013.pdf>.

²⁸ In addition to St. Luke’s, the FTC challenged the combination of OSF Healthcare System and Rockford Health System, alleging that the transaction threatened harm to competition in the market for primary care physician services as well as for general acute-care inpatient services. *In the Matter of OSF Healthcare System and Rockford Health System*, Docket No. 9349 (Complaint) Nov. 18, 2011, available at <http://www.ftc.gov/enforcement/cases-proceedings/1110102/osf-healthcare-system-rockford-health-system-matter>. The Commission also challenged the acquisition of two cardiology groups by Renown Health, the largest provider of acute care hospital services in northern Nevada, alleging a reduction in competition for the provision of adult cardiology services in the Reno area. *In the Matter of Renown Health*, Docket No. C-4366 (Decision & Order) Aug. 6, 2012, available at <http://www.ftc.gov/enforcement/cases-proceedings/1110101/renown-health-matter>.

²⁹ See, e.g., Dep’t of Justice & Fed. Trade Comm’n, Commentary on the Horizontal Merger Guidelines 10 (2006), available at <http://www.ftc.gov/sites/default/files/attachments/merger-review/commentaryonthehorizontalmergerguidelinesmarch2006.pdf>.

Specifically, the medical center was operating near full capacity, and thus often declined transfers from other hospitals and did not actively seek new patients through price competition. Moreover, the hospitals had previously entered into a collaborative relationship: the medical center's surgeons performed cardiac surgery at the community hospital as part of a program to address capacity constraints at the medical center and provide high-quality care locally at lower costs.

Another investigation we closed involved a combination of a health care system with a large teaching hospital that was less than 10 miles from the nearest system hospital. While the merger involved hospitals that were located relatively close to each other, there were dozens of other hospitals within 20 miles and patients also traveled to a nearby city to obtain care at large academic medical centers. We also looked at patient flow data which showed that the hospitals were not particularly close competitors. On this basis, combined with a lack of concern from major health plans, we chose not to challenge the transaction.

Despite the fact that we have brought limited enforcement actions, virtually always with the support of the local community, some argue that antitrust uncertainty chills procompetitive collaboration and that special antitrust treatment is justified for provider mergers. Proposals pending in several states and before Congress would attempt to counter perceived payer market power by allowing joint physician negotiations or would allow health agencies to exempt provider transactions from antitrust scrutiny.³⁰ As Chairwoman Ramirez noted last month,³¹ the FTC generally opposes exemptions to the antitrust laws because they typically result in higher prices and reduced quality.³² Because procompetitive collaboration is already permitted under the antitrust laws, the primary effect of bills granting immunity would be to encourage the type of collective negotiations unlikely to pass muster under the antitrust laws, resulting in consumer harm.³³

³⁰ See H.R.4077, Quality Health Care Coalition Act of 2014, 113th Cong. (2014) (exempts certain health care professionals from federal and state antitrust laws in connection with negotiations with a health plan).

³¹ Remarks of Chairwoman Edith Ramirez on The FTC and Evolving Health Care Provider Markets at AHLA and ABA Antitrust in Health Care Conference (May 13, 2014), available at <http://www.ftc.gov/news-events/speeches>.

³² See, e.g., FTC Staff Comment to Senator John J. Bonacic Concerning New York S.B. 3186-A to Allow Health Care Providers to Negotiate Collectively with Health Plans (Oct. 2011), available at <http://www.ftc.gov/policy/policy-actions/advocacy-filings/2011/10/ftc-staff-comment-honorable-john-j-bonacic-concerning>. The FTC also engages in advocacy to encourage policymakers to adopt only those limits on scope of practice or additional professional licensure requirements that are justified by concerns about patient health or safety. Even well intentioned laws and regulations may impose unnecessary, unintended, or overbroad restrictions on competition, thereby depriving health care consumers of the benefits of vigorous competition. Rigid statutory requirements can increase health care costs and prices, needlessly constrain innovation in health care delivery, and exacerbate well-documented provider shortages. Fed. Trade Comm'n Staff, *Policy Perspectives: Competition and Regulation of Advance Practice Nurses* (Mar. 2014), available at <http://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf>. We thus urge policymakers to view competition and consumer safety as complementary objectives, and to integrate consideration of competition into their deliberations.

³³ We are not alone in this view. Some states – like Connecticut – are requiring greater reporting of provider transactions to the state to allow them to examine the antitrust consequences. See An Act Concerning Notice of Acquisitions, Joint Ventures, Affiliations of Group Medical Practices and Hospital Admissions, Medical

What Counts as an Efficiency Claim?

When assessing a transaction's likely competitive effect, we worry about market power -- because that is the source of the power to raise prices -- but also analyze efficiencies. Merging hospitals often claim their combination will produce significant efficiencies, such as improved quality of care, avoidance of capital expenditures, consolidation of management and operational support jobs, consolidation of specific services to one location (e.g., all cardiac care at Hospital A and all cancer treatment at Hospital B), and reduction of operational costs, such as purchasing and accounting costs. Efficiencies may enhance a merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products.

Under the Horizontal Merger Guidelines, efficiencies must meet several criteria to be credited.³⁴ First, they must be merger-specific in that they could not likely be accomplished in the absence of the merger. Second, they must not be vague or speculative. Finally, they must be cognizable, by which we mean the efficiencies are verified and do not arise from anticompetitive reductions in output. If merger-specific cognizable efficiencies are of a character and magnitude such that the merger is not likely to be anticompetitive, the Commission is unlikely to challenge the transaction.

In assessing quality arguments, we examine a variety of evidence. We look at the comparative quality of the hospitals merging. If the acquired hospital already has strong quality measurements comparable to those of the acquiring hospital, we may question the ability of the acquiring hospital to improve those metrics. If the acquiring hospital has made prior acquisitions, we will want to see whether those mergers resulted in quality improvements. The parties must explain more than just the processes and practices that the acquiring hospital system can transfer to an additional hospital; they need to address the specifics of how those processes and practices will benefit patients through improved care. In addition, we also want to understand why the acquired hospital could not improve its quality without a merger with this particular acquirer. Ultimately, given that competition spurs competitors to innovate, we will want to understand why a reduction in competition will enhance rather than diminish those incentives.

Another question sometimes raised is how we balance the possibility and magnitude of a price increase against the possibility and magnitude of efficiencies. In cases where the parties argue that efficiencies will lower costs, we can predict the likely overall effects of a transaction on prices. However, it is more difficult to determine how best to balance a possible price increase on the one hand and a quality improvement on the other hand. To date, however, that is not something we have found necessary to do. In the handful of transactions we have challenged, we have determined that the quality improvements were speculative, not substantiated and/or the merger was not necessary to achieve them.

Foundations and Certificates of Need, Conn. Pub. Act No. 14-168 (Effective Oct. 1, 2014). According to the Bill Summary, the Attorney General must maintain and use the information submitted to him as part of his antitrust investigation and enforcement capability, *available at*

http://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=35&which_year=2014.

³⁴ HMG § 10.

Efficiencies analysis was a key issue in the FTC’s recent challenge to St. Luke’s acquisition of 41-member Saltzer Medical Group. The parties claimed that the acquisition was necessary to advance their effort to transform health care from a fragmented, fee-for-service model that rewards providers based on volume, to a financially and clinically integrated, risk-based system rewarding successful patient outcomes. Such a system could only succeed, they claimed, if the hospital employed a critical mass of doctors.

While we recognized the benefits of coordination and the efficiencies it could generate, there was no persuasive evidence that a merger was needed to generate those efficiencies. As we argued at trial, the evidence did not show that employing physicians is necessary to achieving integrated care.³⁵ For example, shared access to electronic medical records that St. Luke’s cited as a central benefit of the transaction can be achieved without an employment relationship or merger. In fact, as the trial got underway, St. Luke’s itself was in the process of developing and implementing a program providing non-affiliated physicians access to its EMR system. And there are many different ways, short of consolidation, for hospitals to ensure that independent physician practices are aligned with the hospital’s aims, including patient protocols and financial incentives for meeting specified quality goals.

After 34 days of trial, the federal district court in Boise held that St. Luke’s acquisition of Saltzer would substantially lessen competition and ordered a divestiture. While the court acknowledged that moving toward more integrated care and the greater use of electronic medical records can improve patient outcomes, it found that those goals could be achieved in ways other than the acquisition of a physician practice group which created a substantial risk of higher prices. The court emphasized “St. Luke’s is to be applauded for its efforts to improve the delivery of health care in Treasure Valley. But there are other ways to achieve the same effect that do not run afoul of the antitrust laws and do not run such a risk of increased costs.”³⁶

What Counts as a Failing Firm/Financial Health Claim?

In addition to efficiencies defenses, parties often raise failing firm arguments. Specifically, they argue that an acquired hospital is experiencing financial difficulties and its acquisition by a financially stronger hospital is necessary to keep it open. Under the Merger Guidelines, a company can assert what is known as a “failing firm” defense only if (i) the company is unable to meet its obligations as they come due; (ii) would not be able to organize successfully in bankruptcy; and (iii) it has made unsuccessful good-faith efforts to elicit reasonable alternative offers that would keep its assets in the relevant market and pose a less

³⁵ St. Luke’s Health Sys., 1:13-CV-00116-BLW, Plaintiffs’ Amended Corrected Proposed Facts and Conclusions of Law, 72 – 123.

³⁶ St. Luke’s Health Sys., 1:13-CV-00116-BLW, Memorandum Decision and Order at 3 (Jan. 24, 2014). On March 4, 2014, St. Luke’s and Saltzer appealed the court’s order to unwind the existing relationship and requested a stay pending the appeal.

severe danger to competition than does the proposed merger.³⁷ The case law also sets stringent requirements for meeting the failing firm defense.³⁸

In the FTC's successful challenge to the ProMedica/St. Luke's transaction, one of the parties' primary defenses was that St. Luke's was a "flailing firm," i.e., St. Luke's did not meet the strict definition of a failing firm but its financial condition was so weakened that its future competitive significance was limited and overstated by its current market share. The Commission did not credit the "flailing" firm argument. It found that, contrary to the parties' contention, St. Luke's market share was rising prior to the merger and that its financial condition was improving.³⁹ The Sixth Circuit, like the Commission, rejected the argument, commenting that the flailing firm defense is the "hail Mary pass" of "presumptively doomed mergers."⁴⁰

In contrast, in 2009, the Commission voted to close its investigation of Scott & White Healthcare's merger with King's Daughters Hospital in Temple, Texas after the parties raised a *failing* firm defense. In a transaction that did not require premerger notification under the Hart-Scott-Rodino Act, Scott & White merged with King's Daughters. A statement from the Bureau of Competition explained that although King's Daughters had experienced financial deterioration at the time of the transaction, it was still an important provider of hospital services, and the merger eliminated the only independent competitor to Scott & White in Bell County, Texas.⁴¹ Further, Scott & White planned to turn King's Daughters into a freestanding children's hospital rather than continue to serve the Temple community as a general acute care hospital. However, evidence showed that the poor, and deteriorating, financial condition of King's Daughters likely would have caused the hospital to close at some point in the future if it was not acquired by another hospital or health system. A central issue in the investigation, therefore, was whether an alternative purchaser existed at the time of the merger that might have acquired King's Daughters and maintained it as a general acute care hospital in direct competition with Scott & White.

During the investigation, staff learned that another hospital system, the Seton Family of Hospitals (Seton), may have been interested in acquiring King's Daughters, but that its opportunity to acquire the hospital was unnecessarily cut short by the agreement between King's Daughters and Scott & White. In order to ensure that all competitive options were explored, staff and the parties agreed in writing that Scott & White would offer to sell King's Daughters to Seton on specific terms relating to the continued operation of King's Daughters as a general acute care hospital. After conducting due diligence, Seton decided not to acquire King's

³⁷ HMG § 11.

³⁸ See, e.g., *Citizens Publishing v. United States*, 394 U.S. 131, 138-39 (1969)(citing *Int'l Shoe Co. v. FTC*, 280 U.S. 291, 302 (1930); *FTC v. Harbour Grp. Invs.*, 1990 U.S. Dist. LEIX 15542 (D.D.C. 1990).

³⁹ In the Matter of ProMedica Health Sys. Inc., Docket No. 9346 (Commission Opinion) 29-34, June 25, 2012, available at <http://www.ftc.gov/sites/default/files/documents/cases/2012/06/120625promedicaopinion.pdf>.

⁴⁰ ProMedica Health Sys., Inc., No. 12-3583 at 18.

⁴¹ Statement of Bureau of Competition Director Richard Feinstein on the FTC's Closure of Its Investigation of Consummated Hospital Merger in Temple, Texas (Dec. 23, 2009), available at <http://www.ftc.gov/public-statements/2009/12/ftcs-closure-its-investigation-consummated-hospital-merger-temple-texas>.

Daughters. Without a viable alternative purchaser for King's Daughters, staff closed its investigation.

The Commission has closed without comment other investigations that raise similar concerns about the financial health of the acquired hospital, even when the facts would not support a strict "failing firm" defense as set forth in the Guidelines. For instance, although a struggling hospital may have sufficient cash reserves to fund operations and its revenues cover expenses in the short term, the evidence may show that the hospital lacks sufficient reserves to make identified capital improvements, resulting in declines in its competitive significance. To evaluate parties' claims, staff relies on documents, interviews with payers, and evidence of a hospital's financial struggles such as staff layoffs, closed service lines, declining inpatient admissions and outpatient procedures, declining revenues and increased losses, compromised (or potentially compromised) quality, or downgraded credit scores from the rating agencies. In these situations, we often hear that the struggling hospital has not been able to compete, is not likely to be able to improve its competitive offerings, and is no longer a meaningful factor when payers consider network options due to concerns about long-term viability. In these cases, many payers would prefer to see the acquisition occur so the struggling hospital can stay in the market rather than face the prospect of the hospital shutting its doors.

I would caution though that only in limited circumstances will we conclude that the poor financial health of a hospital means that it has limited competitive significance. A mere revenue decrease attributable to changes in the local employment market or the need for increased funds for a significant capital improvement will not be sufficient to show that the hospital will cease to be competitively significant. Moreover, while we often hear that the proposed acquirer is the only interested party, we have seen that other suitors emerge once a given transaction becomes public. We also want to see what efforts a hospital has made to turn around its financial condition before deciding to merge with a competitor. While we are sympathetic to the challenges that health care providers face in adjusting to new market forces, we will continue to assess each merger on the facts before us, including those relating to arguments that a hospital is failing or "flailing."

A Preference for Structural Remedies

Once we have determined that a proposed combination is problematic, our preferred remedy is that the combination be abandoned, or, if it has already been consummated, that one of the competitors to the combination be divested. Thus, in *St. Luke's*, we requested and the Court ordered divestiture of Saltzer. In *ProMedica*, the Commission ordered divestiture of St. Luke's and the Sixth Circuit upheld that order. And in *Carilion*, the parties agreed to divest the two outpatient clinics they acquired. The goal is to restore, to the extent possible, the competitive state prior to the acquisition.

It may appear that the Commission brings challenges against hospital deals more often than deals in other sectors. That likely is because most proposed hospital acquisitions involve the acquisition of a single facility, rendering a partial divestiture impossible. Occasionally, however, we are presented with a merger between hospital chains raising competitive concerns in only a handful of geographic markets. In those cases, we require divestitures only in those localities where the merging parties both have facilities and the merger would have an

anticompetitive effect. For example, this year the Commission accepted a consent agreement to resolve concerns stemming from the proposed merger of two nationwide hospital systems, Community Health Systems and Health Management Associates.⁴² Although the merger involved hospitals in numerous regions, the settlement required CHS to sell only two HMA hospitals -- the Riverview Regional Medical Center in Gadsden, Alabama, and the Carolina Pines Regional Medical Center in Hartsville, South Carolina -- to Commission-approved buyers. This is noteworthy because this is the first time since 1997 that the Commission has entered into a consent agreement to settle charges that a general acute care hospital merger was anticompetitive.

While parties in provider transactions often urge adoption of conduct remedies, the Commission generally rejects such requests.⁴³ Conduct remedies do not restore the competitive status quo and raise several concerns. They are an inferior substitute for allowing competition among separately owned providers to determine market behavior. For example, providers may seek a consent agreement in which they promise not to raise prices above some metric, such as an inflation index or a certain pre-determined percentage. But is that level what the competitive price would have been absent the transaction? Competitive pressures might have caused prices to be lower. Or prices may have increased over time, while simultaneously allowing the provider to invest in equipment and facility improvements, thus benefiting consumers. In addition, conduct remedies are often overly regulatory, requiring the Commission to monitor the parties' behavior. For instance, if parties promise not to increase prices above the level of inflation each year, how do we measure the appropriate provider price when services offered may be changing? And what happens at the end of the consent decree? What then keeps the parties from increasing prices, even to the point of recouping lost profits for all the years they were under decree? Additionally, parties' offers of conduct remedies are often premised on the idea that we need to allow the transaction to proceed to achieve the benefits of the transaction. As St Luke's shows, however, there are often ways short of a full merger to achieve the benefits of increased coordination. We should be hesitant, therefore, to forego structural relief in provider combinations.

Moreover, proposed conduct remedies nearly always focus on price, ignoring the impact of a transaction on quality improvements or innovation. But crafting conduct remedies to maintain quality competition and incentives to innovate raises its own set of issues. The Commission is reluctant to attempt to regulate the level of quality a hospital must maintain, the

⁴² *In the Matter of Community Health Systems and Health Management Associates*, Docket No. C-4427 (Complaint Jan. 22, 2014), available at <http://www.ftc.gov/enforcement/cases-proceedings/131-0202/community-health-systems-health-management-associates-matter>.

⁴³ The Commission did accept a conduct remedy in its challenge to the combination of the Evanston and Highland Park hospitals. See Opinion of the Comm'n on Remedy, *In the Matter of Evanston Northwestern Healthcare Corp.*, Docket No. 9315, Aug. 28, 2008, available at <http://www.ftc.gov/enforcement/cases-proceedings/0110234/evanston-northwestern-healthcare-corporation-enh-medical-group>. Rather than requiring divestiture, it allowed the merged hospitals to establish separate contracting teams to negotiate with health plans and gave health plans the option to negotiate with the hospitals separately or jointly. At the time, the Commission noted the unique circumstances of the case—specifically, that the hospitals had consummated their merger seven years earlier, significant integration had occurred, and that a divestiture could risk patient safety at Highland Park, particularly with respect to cardiac services. See *id.*, (Commission Opinion), Aug. 6, 2007 at 89–91. We have repeatedly rejected this sort of conduct remedy since.

way in which it should make capital improvements, and the like. Yet a remedy focused only on price risks denying consumers the benefits of non-price competition.⁴⁴

Conclusion

We continue to hear claims that antitrust principles are at odds with the mandates of the Affordable Care Act. I believe these arguments misunderstand the focus and intent of federal antitrust enforcement. The antitrust laws have stood the test of time precisely because they do not mandate any particular behavior or way of doing business. Stated simply, there is no “approved way” to compete. Conversely, there is no laundry list of infractions that could automatically undermine a business arrangement. Congress specifically rejected the idea of creating a list of business “don’ts,” opting for general language that would develop in the common law tradition. The wisdom and foresight of this approach can be seen in the myriad ways the antitrust laws have adapted to changes throughout the American economy for more than 100 years. The antitrust laws do not prescribe certain behavior or business models; rather, the antitrust laws proscribe behavior that, on the whole, reduces consumer welfare.

In the final analysis, our actions make clear the important role of antitrust in health care policy. Ultimately, we believe that the imperatives of developing lower cost, higher quality health care can coexist with continued enforcement of the antitrust laws. For those involved in an existing ACO, or those interested in joining one, there are many lessons to be gleaned from the FTC’s competition work in health care markets, including those in which the agency determined not to take action. Coupled with other forms of guidance, there can be little doubt that FTC enforcement in health care markets is intended to promote competition as a primary driver to hold down costs, improve quality, and encourage innovation while allowing procompetitive ventures that do not harm consumers to proceed.

⁴⁴ While some state Attorneys General have accepted conduct-based remedies in a handful of cases, states often have robust state regulatory bodies, with particularized knowledge of the community needs, that may put them in a better position to oversee compliance and regulate these types of conduct remedies.