



UNITED STATES OF AMERICA
Federal Trade Commission
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics
Northeast Regional Office

June 5, 2015

The Honorable Michael H. Ranzenhofer
New York State Senate
188 State Street
Legislative Office Building, Room 609
Albany, New York 12247

The Honorable Thomas Abinanti
New York State Assembly
198 State Street
Legislative Office Building, Room 744
Albany, New York 12248

Re: New York Senate Bill 2647 and New York Assembly Bill 2888, Acts to Amend the Public Authorities Law, in Relation to Authorizing the Erie County Medical Center Corporation and the Westchester County Health Care Corporation, respectively, to Enter into Agreements for the Creation and Operation of a Health Care Delivery System Network

Dear Senator Ranzenhofer and Assemblyman Abinanti:

The staffs of the Federal Trade Commission's ("FTC" or "Commission") Office of Policy Planning, Bureau of Competition, Bureau of Economics, and Northeast Regional Office¹ respectfully submit this letter regarding of the impact of New York Senate Bill 2647 ("S-2647") and New York Assembly Bill 2888 ("A-2888") (collectively, "the bills") on competition for health care services. FTC staff is aware that the New York Attorney General's office ("NY AG") recently submitted a letter opposing this legislation,² and we share its concerns. The proposed bills would authorize Erie County Medical Center Corporation ("ECMC") and Westchester County Health Care Corporation ("WCHC") to collaborate with other public and private health care providers and payors. The proposed bills purportedly would provide these health care corporations, as well as the entities with which they collaborate, with broad immunity from liability under the federal and state antitrust laws – even though this purported immunity would cover the kinds of information sharing and joint contract negotiations that are likely to result in reduced competition and higher prices for consumers. For the reasons described below, FTC staff urges the New York State Senate and Assembly to reconsider whether these entities need state action immunity to engage in beneficial collaborative activities.

FTC staff fully recognizes that collaborations among health care providers often are procompetitive, and we applaud state efforts to achieve meaningful health care reforms, including initiatives that lower the costs of health care services, improve their quality, and expand patient access. We are concerned, however, that the proposed legislation is based on inaccurate premises regarding the antitrust laws and the value of competition among health care providers. The FTC recently submitted a public comment to the New York State Department of Health (“NY DOH”) to express similar concerns regarding the potential competitive impact of the Certificate of Public Advantage (“COPA”) applications submitted by three performing provider systems participating in the Delivery System Reform Incentive Program (“DSRIP”).³

Antitrust immunity is unnecessary for ECMC and WCHC to engage in procompetitive collaborative activities. The antitrust laws are not a barrier to the formation of efficient health care collaborations that benefit health care consumers, as explained in extensive guidance issued by the federal antitrust agencies. Indeed, very few health care provider mergers, joint ventures, or other types of collaborations are challenged by the federal antitrust agencies. Because procompetitive or competitively benign health care collaborations already are permissible under the antitrust laws, the main effect of this legislation is to immunize conduct that would *not* generate efficiencies that are greater than consumer harms, and therefore would *not* pass muster under the antitrust laws. Therefore, these bills are likely to lead to increased health care costs – in the form of higher premiums, co-pays, deductibles, and other out-of-pocket expenses – and decreased access to health care services for New York consumers. As discussed in greater detail below, this may result from information sharing and joint contract negotiations among competitors, as well as increased market power through provider consolidation.

I. Interest and Experience of the Federal Trade Commission

Congress has charged the FTC with enforcing the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.⁴ Competition is at the core of America’s economy,⁵ and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality goods and services, greater access to goods and services, and innovation.⁶ Pursuant to its statutory mandate, the FTC seeks to identify business practices, laws, and regulations that may impede competition without providing countervailing benefits to consumers.

Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,⁷ research,⁸ and advocacy.⁹ Of particular relevance, the Commission and its staff have long advocated against federal and state legislative proposals that seek to create antitrust exemptions for collective negotiations by health care providers, as such exemptions are likely to harm consumers.¹⁰

II. New York Senate Bill 2647 and New York Assembly Bill 2888

These two bills, introduced in the New York state legislature in January 2015, are intended to extend state action immunity to ECMC and WCHC, public benefit corporations created by the New York State Public Authorities Law,¹¹ as well as any private and public entities with which they collaborate. These bills are identical to a bill enacted in June 2013, which conferred state action immunity to the Nassau Health Care Corporation (“NHCC”) and the entities with which it collaborates.¹²

Sponsors of the bills claim that ECMC and WCHC have always had the authority to collaborate with private and public entities under the general and special powers granted to them under the Public Authorities Law.¹³ However, following the recent U.S. Supreme Court decision in *FTC v. Phoebe Putney Health System, Inc.*,¹⁴ the bills “seek[] to clarify [the state’s] intention that such collaborations may be carried out regardless of whether they displace competition and may otherwise be considered violations of state or federal antitrust laws.”¹⁵

According to the proposed bills, “the benefits of collaboration by the corporation outweigh any adverse impact on competition.”¹⁶ These purported benefits include expanding access to health care services, as well as consolidating unneeded or duplicative health care services, enhancing the quality of health care services, lowering the costs and improving the efficiencies of health care services, and achieving improved reimbursement from commercial payors. Based on these alleged benefits, the bills propose to amend the public authorities law to expressly allow these corporations “to engage in collaborative activities consistent with [their] health care purposes, notwithstanding that those collaborations may have the effect of displacing competition in the provision of hospital, physician or other health care-related services.”¹⁷

The bills also discuss the state’s oversight of ECMC and WCHC. However, it is unclear to what degree the collaborative activities of ECMC and WCHC will be actively supervised by the state. States may provide antitrust immunity for certain activities when there is a clearly articulated state policy to displace competition and there is active supervision of the policy or activity.¹⁸ FTC staff takes no position at this time on whether the amendments contemplated by the bills would satisfy the active supervision prong of the state action doctrine. According to the language in the bills, it appears that these corporations would oversee their own operations, with the NY DOH providing some additional state oversight by reviewing annual reports filed by ECMC and WCHC.¹⁹ The bills specify that these reports must include information concerning the benefits of collaboration and disadvantages of reduced competition, as identified by the NY DOH in its “Restructuring Initiatives in Medicaid Redesign” initiative.²⁰ These reports must also assess the impact on reimbursement by managed care organizations, particularly the extent to which negotiated rates “more fairly compensate the corporation’s facilities for the cost of providing services to commercial enrollees, without cross-subsidy from Medicaid or other governmental programs.”²¹ The NY DOH would have 60 days from the date a report is filed to request that ECMC or WCHC make policy changes to ensure that the collaborations further the state’s interests.²²

III. Concerns Regarding Potential Anticompetitive Effects of New York Senate Bill 2647 and New York Assembly Bill 2888

FTC staff recognizes the stated need for ECMC and WCHC to collaborate with other public and private health care providers to improve their ability to deliver high-quality health care to medically underserved patient populations. Despite what some health care providers – and proponents of the bills – may claim, however, the antitrust laws already allow for efficient competitor collaborations in health care markets. FTC staff is concerned that the proposed legislation may encourage ECMC and WCHC, as well as any public or private health care providers with whom they choose to collaborate, to share competitively sensitive information and engage in joint negotiations with payors in ways that will not yield efficiencies or benefit consumers. These types of activities are unlikely to further the legitimate public policy goals of health care reform. Indeed, FTC staff is unaware of any credible economic evidence demonstrating that these types of activities are likely to lower the cost or improve the quality of health care services, or expand access to health care services for medically underserved patient populations. Rather, there is a significant and growing body of empirical economic research showing that increased consolidation and certain kinds of coordination among health care providers increase the risk of higher prices without offsetting improvements in quality.²³

The bills specifically authorize these corporations “to engage in arrangements, contracts, information sharing and other collaborative activities[.]” which “may include without limitation: joint ventures, joint negotiations with physicians, hospitals and payors, whether such negotiations result in separate or combined agreements; leases; and/or agreements which involve delivery system network creation and operation[.]”²⁴ Among the purported benefits of the corporations’ collaborative efforts, as described in the bills, is “achieving improved reimbursement from non-governmental payors.”²⁵ Thus, it appears that a goal of the bills is to allow ECMC and WCHC to engage in collaborations or transactions that improve their bargaining leverage with commercial payors to increase their reimbursement rates. These higher reimbursement rates are likely to lead to higher health care costs for employers and commercially insured patients. Commercially insured patients likely would face higher premiums, co-pays, deductibles, and other out-of-pocket expenses. Self-insured employers would be particularly vulnerable to higher prices because they pay directly for the costs of their employees’ health care claims.

Notwithstanding the bills’ stated goal of improving health care services for medically underserved patients, it is important to understand that competition among health care providers benefits *all* patients, regardless of whether covered by commercial or governmental programs. FTC staff disagrees with the bills’ suggestion that Medicaid or other governmental programs can cross-subsidize commercially insured patients.²⁶ In reality, case-mix-adjusted commercial health care prices are usually higher than Medicaid or Medicare prices, and there is little evidence of dynamic cost-shifting in either direction.²⁷ Furthermore, charging higher prices for providing services to commercial patients is unlikely to benefit Medicaid, Medicare, and uninsured patients. Empirical

economic literature shows that non-profit hospitals with market power – which ECMC and WCHC may achieve through many of the activities that purportedly would now be immunized by the bills – tend to have higher commercial prices and higher costs, the latter of which can harm non-commercial patients, particularly the uninsured.²⁸ Finally, economic literature also shows that competition among health care providers usually leads to higher quality care for all patients.²⁹

Another cause for concern is that, unlike the New York COPA regulations that were the subject of FTC staff’s recent comment to the NY DOH,³⁰ the bills do not expressly preserve the authority of the NY AG to challenge any collaborative activity undertaken by these public health care entities in the event that the anticompetitive harms outweigh the potential benefits of coordination. Notwithstanding our overall concerns with the purported grant of antitrust immunity in the COPA regulations, these bills appear to confer broader antitrust immunity than the COPA regulations without the same degree of state oversight and, if needed, remedial authority.

Finally, FTC staff has concerns that, as written, these bills may be construed to purport to grant antitrust immunity when ECMC and WCHC collaborate with private or public entities located outside of New York, even if neighboring states have not themselves attempted to confer antitrust immunity to health care collaboratives. Such geographically unbound antitrust immunity would cause FTC staff to further question whether this legislation is appropriately tailored to further New York’s legitimate public policy goals.

IV. Legislation Is Unnecessary Because the Antitrust Laws Already Permit Efficient Health Care Collaborations

The proposed legislation appears to be based on two fundamentally flawed premises: that efficient, procompetitive collaborations among otherwise independent health care providers are prohibited under the antitrust laws, and that antitrust immunity is necessary to encourage such collaborations.

The antitrust laws already recognize, and, indeed, have long stood for the proposition that competitor collaborations can be procompetitive. As explained in numerous sources of guidance issued by the federal antitrust agencies,³¹ this position extends to collaborations among competing health care providers. FTC officials have recently emphasized that “[t]he FTC supports the key aims of health care reform, and . . . recognize[s] that collaborative and innovative arrangements among providers can reduce costs, improve quality, and benefit consumers. But these goals are best achieved when there is healthy competition in provider markets fostering the sort of dynamic, high-quality, and innovative health care that practitioners seek and patients deserve.”³² The federal antitrust agencies have challenged very few of the thousands of health care provider mergers, joint ventures, and other types of collaborations that have occurred in recent years, and have “brought those challenges only after rigorous analysis of market conditions showed that the acquisition was likely to substantially lessen competition.”³³

Moreover, the goals of antitrust are consistent with the goals of the Patient Protection and Affordable Care Act (“ACA”),³⁴ and health care reform efforts more generally. Despite what some health care industry participants have claimed, the antitrust laws do not prohibit the kinds of collaboration necessary to achieve the health care reforms contemplated by the ACA.³⁵ Specifically, antitrust is not a barrier to New York health care providers who seek to form procompetitive collaborative arrangements that are likely to reduce costs and benefit health care consumers through increased efficiency and improved coordination of care. Indeed, the antitrust agencies seek only to prevent mergers and other collaborations when there is substantial anticompetitive harm and when that harm is not offset by likely procompetitive benefits of the transaction, including reduced costs, higher quality, and increased access to care.

V. Antitrust Exemptions That Immunize Otherwise Anticompetitive Conduct Pose a Substantial Risk of Consumer Harm and Are Disfavored

Because antitrust law permits procompetitive collaborations among health care providers, no special “exemption” or “immunity” from existing antitrust laws is necessary to ensure that such procompetitive or competitively benign collaborations occur. The U.S. Supreme Court recently reiterated its long-standing position that “the antitrust laws’ values of free enterprise and economic competition” make such special exemptions or immunities “disfavored.”³⁶ There is no reason to treat the health care industry differently with regard to application of the antitrust laws. Indeed, in the health care industry, just like in other industries, consumers benefit from vigorous competition and are harmed by anticompetitive conduct and transactions.³⁷

Health care providers have repeatedly sought antitrust immunity for various forms of joint conduct, including agreements on the prices they will accept from payors, asserting that immunity for joint bargaining is necessary to “level the playing field” so that providers can create and exercise countervailing market power.³⁸ In a 2004 report on health care competition, the federal antitrust agencies jointly responded to and countered this argument, explaining that antitrust exemptions “are likely to harm consumers by increasing costs without improving quality of care.”³⁹ In its 2007 report, the bipartisan Antitrust Modernization Commission succinctly stated a widely recognized proposition: “[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality and reduced innovation.”⁴⁰ In other words, antitrust exemptions threaten broad consumer harm while benefitting only certain market participants.

FTC officials further have noted that state legislation aimed at exempting health care providers engaging in collaborative activities from antitrust scrutiny may “encourage providers to negotiate collectively with health plans in order to extract higher rates, in effect allowing providers to fix their prices. By permitting conduct that would ordinarily violate antitrust laws, the bills would lead to higher prices and lower-quality care – undercutting the very objectives they aim to achieve.”⁴¹ While FTC officials have acknowledged that “[c]ollaboration designed to promote beneficial integrated care can

benefit consumers,” they also have warned that “collaboration that eliminates or reduces price competition or allows providers to gain increased bargaining leverage with payors raises significant antitrust concerns. Antitrust concerns can arise if integration involves a substantial portion of the competing providers of any particular service or specialty[.]”⁴² We note that NHCC, ECMC, and WCHC all participate in performing provider systems under the DSRIP program, and all of these systems appear to involve substantial portions of competing health care providers in their respective geographic regions,⁴³ thereby increasing the potential for anticompetitive harm.

Given that efficient collaborations among health care providers likely to benefit consumers are already consistent with the antitrust laws, FTC staff is concerned that these bills will encourage precisely the types of agreements among competitors that likely would *not* pass muster under the antitrust laws – conduct that would reduce competition, raise prices, and provide few or no benefits to consumers. Any effort to shield such harmful conduct from antitrust enforcement, including attempts to confer state action immunity, is likely to harm New York health care consumers.

VI. Conclusion

In summary, FTC staff believes that the antitrust immunity contemplated by the proposed bills is unnecessary to facilitate procompetitive collaborations, and is concerned that the bills are likely to foster anticompetitive conduct to the detriment of New York health care consumers. FTC staff urges the New York State Senate and Assembly to carefully consider whether antitrust immunity – especially the broad immunity these bills purport to grant – would further legitimate public policy goals or, instead, result in higher prices for consumers without any offsetting improvements to health care quality and access.

As always, the FTC will investigate and challenge transactions that are anticompetitive. In addition, we will continue to challenge defenses based on asserted state action immunity where the state fails to provide adequate active supervision.

Respectfully submitted,

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- ¹ This letter expresses the views of the FTC’s Office of Policy Planning, Bureau of Competition, Bureau of Economics, and Northeast Regional Office. The letter does not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.
- ² See Dan Goldberg, *Senate Passes Antitrust Bill Despite A.G.'s Concern*, CAPITAL NEW YORK (Jun. 1, 2015), <http://www.capitalnewyork.com/article/albany/2015/06/8569185/senate-passes-antitrust-bill-despite-ags-concern>.
- ³ See FTC Staff Comment to New York State Department of Health, Concerning Certificate of Public Advantage Applications, Intended to Exempt Performing Provider Systems from the Antitrust Laws (Apr. 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-center-health-care-policy-resource-development-office-primary-care-health-systems/150422newyorkhealth.pdf.
- ⁴ Federal Trade Commission Act, 15 U.S.C. § 45.
- ⁵ *Standard Oil Co. v. FTC*, 340 U.S. 231, 248 (1951) (“The heart of our national economic policy long has been faith in the value of competition.”).
- ⁶ See *Nat’l Soc. of Prof. Eng’rs v. United States*, 435 U.S. 679, 695 (1978) (The antitrust laws reflect “a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain – quality, service, safety, and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.”).
- ⁷ See generally FED. TRADE COMM’N, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (Mar. 2013), <https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/hcupdate.pdf>. See also *Competition in the Health Care Marketplace*, FED. TRADE COMM’N, <https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care> (“Cases”).
- ⁸ See, e.g., FED. TRADE COMM’N & U.S. DEP’T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), <https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf> [hereinafter FTC & DOJ, IMPROVING HEALTH CARE]. The report was based on, among other things, 27 days of formal hearings on competitive issues in health care, an FTC sponsored workshop, independent research, and the Agencies’ enforcement experience. See also FTC-DOJ workshop series, *Examining Health Care Competition*, Mar. 20-21, 2014 and Feb. 24-25, 2015, <https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition>.
- ⁹ FTC and staff advocacy may comprise letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports.
- ¹⁰ See, e.g., FTC Staff Comment to Sen. John J. Bonacic, N.Y. State Senate, Concerning N.Y. Senate Bill S.3186-A, Intended to Permit Collective Negotiations by Health Care Providers (Oct. 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-john-j.bonacic-concerning-new-

[york-s.b.3186-allow-health-care-providers-negotiate-collectively-health-plans/111024nyhealthcare.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-oregon-senate-bill-231a-which-includes-language-intended-provide-federal/150519oregonstaffletter.pdf); FTC Staff Comment to Sen. Chip Shields, Or. State Legislature, Concerning S.B. 231-A, Intended to Exempt Certain Collaborations Among Competing Health Care Providers and Payers Participating in a Primary Care Transformation Initiative (May 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-oregon-senate-bill-231a-which-includes-language-intended-provide-federal/150519oregonstaffletter.pdf; FTC Staff Comment to Sen. Catherine Osten and Rep. Peter Tercyak, Conn. Gen. Assembly, Concerning H.B. 6431, Intended to Exempt Health Care Collaboratives from the Antitrust Laws (June 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-connecticut-general-assembly-labor-and-employees-committee-regarding-connecticut/130605conncoopcomment.pdf; FTC Staff Comment to Sens. Coleman and Kissel and Reps. Fox and Hetherington, Conn. Gen. Assembly, Concerning Connecticut H.B. 6343, Intended to Exempt Members of Certified Cooperative Arrangements from the Antitrust Laws (June 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-senatorscoleman-andkissel-and-representativesfox-and-hetherington-concerning.b.6343intended-toexempt-members-certified-cooperative-arrangements-antitrust-laws/110608chc.pdf; FTC Staff Comment to the Hon. Elliott Naishtat Concerning Tex. S.B. 8 to Exempt Certified Health Care Collaboratives from the Antitrust Laws (May 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.elliott-naishtat-concerning-texas-s.b.8-exempt-certified-health-care-collaboratives-antitrust-laws/1105texashealthcare.pdf; FTC Staff Comment to Rep. Tom Emmer of the Minn. House of Reps. Concerning Minn. H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-representative-tom-emmer-minnesota-house-representatives-concerning-minnesota-ok-h.f.no.120-and-senate-bill-s.f.no.203-health-care-cooperatives/v090003.pdf; FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.william-j.seitz-concerning-ohio-executive-order-2007-23s-establish-collective-bargaining-home-health-care/v080001homecare.pdf; FTC Staff Comment before the P.R. House of Reps. Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-puerto-rico-house-representatives-concerning-s.b.2190-permit-collective-bargaining-health-care-providers/v080003puerto.pdf. All advocacies are available at <https://www.ftc.gov/policy/advocacy/advocacy-filings>.

¹¹ N.Y. PUB. AUTH. LAW §§ 3300-3321 (2015) (“Title 1: Westchester County Health Care Corporation”); *id.* §§ 3625-3646 (“Title 6: Erie County Medical Center Corporation”).

¹² *See* S.B. 4624, 2013-2014 Leg., Reg. Sess. (N.Y. 2013) (same as New York Assembly Bill 7993-A). FTC staff learned of this legislation after it had passed. In October 2013, the Governor of New York signed S-4624/A-7993 into law. The NY AG opposed this bill as unnecessary and overbroad. *See* Memorandum Regarding New York Assembly

Bill 7993-A, from Harlan A. Levy, Chief Deputy Attorney General and Counsel to the Attorney General, to Mylan L. Denerstein, Counsel to the Governor of New York (Aug. 13, 2013). Interestingly, the Nassau University Medical Center DSRIP PPS (which is affiliated with NHCC) stated its intention to apply for a COPA to protect itself from regulatory challenges based on antitrust laws. *See* Nassau University Medical Center DSRIP PPS Organizational Application 9 (Dec. 22, 2014), https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/nassau_university_medical_center/nassau_queens_organizational_application.pdf. This antitrust exemption would presumably be in addition to the broad exemption already purportedly conferred to NHCC under S-4624/A-7993.

¹³ *See* New York State Senate Memorandum In Support Of Legislation S-2647, submitted by Sen. Ranzenhofer; New York State Assembly Memorandum In Support Of Legislation A-2888, submitted by Rep. Abinanti. However, although the current Public Authorities Law states that ECMC has the ability to participate in “joint and cooperative arrangements for the provision of general comprehensive and specialty health care services” and WCHC has the ability to “[t]o provide health and medical services for the public directly or by agreement or lease with any person, firm or private or public corporation or association through or in the health facilities of the corporation or otherwise[,]” there are no provisions that allow them to collaborate with private and public entities in violation of the antitrust laws. N.Y. PUB. AUTH. LAW §§ 3306.2, 3621.5 (2015).

¹⁴ *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003 (2013).

¹⁵ New York State Senate Memorandum In Support Of Legislation S-2647, *supra* note 13.

¹⁶ S.B. 2647, 2015-2016 Leg., Reg. Sess. § 1 (N.Y. 2015) (amending § 3626 of New York public authorities law); A.B. 2888, 2015-2016 Leg., Reg. Sess. § 1 (amending § 3301 of New York public authorities law).

¹⁷ S.B. 2647 § 1; A.B. 2888 § 1.

¹⁸ *See Parker v. Brown*, 317 U.S. 341 (1943); *Phoebe Putney*, 133 S. Ct. at 1003 (2013); and *North Carolina State Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101 (2015).

¹⁹ S.B. 2647 § 2 (amending § 3631 of New York public authorities law); A.B. 2888 § 2 (amending § 3306 of New York Public Authorities Law).

²⁰ N.Y. STATE DEP’T OF HEALTH, RESTRUCTURING INITIATIVES IN MEDICAID REDESIGN, REQUEST FOR APPLICATIONS § 7 (2011), <http://www.health.ny.gov/funding/rfa/inactive/1111091042/1111091042.pdf> (“§ 7 Competition and Antitrust Concerns” references the state budget legislation and NY DOH COPA regulations).

²¹ S.B. 2647 § 2; A.B. 2888 § 2.

²² S.B. 2647 § 2; A.B. 2888 § 2.

²³ *See, e.g.*, Jeff Goldsmith, Lawton R. Burns, Aditi Sen, & Trevor Goldsmith, *Integrated Delivery Networks: In Search of Benefits and Market Effects*, NAT’L ACAD. OF SOCIAL INSURANCE (Feb. 2015), http://www.nasi.org/sites/default/files/research/Integrated_Delivery_Networks_In_Search_of_Benefits_and_Market_Effects.pdf;

Katherine Baicker & Helen Levy, *Coordination versus Competition in Health Care Reform*, 369 NEW ENG. J. MED. 789 (2013), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1306268>; Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update* (Robert Wood Johnson Found., Synthesis Project Report, June 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; 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 (Nov. 2010), <http://www.hschange.com/CONTENT/1162/>; Robert A. Berenson, Paul B. Ginsburg & Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFFAIRS 699 (2010), available at <http://content.healthaffairs.org/content/29/4/699.full>; Lawton Robert Burns & Ralph W. Muller, *Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration*, 86 MILBANK Q. 375 (2008), available at <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2008.00527.x/epdf>; William B. Vogt & Robert Town, *How has hospital consolidation affected the price and quality of hospital care?* (Robert Wood Johnson Found. Synthesis Project Report, Feb. 2006), <http://www.rwjf.org/files/research/no9researchreport.pdf>; Cory Capps & David Dranove, *Hospital Consolidation & Negotiated PPO Prices*, 23 HEALTH AFFAIRS 175 (2004), available at <http://content.healthaffairs.org/content/23/2/175.full>.

²⁴ S.B. 2647 § 2; A.B. 2888 § 2.

²⁵ S.B. 2647 § 1; A.B. 2888 § 1.

²⁶ See *supra* note 21 and accompanying text.

²⁷ For a review of the economic literature on this subject, see Austin Frakt, *Hospitals Are Wrong About Shifting Costs to Private Insurers*, THE INCIDENTAL ECONOMIST (Mar. 25, 2015), <http://theincidentaleconomist.com/wordpress/hospitals-are-wrong-about-shifting-costs-to-private-insurers/>.

²⁸ See Jeffrey Stensland, Zachary R. Gaumer, & Mark E. Miller, *Private-Payer Profits Can Induce Negative Medicare Margins*, 29 HEALTH AFFAIRS 1045 (2010), available at <http://content.healthaffairs.org/content/early/2010/03/18/hlthaff.2009.0599.full>. Under the Patient Protection and Affordable Care Act, prices that non-profit hospitals charge to uninsured patients eligible for financial assistance can be no more than “amounts generally billed to insured patients.” See *infra* note 34, at § 9007; Sara Rosenblum, *Additional Requirements For Charitable Hospitals: Final Rules On Community Health Needs Assessments And Financial Assistance*, HEALTH AFFAIRS BLOG (Jan. 23, 2015), <http://healthaffairs.org/blog/2015/01/23/additional-requirements-for-charitable-hospitals-final-rules-on-community-health-needs-assessments-and-financial-assistance/>. Therefore, hospitals with market power that negotiate higher commercial prices can also charge higher prices to uninsured patients.

²⁹ See *supra* note 23.

³⁰ See *supra* note 3.

³¹ To assist the business community in distinguishing between lawful and potentially harmful forms of competitor collaboration, the FTC and its sister federal antitrust

agency, the DOJ, have issued considerable guidance over the years. Key sources of guidance include the Agencies' general guidelines on collaborations among competitors, as well as joint statements specifically addressing the application of the antitrust laws to the health care industry, including physician network joint ventures and other provider collaborations. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (2000), https://www.ftc.gov/sites/default/files/documents/public_events/joint-venture-hearings-antitrust-guidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf; U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), <https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf> (see, e.g., *id.* at Statement 8 regarding physician network joint ventures, Statement 7 regarding joint purchasing arrangements among providers of health care services, and Statement 6 regarding provider participation in exchanges of price and cost information).

In addition, FTC staff has issued and made public numerous advisory opinion letters containing detailed analyses of specific proposed health care collaborations. These letters have helped the requesting parties avoid potentially unlawful conduct as they seek to devise new ways of responding to the demands of the marketplace. They also have provided further guidance to the health care industry as a whole. See, e.g., Letter from Markus H. Meier, Fed. Trade Comm'n, to Michael E. Joseph, Esq., McAfee & Taft, Re: Norman PHO Advisory Opinion, Feb. 13, 2013, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr_0.pdf; Letter from Markus H. Meier, Fed. Trade Comm'n, to Christi Braun, Ober, Kaler, Grimes & Shriver, Re: TriState Health Partners, Inc. Advisory Opinion, Apr. 13, 2009, <https://www.ftc.gov/sites/default/files/documents/advisory-opinions/tristate-health-partners-inc./090413tristatealetter.pdf>; Letter from Markus Meier, Fed. Trade Comm'n, to Christi Braun & John J. Miles, Ober, Kaler, Grimes & Shriver, Re: Greater Rochester Independent Practice Association, Inc. Advisory Opinion, Sept. 17, 2007, <https://www.ftc.gov/sites/default/files/documents/advisory-opinions/greater-rochester-independent-practice-association-inc./gripa.pdf>.

³² Edith Ramirez, *Antitrust Enforcement in Health Care – Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245 (2014), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1408009>. See also Deborah L. Feinstein, Dir., Bureau of Competition, Remarks at the Fifth National Accountable Care Organization Summit in Washington, DC: Antitrust Enforcement in Health Care: Proscription, not Prescription (June 19, 2014), https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf (“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. . . . 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.”); Commissioner Julie Brill, Fed. Trade Comm'n, Keynote Address at the Catalyst For Payment Reform 2013 National Summit on Provider Market Power: Promoting

Healthy Competition in Health Care Markets: Antitrust, the ACA, and ACOs (June 11, 2013), https://www.ftc.gov/sites/default/files/documents/public_statements/promoting-healthy-competition-health-care-markets-antitrust-aca-and-acos/130611cprspeech.pdf (“By serving as a watchdog against anticompetitive conduct, antitrust promotes market behavior that creates efficiencies and benefits consumers.”).

- ³³ Feinstein, *supra* note 32. From 2002 to 2012, the Commission challenged six hospital mergers out of 970 total hospital transactions, less than one percent. *See* Greg Koonsman, *Analyzing the Health System Market*, VMG Health 24 (Oct. 24, 2013), <http://www.vmghealth.com/Downloads/BeckerASCKoonsman2013.pdf>.
- ³⁴ Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395 (2010).
- ³⁵ *See, e.g.* FED. TRADE COMM’N & 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 (Oct. 28, 2011), <http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf>. *See also* Brill, *supra* note 32 (“Antitrust law permits providers to engage in a wide array of legitimate collaborative activities, including ACO [Accountable Care Organization] 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.”).
- ³⁶ *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003, 1010 (2013) (quoting *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 636 (1992)). *See also* *North Carolina State Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101, 1117 (2015) (“The Sherman Act protects competition while also respecting federalism. It does not authorize the States to abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies. If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked.”).
- ³⁷ *Phoebe Putney*, 133 S. Ct. at 1015 (state legislature’s objective of improving access to affordable health care does not logically suggest contemplation of anticompetitive means, and “restrictions [imposed upon hospital authorities] should be read to suggest more modest aims.”). As the U.S. Court of Appeals for the Fourth Circuit has observed, “[f]orewarned by the [Supreme Court’s] decision in *National Society of Professional Engineers . . .* that it is not the function of a group of professionals to decide that competition is not beneficial in their line of work, we are not inclined to condone anticompetitive conduct upon an incantation of ‘good medical practice.’” *Va. Acad. of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476, 485 (4th Cir. 1980).
- ³⁸ In general, the Supreme Court has flatly rejected the notion that members of the learned professions should be free from antitrust scrutiny: “The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . nor is the public-service aspect of professional practice controlling in determining whether § 1 includes professions.” *Goldfarb v. Va. State Bar*, 421 U.S. 773, 787 (1975). *See also* *Nat’l Soc. of Prof. Eng’rs v. United States*, 435 U.S. 679, 695 (1978) (Supreme Court rejection of argument that competition itself poses a “potential threat . . . to the public safety”); *FTC v. Indiana Fed’n of Dentists*, 476 U.S. 447 (1986).

³⁹ FTC & DOJ, IMPROVING HEALTH CARE, *supra* note 8, at 14.

⁴⁰ ANTITRUST MODERNIZATION COMM’N, REPORT AND RECOMMENDATIONS 335 (2007), http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

⁴¹ Ramirez, *supra* note 32.

⁴² Feinstein, *supra* note 32. There is a significant and ever-growing body of empirical research showing that increased concentration among health care providers results in higher prices without offsetting improvements in quality. *See, e.g.*, Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update* (Robert Wood Johnson Found., Synthesis Project Report, June 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

⁴³ *See* Nassau University Medical Center DSRIP PPS Organizational Application 25-26 (Dec. 22, 2014), https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/nassau_university_medical_center/nassau_queens_organizational_application.pdf (stating that this PPS would include all 15 hospitals in this region, as well as a substantial portion of ambulatory surgical centers, primary care providers, specialty care providers, rehabilitative and behavioral health services facilities, and skilled nursing facilities); Millennium Collaborative Care DSRIP PPS (ECMC) Organizational Application 14 (Dec. 22, 2014), https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/erie_county/millennium_collaborative_care_pps_org_app.pdf (stating that the Millennium Collaborative Care LLC will be a wholly-owned subsidiary of Erie County Medical Center Corporation, the lead entity in the PPS), *id.* at 17 (“All providers in the region have been invited to participate in the PPS, including the Catholic Medical Partners PPS and Finger Lakes PPS.”), *id.* at 27-28 (throughout western New York, there are 22 acute care hospitals, 10 of which are in the MCC PPS; 74 nursing home facilities, 41 of which are in the MCC PPS; in addition, MCC PPS will include all of the urgent care centers, health homes, rehabilitative and behavioral health services facilities, specialty medical programs, home care services, and managed care organizations, and more than half of the ambulatory surgical centers, federally qualified health centers, primary care and specialty medical providers, laboratory and radiology services, and pharmacies); and Westchester Medical Center DSRIP PPS Organizational Application 26-27, 33 (Dec. 22, 2014), https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/westchester_medical_center/westchester_org_app.pdf (it appears that this PPS covers 8 counties in the Hudson Valley region, and may include lower percentages of health care providers than the PPS networks associated with NHCC and ECMC, with 11 of 51 hospitals, 1,868 of 5,048 primary care providers, and 1,551 of 43,460 specialty care providers).