UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition

March 9, 2016

The Hon. Mike Pushkin
West Virginia House of Delegates
Room 150R, Building 1
State Capitol Complex
Charleston, WV 25305

Re: West Virginia Senate Bill 597

Dear Delegate Pushkin:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics ("FTC staff" or "staff")[1] appreciate the opportunity to respond to your invitation to comment on West Virginia Senate Bill 597 ("S. 597" or the "Bill"),[2] particularly the provisions relating to the federal antitrust laws.

The Bill includes numerous provisions regarding the goals and organization of health care regulation in West Virginia, and this comment does not address most of these provisions. FTC staff recognize the state's important interest in the health and well-being of its citizens, and we do not seek to suggest to West Virginia a preferred balance of health, safety, and other policy priorities. Neither do we express opinions on the organization of regulatory agencies by which the legislature might try to achieve such a balance.

FTC staff write to express strong concerns about the competitive implications of two sets of provisions in the Bill: provisions regarding certain "cooperative agreements"[3] between health care providers; and provisions purporting to confer "exemptions" from federal antitrust laws on health care providers.[4]

The drafters of those provisions appear to share our interest in the competitive effects of such cooperative agreements, and also appear to acknowledge the relevance of policy statements and antitrust guidance issued by the FTC (or jointly by the FTC and the U.S. Department of Justice, collectively, "the Antitrust Agencies" or the "Agencies"). The Agencies and their staffs have been clear and consistent in recognizing that many collaborations among health care providers can be efficient and beneficial. We are concerned, however, that the relevant provisions of the Bill reflect mistaken beliefs about the antitrust laws and the value of competition among health care providers. If enacted, these provisions will very likely benefit only certain providers, and will do so by harming

health care competition and health care consumers in West Virginia. These provisions may also tend to decrease the quality of health care services in West Virginia. Our main concerns are as follows:

- First, the antitrust laws permit health care collaborations that benefit consumers. As the federal Antitrust Agencies have explained, many competitor collaborations – including health care provider collaborations and mergers –are efficient and procompetitive, and are therefore lawful.

- Second, because the antitrust laws already permit procompetitive health care collaborations, the Bill's main effect would be to foster precisely those mergers and collective negotiations that would *not* generate efficiencies and therefore would *not* pass muster under the antitrust laws. Therefore, the collaborative agreements contemplated by the Bill would likely increase health care costs, diminish incentives to improve quality, and decrease access to health care services for West Virginia consumers.

I. Interest and Experience of the Federal Trade Commission

Congress has charged the Federal Trade Commission ("FTC" or "Commission") with enforcing the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[5] The FTC also enforces Section 7 of the Clayton Act, which prohibits transactions that may substantially lessen competition or tend to create a monopoly.[6] Competition is at the core of America's economy,[7] 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.[8] Pursuant to its statutory mandate, the FTC seeks to identify business practices and governmental laws and regulations that may impede competition without also 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,[9] research,[10] and advocacy.[11] 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.[12]

II. Senate Bill 597

As noted above, the Bill includes a variety of provisions regarding the goals and organization of health care regulation in West Virginia. This comment focuses on a limited number of those provisions. FTC staff are concerned about the potential competitive implications of the Bill's "cooperative agreements" and its provisions purporting to confer "exemptions" from federal antitrust laws.

With respect to exemptions, the Bill asserts that,

> Actions of the authority shall be exempt from antitrust action under state and federal antitrust laws. Any actions of hospitals and health care providers under the authority's jurisdiction, when made in compliance with orders, directives, rules, approvals or regulations issued or promulgated by the authority, shall likewise be exempt. Health care providers shall be subject to the antitrust guidelines of the federal trade commission and the department of justice.[13]

Thus, the Bill apparently seeks to confer an exemption from the antitrust laws on "any" actions by hospitals and other health care providers that fall under the jurisdiction of the newly constituted West Virginia Health Care Authority (the "Authority") and comply with the Authority's regulations or administrative decisions.

Proposed Section 16-29B-28 contemplates "cooperative agreements" – including, but not limited to, mergers and acquisitions – among health care providers, as long as one of the providers is "a teaching hospital which is a member of an academic medical center."[14] The other party or parties to the cooperative agreement need be only "one or more other hospitals, or other health care providers."[15] These cooperative agreements presumably would vary widely depending on the parties, and might broadly contemplate "the sharing, allocation, consolidation by merger or other combination of assets, or referral of patients, personnel, instructional programs, support services, and facilities or medical, diagnostic, or laboratory facilities or procedures or other services traditionally offered by hospitals or other health care providers."[16]

According to the Bill, such agreements are supposed to be desirable "if the likely benefits of such agreements outweigh any disadvantages attributable to a reduction in competition."[17] In particular,

> [T]he goal of any cooperative agreement would be to:
> (A) Improve access to care;
> (B) Advance health status;
> (C) Target regional health issues;
> (D) Promote technological advancement;
> (E) Ensure accountability of the cost of care;
> (F) Enhance academic engagement in regional health;
> (G) Preserve and improve medical education opportunities;
> (H) Strengthen the workforce for health-related careers; and
> (I) Improve health entity collaboration and regional integration, where appropriate.[18]

In addition, the Bill stipulates various ways in which such cooperative agreements and antitrust exemptions should comply with competition guidance and policy statements issued by the Antitrust Agencies. For example,

> [i]f the cooperative agreement involves a combination of hospitals through merger, consolidation or acquisition, the qualified hospital must have been awarded a certificate of need for the project by the authority . . . . [and] [i]n reviewing a certificate of need application the authority shall give deference to the policy statements of the Federal Trade Commission.[19]

Moreover, as noted above, the provision that purports to confer an exemption from the antitrust laws on health care providers stipulates that those providers "shall be subject to the antitrust guidelines of the federal trade commission and the department of justice."[20]

III. The Bill Is Unnecessary Because the Antitrust Laws Already Permit Efficient Health Care Collaborations

The Bill assumes that antitrust laws prohibit efficient health care mergers, acquisitions, and collaborations to the detriment of health care and consumers in West Virginia. That assumption is simply and categorically wrong.

FTC staff recognize that cooperation among competing health care providers often can benefit competition and health care consumers. The stated ends of the Bill's "cooperative agreements" are not objectionable and may often be the welcome results of robust provider competition. We nonetheless have two basic concerns about the "cooperative agreement" provisions. First, to the extent that federal and state antitrust laws already apply to such cooperative agreements, and to the extent that West Virginia certificate of need laws already apply to entry or expansion by health care providers, the need for new regulatory oversight of such cooperative agreements is unclear. It is, potentially, an undue additional regulatory barrier to procompetitive agreements. Second, to the extent that the Bill purports to confer antitrust immunity on such cooperative agreements, as well as other entities and conduct subject to the jurisdiction of the Authority, the combined effect of the cooperative agreement provisions and the exemption provisions seems, if anything, both unnecessary and likely harmful.

The antitrust laws already recognize, and have long stood for the proposition, that competitor collaborations can be procompetitive. As explained in numerous sources of guidance issued by the Antitrust Agencies,[21] this position extends to collaborations – or "cooperative agreements" – among competing health care providers. For example, statements issued jointly by the Agencies recognize that, "[n]ew arrangements and variations on existing arrangements involving joint activity by health care providers continue to emerge to meet consumers', purchasers', and payors' desire for more efficient delivery of high quality health care services."[22] More recently, FTC officials have 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.[23]

With respect to mergers in particular, the Horizontal Merger Guidelines issued jointly by the Antitrust Agencies recognize that merger-generated efficiencies "may result in lower prices, improved quality, enhanced service, or new products."[24] Those efficiencies are assessed in merger investigations and weighed against the potential anticompetitive harm stemming from a merger or acquisition. For those reasons, and because many mergers do not threaten competition, the 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."[25] These outcomes confirm that the antitrust laws already balance likely benefits and competitive harms, as suggested by S. 597, and therefore already accomplish many of the Bill's objectives.

Moreover, the goals of antitrust law are consistent with the policy goals of fostering the integration of health care via collaboration among health care providers through, for example, the formation of Accountable Care Organizations.[26] 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 Affordable Care Act and other policy initiatives.[27] Specifically, antitrust is not a barrier to West Virginia health care providers that 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.

IV. Conferring Market Power on Otherwise Competing Health Care Providers Poses a Substantial Risk of Consumer Harm

FTC staff understand that West Virginia may take particular interest in its academic medical centers. Still, given that antitrust law allows efficient collaborations among health care providers, FTC staff are deeply concerned that the Bill would mainly serve to encourage mergers and conduct that likely would *not* pass muster under the antitrust laws because they would reduce competition, raise prices, diminish incentives to improve quality, and provide relatively small or no benefits to consumers.

Even though the "cooperative agreements" contemplated by the Bill are supposed to include a teaching hospital, they also would include "one *or more* other hospitals, or other health care providers," independent of any teaching mission those other providers might or might not share.[28] Hence, any competitive harm inflicted by such agreements might originate from the loss of competition between two or more *other* hospitals, or other health care providers, and the effects might spread well beyond a teaching hospital. Any effort to shield such harmful conduct from antitrust enforcement – including

attempts to confer state action immunity – is likely to harm West Virginia's health care consumers, including patients as well as both public and private third-party payors.

In its 2007 report, the Congressionally established, bipartisan Antitrust Modernization Commission[29] 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."[30] In other words, antitrust exemptions threaten broad consumer harm while benefitting only certain market participants.

Yet, health care providers repeatedly have 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.[31] In a 2004 report on health care competition, the Antitrust Agencies jointly responded to and countered this argument:

> Some physicians have lobbied heavily for an antitrust exemption to allow independent physicians to bargain collectively. They argue that payors have market power, and that collective bargaining will enable physicians to exercise countervailing market power. The Agencies have consistently opposed these exemptions, because they are likely to harm consumers by increasing costs without improving quality of care. The Congressional Budget Office estimated that proposed federal legislation to exempt physicians from antitrust scrutiny would increase expenditures on private health insurance by 2.6 percent and increase direct federal spending on health care programs such as Medicaid by $11.3 billion.[32]

The Bill under consideration in West Virginia seeks to immunize, and thereby potentially promote, precisely this form of anticompetitive collaboration between health care providers.

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

The U.S. Supreme Court recently reiterated its long-standing position that, "given the antitrust laws' values of free enterprise and economic competition, 'state-action immunity is disfavored.'"[33] As the Court recognized, this general principle applies with equal force in the health care industry, where consumers benefit from vigorous competition, and where anticompetitive conduct can cause significant harm.[34] As discussed above, antitrust law permits many forms of procompetitive collaborations among health care providers. Antitrust law also serves the important function of protecting health care consumers from pernicious forms of joint conduct, which is why antitrust immunity for otherwise anticompetitive provider collaborations is likely to harm consumers.

VI. Conclusion

Competitor collaborations, mergers, and acquisitions, can be procompetitive, benefitting patients and payors alike. Interest in such "cooperative agreements" among health care providers is understandable and, indeed, important. As we have explained, however, both in this comment and in numerous and detailed guidance documents, the antitrust laws already permit efficient and pro-consumer collaborations among competing health care providers, and already permit efficient and pro-consumer mergers. The Bill's apparent attempt to confer antitrust immunity is, therefore, unnecessary for legitimate collaborations and, if effective, would encourage groups of private health care providers to engage in blatantly anticompetitive conduct.

In summary, FTC staff are concerned that this legislation is likely to foster mergers and conduct that are anticompetitive, inconsistent with federal antitrust law and policy, and liable to cause serious harm to West Virginia health care consumers.

We appreciate your consideration of these issues.

Respectfully submitted,

Marina Lao, Director
Office of Policy Planning

Ginger Jin, Director
Bureau of Economics

Markus H. Meier, Acting Deputy Director
Bureau of Competition

Attachments

[1] This letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The letter does not necessarily represent the views of the Federal Trade Commission (Commission) or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

[2] Letter from the Hon. Mike Pushkin, West Virginia House of Delegates, to Marina Lao, Director, Fed. Trade Comm'n Office of Pol'y Planning (March 9, 2016). Specifically, we write regarding provisions of

the Committee Substitute for Senate Bill 597 by Senators Ferns and Plymale, Originating in the Senate Committee on Health and Human Resources; reported on February 16, 2016 [hereinafter S. 597].

[3] *Id.* at § 16-29B-28.

[4] *Id.* at § 16-29B-26.

[5] Federal Trade Commission Act, 15 U.S.C. § 45.

[6] Clayton Act, 15 U.S.C. § 18.

[7] 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.").

[8] *See* Nat'l Soc. of Prof. Engineers 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.").

[9] *See generally* Fed. Trade Comm'n, An Overview of FTC Antitrust Actions In Health Care Services and Products (Mar. 2013), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/hcupdaterev.pdf; *see also* Fed. Trade Comm'n, Competition in the Health Care Marketplace: Formal Commission Actions, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care.

[10] *See, e.g.*, FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE ("DOJ"), IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), http://www.ftc.gov/reports/healthcare/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.

[11] 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. *See, e.g.*, FTC Staff Letter to the Honorable Theresa W. Conroy, Connecticut House of Representatives, Concerning the Likely Competitive Impact of Connecticut House Bill 6391 on Advance Practice Registered Nurses ("APRNs") (Mar. 2013), https://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice (competitive impact of statutorily required "collaborative practice agreements" for nurse practitioners); FTC and DOJ Written Testimony Before the Illinois Task Force on Health Planning Reform Concerning Illinois Certificate of Need Laws (Sept. 2008), http://www.ftc.gov/os/2008/09/V080018illconlaws.pdf; Brief of the Fed. Trade Comm'n as Amicus Curiae, St. Joseph Abbey, et al. v. Castille, 712 F.3d 215 (5th Cir. 2013) (No. 11-30756) (refuting argument that the policies of FTC funeral rule support restrictions of sort challenged by petitioner); FTC & DOJ, IMPROVING HEALTH CARE, *supra* note 10.

[12] *See, e.g.*, FTC Staff Comment Regarding Oregon Senate Bill 231A, Which Includes Language Intended To Provide Federal Antitrust Immunity To Conversations, Information Exchanges, and Agreements Among Participants (Including Competitors) In Oregon's Health Care Markets (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 Before the Connecticut General Assembly Labor and Employees Committee Regarding Connecticut House Bill 6431 Concerning Joint Negotiations by Competing Physicians in Cooperative Health Care Arrangements (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 the Hon. Elliott Naishtat Concerning Texas S.B. 8 to Exempt Certified Health Care Collaboratives From the Antitrust Laws (May 2011), http://www.ftc.gov/os/2011/05/1105texashealthcare.pdf; FTC Staff Comment to Rep. Tom Emmer of the Minnesota House of Representatives Concerning Minnesota H.F. No. 120 and Senate Bill S.F. No. 203 on

Health Care Cooperatives (Mar. 2009), http://www.ftc.gov/opp/advocacy/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), http://www.ftc.gov/os/2008/02/V080001homecare.pdf; FTC Staff Comment Before the Puerto Rico House of Representatives Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008); http://www.ftc.gov/os/2008/02/v080003puerto.pdf (all advocacies http://www.ftc.gov/opp/advocacy_date.shtm). *See also* Prepared Statement of the Fed. Trade Comm'n Before the H. Comm. on the Judiciary, Subcomm. on Intellectual Property, Competition, and the Internet Concerning H.R. 1946, the "Preserving Our Hometown Independent Pharmacies Act of 2011," Mar. 29, 2012, http://www.ftc.gov/os/testimony/120329pharmacytestimony.pdf.

[13] S. 597 at § 16-29B-26. With regard to "antitrust guidelines," see *infra* note 19.

[14] *Id.* at § 16-29B-28(a)(2).

[15] *Id.*

[16] *Id.*

[17] *Id.* at §16-29B-28(c).

[18] *Id.* at §16-29B-28(d)(2).

[19] *Id.* at §16-29B-28(d)(4)(A). FTC staff are unclear about the drafter's intent in this provision. On the one hand, the Bill contemplates that anticompetitive agreements might be somehow desirable, and it purports to confer an exemption from the antitrust laws on such cooperative agreements and the parties to them, among others. On the other hand, the Bill suggests that such agreements should be reviewed "with deference to the [antitrust] policy statements of the Federal Trade Commission" and that health care providers "shall be subject to the antitrust guidelines of the federal trade commission and the department of justice."

[20] *Id.* at §16-29B-28(d)(4)(C).

[21] 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./090413tristateaoletter.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.

[22] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *supra* note 21, at 2.

[23] 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.

[24] FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, HORIZONTAL MERGER GUIDELINES, 29 (2010), https://www.ftc.gov/tips-advice/competition-guidance.

[25] Feinstein, *supra* note 23.

[26] These widely shared policy goals are central to the Accountable Care Organizations contemplated under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3022, 14 Stat. 119, 395 ("Affordable Care Act"). Ctrs. Medicare & Medicaid Servs., Fast Facts, All Shared Savings Program and Pioneer ACOs Combined (Apr. 2015) (404 shared savings ACOs and 19 Pioneer ACOs with 7.92 million assigned beneficiaries in 49 states plus Washington, DC and Puerto Rico). The FTC has not challenged any of these 423 ACOs.

[27] *See* Brill, *supra* note 23 ("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.").

[28] S. 597 at § 16-29B-28(a)(2).

[29] The Antitrust Modernization Commission was created pursuant to the Antitrust Modernization Commission Act of 2002, Pub. L. No. 107-273, §§ 11051-60, 116 Stat. 1856.

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

[31] 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'y Prof'l Engineers 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).

[32] FTC & DOJ, IMPROVING HEALTH CARE, *supra* note 10, at 14. For example, a recent FTC enforcement action concerned "an agreement among eight independent nephrologists in southwestern Puerto Rico to fix the prices and the conditions under which they would participate in "Mi Salud," the Commonwealth of Puerto Rico's Medicaid program for providing healthcare services to indigent residents. In furtherance of their conspiracy, Respondents collectively terminated their participation in the Mi Salud program in

southwestern Puerto Rico after the program's regional administrator . . . refused to accede to Respondents' demands to restore a cut in reimbursements for certain patients eligible for benefits under both Medicare and Mi Salud ("dual eligibles"). After Respondents terminated their service agreements with Humana, they refused to treat any of Humana's Mi Salud patients." *In the Matter of* Práxedes E. Alvarez Santiago, M.D., Daniel Pérez Brisebois, M.D., Jorge Grillasca Palou, M.D., Rafael Garcia Nieves, M.D., Francis M. Vázquez Roura, M.D., Angel B. Rivera Santos, M.D., Cosme D. Santos Torres, M.D., and Juan L. Vilaró Chardón, M.D., FTC File No. 121-0098, C-4402 (Complaint), 2 (May 3, 2013), http://ftc.gov/os/caselist/1210098/130503prnephrologistscmpt.pdf.

[33] FTC v. Phoebe Putney Health System, 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 Examiners v. FTC, 135 S. Ct. 1101, 1117 (2015) (no state action immunity for dental board that sought to exclude non-dentist competitors in teeth whitening services).

[34] FTC v. 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.'" Virginia Acad. of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476, 485 (4th Cir. 1980).