A Common Goal: The U.S. Federal Trade Commission's Healthcare Enforcement Program and Its Implications for ACOs
Keynote Address
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The history of healthcare delivery in the United States has been one of constant evolution. Employee health benefits grew as a way to avoid wage caps imposed by the government during World War II, helped by a 1943 IRS ruling that employers' contributions to group health insurance policies were tax-free.[1] Over 20 years later, in 1966, the federal government became heavily involved in health insurance with the launch of Medicare and Medicaid programs.[2] And, in the mid-1970s, the concept of the HMO was thought to be the latest and greatest way to contain the growing portion of pocketbook spend that healthcare accounted for.[3]

Now, with the passage of the Affordable Care Act,[4] there is renewed focus not only on containing costs, but also on promoting quality improvements for millions of U.S. healthcare consumers. Concurrently, we are seeing a wave of mergers, ACOs, and other collaborations—not only among competing healthcare providers, but also among hospitals and physicians, as well as between health systems and health plans.[5]

As the form and delivery of healthcare has shifted over the past 100 years, so have U.S. antitrust agencies evolved to adapt to the changing economy. When the FTC opened its doors in 1914, we were far more likely to be investigating steel and oil mergers. While those industries are still closely monitored today, other products and services not even in existence in 1914 have become an important part of the FTC's enforcement mission. We have taken action to protect competition in widely-varied healthcare markets ranging from nicotine replacement therapy[6] to outpatient imaging services[7] to photochromic lenses for eyeglasses.[8]

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[1] *See* Ezekiel J. Emanuel & Ron Wyden, Commentary, *Why Tie Health Insurance to a Job?*, WALL ST. J., Dec. 10, 2008, http://www.wsj.com/articles/SB122887085038593345; CBO Study, The Tax Treatment of Employment-Based Health Insurance (Mar. 1994), available at http://cbo.gov/sites/default/files/1994_03_taxtreatmentofinsurance.pdf.

[2] *See, e.g.*, Alain C. Enthoven & Victor R. Fuchs, Employment-Based Health Insurance: Past, Present, and Future, 25 HEALTH AFFAIRS 1472, 1538-47 (2006).

[3] Laura A. Scofea, The development and growth of employer-provided health Insurance, Monthly Labor Review, Marcy 1994 at 7; Robert B. Helms, Tax Policy and the History of the Health Insurance Industry, Conference by The Tax Policy Center and the American Tax Policy Institute, The Brookings Institution, Feb. 29, 2008.

[4] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

[5] *See, e.g.*, Ellen Jean Hirst, *Hospital Mergers Continued to Create Larger Systems in 2014*, CHI. TRIB., Feb. 10, 2015, http://www.chicagotribune.com/business/breaking/ct-hospital-mergers-0211-biz-20150210-story.html.

[6] Press Release, FTC Puts Conditions on Pharmaceutical Joint Venture Between GlaxoSmithKline and Novartis (Nov. 26, 2014), *available at* http://www.ftc.gov/news-events/press-releases/2014/11/ftc-puts-conditions-pharmaceutical-joint-venture-between.

[7] Press Release, Commission Order Restores Competition Eliminated by Carilion Clinics Acquisition of Two Outpatient Clinics (Oct. 7, 2009), *available at* https://www.ftc.gov/news-events/press-releases/2009/10/commission-order-restores-competition-eliminated-carilion-clinics.

Fortunately, antitrust is flexible—and we ensure that the analytical approach keeps up with industry changes to allow innovation and change to flourish. The FTC's commitment to adapting to changes in the market is shown in many ways. With the DOJ, we bring together leaders in the healthcare field, including hospital executives, physicians, academic researchers, economists, and other experts, as we did recently in our joint Workshop Series "Examining Healthcare Competition."[9] Our economists publish important research that provides an empirical basis for analyzing healthcare transactions.[10] These and other efforts help ensure that we are on the right side of this evolution, equipping us with the tools needed to expertly and effectively investigate healthcare transactions in the modern era.

The FTC's Approach to Healthcare Provider Collaborations

It is no surprise that the FTC devotes considerable resources to healthcare. According to the OECD, health care spending makes up approximately 17% of the Gross Domestic Product of the United States.[11] In terms of its impact on consumer quality of life and ascendancy in our economy, the healthcare market is to today's FTC what steel and oil were to the original Commission.

The FTC Act, Clayton Act, and the ACA share the common goal of promoting high quality and cost-effective health care. We all have hope, perhaps more so now than ever before, that new reimbursement incentives will align to encourage value in healthcare.[12] To that end, we are vigilant to act when collaborations violate the antitrust laws. That is, we step in when collaborations create or enhance market power that results in higher rates charged to patients and erodes incentives to compete on clinical quality or other non-price bases.

As we are here at the Sixth Annual ACO Summit, it's important to note that the FTC's enforcement actions to date have principally focused on mergers and price fixing by unaffiliated providers—not ACOs. Of course, the antitrust laws apply to ACOs; however, to date, the FTC has not filed a single enforcement action against an ACO. When appropriate, the FTC will investigate to determine whether an ACO's formation or operation violates the antitrust laws. But so far we have received no complaints that warrant further antitrust scrutiny.

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[8] Press Release, FTC Bars Transitions Optical, Inc. from Using Anticompetitive Tactics to Maintain its Monopoly in Darkening Treatments for Eyeglass Lenses (Mar. 3, 2010), https://www.ftc.gov/news-events/press-releases/2010/03/ftc-bars-transitions-optical-inc-using-anticompetitive-tactics.

[9] *See e.g.*, Fed. Trade Comm'n & Dep't of Justice, Examining Healthcare Competition Workshop (2014-2015); Fed. Trade Comm'n & Dep't of Justice, Health Care and Competition Law and Policy Workshop (2003).

[10] *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); Christopher Garmon & Deborah Haas-Wilson, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 INT'L J. ECON. BUS. 17 (2011); Aileen Thompson, *The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover – Cape Fear Transaction*, 18 INT'L J. ECON. BUS. 91 (2011); Orley Ashenfelter, Daniel Hosken, Michael Vita & Matthew Weinberg, *Retrospective Analysis of Hospital Mergers*, 18 INT'L J. ECON. BUS. 5 (2011).

[11] OECD, "Briefing Note, OECD Health Statistics 2014: How Does the United States Compare?" *available at* http://www.oecd.org/unitedstates/Briefing-Note-UNITED-STATES-2014.pdf.

[12] *See, e.g.*, Atul Gawande, *Overkill*, THE NEW YORKER, May 11, 2015, *available at* http://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande.

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

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

The district court agreed, finding it "highly likely" that health care costs would rise as the merged firm "obtains a dominant market position," allowing the firm to negotiate higher rates from managed care organizations, which in turn would be passed on to consumers.[14] The court also noted that improving healthcare quality and lowering costs was not dependent on this merger, or on any specific organizational structure.[15] Importantly, the appeals court agreed that the claimed benefits were not specific to this particular merger and could be obtained other ways.[16]

Yet another federal court, in enjoining the merger between two of the three hospitals in Rockford, Illinois, evaluated the parties' claims that the merger would improve patient quality of care. In finding for the FTC, the court reviewed extensive evidence on the claimed clinical benefits before ruling that it was "unable to declare that these goals would be realized with, and only with, the proposed merger."[17]

Along similar lines, we often hear arguments that such mergers are required because, in this age of needing to do more with less, community hospitals cannot afford to go it alone. When a transaction raises meaningful antitrust concerns, the FTC does a deep dive into the merging hospitals' financial condition. But, as the Sixth Circuit Court of Appeals made clear in affirming the Commission's *ProMedica Health System/St. Luke's* decision, when the evidence shows that the acquired hospital has ample cash reserves to pay its obligations and meet its capital needs, courts will treat these claims skeptically.[18]

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[13] Complaint at ¶ 33, FTC v. St. Luke's Health Sys., Ltd., 1:13-cv-00116-BLW (D. Idaho filed Mar. 26, 2013), *available at* http://www.ftc.gov/sites/default/files/documents/cases/2013/03/130312stlukescmpt.pdf.
[14] FTC v. St. Luke's Health Sys., Ltd., 1:13-cv-00116-BLW, 2014 U.S. Dist. LEXIS 9264, at *6 (D. Idaho Jan. 24, 2014).
[15] FTC v. St. Luke's Health Sys., Ltd., Findings of Fact and Conclusions of Law, 1:13-CV-00116-BLW, at ¶¶ 184-85 (D. Idaho Jan. 24, 2014), *available at* http://www.ftc.gov/system/files/documents/cases/140124stlukesfindings.pdf.
[16] FTC v. St. Luke's Health Sys., Ltd., 2015 U.S. App. LEXIS 2098, *34 (9th Cir. 2015).
[17] FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1094 (N.D. Ill. 2012).
[18] ProMedica Health Sys. v. FTC, 749 F.3d 559, 572 (6th Cir. 2014).

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

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

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

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

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

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

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[19] Ezekiel J. Emanuel, MD, PhD, Chair, Dept. of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, Framing Presentation at the "Examining Healthcare Competition" Workshop (Feb. 24, 2015), *available at* https://www.ftc.gov/system/files/documents/public_events/618591/transcript-day1.pdf.

[20] Terri L. Postma, MD, CHCQM, Medical Officer, Centers for Medicare & Medicaid Services, Presentation: Medicare Shared Savings Program at 6 (Feb. 24, 2015), *available at* https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition.

There is early data showing that these ACOs, as a group, have experienced certain cost and quality improvements. For example, CMS reported that Shared Savings Program ACOs improved on 30 of 33 quality measurements.[21] Another study in the New England Journal of Medicine found that Year 1 of the Pioneer ACO program was associated with modest reductions in Medicare spending.[22] Of course, there is more work to be done in working to achieve these goals, as well as obtaining the data needed to assess whether those goals have been achieved.[23]

CMS and the antitrust agencies are aligned in the belief that competition is good for healthcare consumers, including competition among ACOs. CMS endorsed this view in its final implementing legislation on ACOs, stating that "competition 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."[24] Indeed, CMS shares the applications of newly-formed ACOs with the FTC and DOJ.[25]

What does the FTC do to support these goals? Along with DOJ, we have provided industry players with guidance on how to form procompetitive or competitively-neutral ACOs.[26] Moreover, newly-formed ACOs applying to the Medicare Shared Savings Program may request expedited review of whether the ACO would raise concerns under the antitrust laws. In addition, we will continue to be available on a voluntary basis to advise ACOs of antitrust risk. As you know, ACOs do not undergo mandatory review by the antitrust authorities. But collaborating providers have long sought written guidance from the FTC or DOJ by asking for advisory opinions or business review letters.[27] Where appropriate, staff also responds to requests for informal guidance. Together with the extensive healthcare antitrust guidance already put out by the FTC and DOJ, these access avenues are sure to give comfort to any new ACO that has questions about where they stand in relation to the antitrust laws.

We will continue to coordinate with CMS and other organizations to ensure that antitrust is working in tandem with health policy efforts to promote high-quality, affordable health care. CMS consults with the FTC on development of new ACO models, as well. We will continue to meet with, and bring together various stakeholders in healthcare to discuss shared challenges and experiences.

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[21] *Id*. at 8.
[22] J. Michael McWillians, Michael E. Chernew, Bruce E. Landon, and Aaron L. Schwartz, N Eng J Med 2015; 1927-36 (May 14, 2015), *available at* http://www.nejm.org/doi/full/10.1056/NEJMsa1414929?query=TOC#discussion.
[23] *See, e.g.*, Transcript of at "Examining Healthcare Competition" Workshop at 16-18, Feb. 25, 2015, *available at* https://www.ftc.gov/system/files/documents/public_events/618591/transcript-day2.pdf.
[24] 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.
[25] *See* 42 C.F.R. §§ 425.202(a)(3) and 425.224(a)(3).
[26] 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).
[27] *See, e.g.*, Health Care Division, Bureau of Competition, Topic and Yearly Indices of Health Care Antitrust Advisory Opinions by Commission and Staff (Mar. 2013), *available at* https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/indexadop.pdf; Dep't of Justice, Business Review Letters and Request Letters, *available at* http://www.justice.gov/atr/public/busreview/letters.html#page=page-2.

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

We will continue our scalpel-like approach to antitrust enforcement, which only targets those few combinations that raise serious competition concerns. We think we have struck the right balance. As I said earlier, not one ACO has been challenged by the antitrust agencies. We do, however, remain watchful for evidence suggesting that certain provider collaborations, including ACOs, may raise antitrust concerns. We will continue to carefully consider parties' specific claims of how collaborations help them provide better care, bringing in clinical experts to help us assess such claims as needed. We will closely monitor the growing body of empirical work regarding which types of consolidation are most likely to yield consumer benefits. And we will continue to be appropriately aggressive in the very small minority of transactions—whether mergers, joint ventures, or ACOs—that may create or enhance market power to the detriment of consumers.

[28] FTC Staff Comment Before the Office of the National Coordinator for Health Information Technology, Regarding its Draft Shared Nationwide Interoperability Roadmap for Health Information Technology Systems, *available at* https://www.ftc.gov/news-events/press-releases/2015/04/ftc-staff-offers-guidance-promoting-competition-health