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Working Party No. 2 on Competition and Regulation

COMPETITION IN HOSPITAL SERVICES

-- United States --

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The attached document is submitted to Working Party No.2 of the Competition Committee FOR DISCUSSION under item III of the agenda at its forthcoming meeting on 13 February 2012.

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1. The competition enforcement agencies of the United States – the Federal Trade Commission (“FTC”) and the Antitrust Division of the Department of Justice (“DOJ”) (collectively “the Agencies”) – have been active in applying competition laws to the health care marketplace, including the hospital industry, for several decades.¹ We are pleased to contribute to this roundtable discussion of whether competition can deliver improvements in the provision of hospital services, and if so, under what regulatory conditions and market structures.

2. This submission describes the market environment in which hospitals in the United States operate, including competitive and other pressures that hospitals face; the restructuring of the hospital industry that has occurred in recent years, through consolidations and the growth of hospital networks; and recent changes in health care law designed to promote efficiencies, improve quality, and restrain further price increases in the provision of services. The submission also highlights the intensive empirical retrospectives of hospital mergers conducted by FTC staff in recent years, which measure the impacts of consummated mergers on price and quality. Finally, the submission considers the application of competition laws to hospital competition, focusing primarily on how the lessons learned in the hospital merger retrospectives have influenced the Agencies’ recent enforcement.

1. Introduction to Structural Conditions in the Hospital Industry²

3. In cities and towns throughout the United States, hospitals are a key part of the health care delivery system. Currently, payments to hospitals for inpatient care account for approximately 33 percent of total health care expenditures in the United States.³ Expenditures on hospital services have grown over the past three decades, but the rate of spending growth has varied. The federal government’s introduction of a prospective payment system in the early 1980’s (see discussion in Section II) slowed the rate of hospital expenditure growth. The rise of private sector managed care plans slowed the rate of expenditure growth further; from 1993 through 1998, hospital expenditures increased at an average annual rate of 3.7 percent, and, in some areas of the country, the per diem price of a hospital stay actually decreased. In the past decade, however, rising hospital prices have driven spending on hospitals higher, even though hospital utilization has leveled off.⁴ As discussed below, analysts attribute rising hospital prices to a variety of factors, including hospitals’ increasing ability to negotiate higher prices from private payers.⁵

¹ Much of the material in this paper is drawn from Improving Health Care: A Dose of Competition-A Report by the Federal Trade Commission and the Department of Justice (2004) [hereinafter Improving Health Care Report], <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>.

² The introductory sections of this paper are taken largely from the Agencies’ 2005 submission to the OECD Roundtable on Competition to Promote Efficiency in the Provision of Hospital Services (Oct. 17, 2005), <http://www.ftc.gov/bc/international/docs/compcomm/2005--Hospitals.pdf>. These sections have been updated to reflect current conditions.

³ Centers for Medicare & Medicaid Services (“CMS”), Office of the Actuary, National Health Statistics Group, “National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960-2009” (2011), <https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

⁴ See Margaret Jean Hall et. al., “National Hospital Discharge Survey: 2007 Summary” (Oct. 2010), <http://www.cdc.gov/nchs/data/nhsr/nhsr029.pdf>.

⁵ See William B. Vogt & Robert Town, “How has Hospital Consolidation Affected the Price and Quality of Hospital Care?” Robert Wood Johnson Foundation Research Synthesis Report No. 9 (Feb. 2006), <http://www.rwjf.org/files/research/15231.hospitalconsolidation.report.pdf>; Laura Summer, “Integration, Concentration, and Competition in the Provider Marketplace,” Academy Health Research Insights Brief (Dec. 2010), http://www.academyhealth.org/files/publications/AH_R_Integration%20FINAL2.pdf.

4. By way of background, hospitals in the United States vary by the types of services they offer, ranging from specialty hospitals that treat only a single type of patient (pediatric and women’s hospitals) or condition (cardiac, orthopedic, psychiatric and rehabilitation hospitals) to “general acute care hospitals,” which treat a variety of acute medical conditions. Hospitals that provide general acute care services may or may not also offer treatments such as long term rehabilitation, psychiatric care, or substance abuse care. Hospitals also vary in the sophistication of the services they offer, ranging from the most basic hospital services, to the most sophisticated, cutting edge procedures.

5. Hospitals in the United States are also differentiated by their ownership structure into one of three categories: (1) non-profit (58 percent of hospitals); (2) for-profit (20 percent of hospitals); and (3) governmentally owned (or “public”) (22 percent of hospitals).⁶ Although these classifications might appear mutually exclusive and immutable, they are not. Many non-profit hospitals own for-profit institutions or have for-profit subsidiaries. Similarly, for-profit systems often manage non-profit and publicly owned hospitals. Hospitals also may change their institutional status. Even without changing their status, hospitals that previously have not competed in the marketplace can choose to do so. For example, some states have granted local governments broad authority to determine how public hospitals under their control will be operated. Relying on that authority, public hospitals are increasingly entering into competition with private hospitals.⁷

2. Contracting and Competition Mechanisms

2.1. Public Payors

6. Federal and state governments are responsible for almost 55 percent of national expenditures on hospital care.⁸ A substantial share of hospital spending is provided by the Federal Centers for Medicare & Medicaid Services (CMS), chiefly for care of the elderly. Each state also has a Medicaid program, which pays for care provided to the poor and disabled. Within broad guidelines established by Federal law, each state sets its own payment rates for Medicaid services and administers its own program.

7. Prior to 1983, CMS and most other insurers paid hospitals on a cost-based reimbursement system. Under the cost-based reimbursement system, hospitals informed payors of the cost of the care that was provided, and payors reimbursed hospitals for those amounts. The cost-based payment system led to substantial increases in health care spending over time. An important initial effort to curb these increases

⁶ <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml>.

⁷ Authorizing health care statutes in several states, including Michigan, Kentucky, and Ohio, have granted local governments the broad power to operate hospitals. Mich. Comp. Laws Ann. §§ 331.1301(g) et seq.; Ky. Rev. Stat. § 216.335(6); and Ohio Rev. Code § 339.06 (boards of municipal hospital corporations in Ohio “shall have the entire management and control of the hospital, and shall establish such rules for its government and the admissions of persons as are expedient”). The purpose behind many of these broad grants of authority has been to remove the legal constraints upon the operation of public hospitals that inhibit their ability to compete with private hospitals. See, e.g., *Surgical Care Ctr. of Hammond v. Hospital Serv. Dist. No. 1 of Tangipahoa Parish*, 171 F.3d 231, 235 (5th Cir. 1999) (en banc) (Louisiana statutes granted additional powers to hospital service districts so they could compete with other entities on a level playing field); *Jackson, Tenn. Hosp. Co. v. West Tenn. Healthcare, Inc.*, 414 F.3d 608, 610 (6th Cir. 2005) (Tennessee statutes intended to remedy a competitive disadvantage of some public hospitals by removing certain legal constraints upon their operations and giving them the same operating and organizational powers enjoyed by private hospital authorities).

⁸ See <http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf> at Table 7. Because private insurance tends to cover a younger and typically healthier population, it accounts for a smaller share of overall health care spending.

in spending was launched in 1983, when CMS implemented a prospective payment system for inpatient care.

2.1.1. Prospective Payment Systems

8. Under the prospective payment system CMS uses for inpatient care (IPPS), the payment that a hospital receives for treating a patient is based on the diagnosis-related group (DRG) that justified the episode of hospitalization. Each DRG has a payment weight assigned to it, based on the average cost of treating patients in that DRG.⁹ The hope is that, by receiving a predetermined amount, hospitals will have reduced incentives to use more resources than are necessary to treat patients. The IPPS was intended to moderate rising federal expenditures, create a more “competitive, market-like environment, and curb inefficiencies in hospital operations engendered by reimbursement of incurred cost.”¹⁰ Further changes to this system were provided for in the Affordable Care Act of 2010. For example, the act provides for bundled payments by CMS for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement. CMS views this as a way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients both when they are in the hospital and after they are discharged.¹¹ Such initiatives can help improve patient health, improve the quality of care, and lower costs.

2.1.2. The Impact of Government Purchasing

9. As the largest purchaser of health care in the United States, CMS has tremendous influence in the market for medical services, and providers are extremely responsive to the incentives created by CMS. Prior to the adoption of the IPPS, average hospital length-of-stay had been stable for seven years. Once IPPS went into effect, the length-of-stay began an immediate decline.

10. There are limitations, however, to CMS’s ability to create incentives that encourage price and non-price competition among providers. CMS does not have the freedom to respond to changes in the marketplace as do many private purchasers. For example, CMS has only limited authority to contract selectively with providers or to use competitive bidding to meet its needs. With a few exceptions, CMS cannot require providers to compete for CMS’s business or encourage suppliers to reduce their costs and enhance their quality by rewarding them with substantially increased volume or substantially higher payments if they do.

11. One Medicare program that has generated competitive incentives for providers is a managed care option, the Medicare Advantage (MA) program. MA programs provide Medicare beneficiaries with a range of managed care options, including health maintenance organizations and preferred provider organizations. Medicare beneficiaries who have joined MA plans have often received greater benefits (e.g., prescription drug coverage) in exchange for accepting limits on their choice of providers. Nevertheless, these plans are new and have limited acceptance among Medicare participants, but acceptance is growing and enrollment is greater in urban as opposed to rural areas. In 2009, MA plans

⁹ The average reimbursement for each DRG is derived from an analysis of the costs of treating both the very ill patients who require more intensive care for a particular DRG, and the “healthier” ill, who do not cost as much to treat.

¹⁰ Gregory C. Pope, “Hospital Nonprice Competition and Medicare Reimbursement Policy,” 8 J. Health Econ. 147 (1989).

¹¹ See CMS, “Bundled Payment for Care Improvement Initiative” (Aug. 23 2011), <http://innovations.cms.gov/documents/pdf/Fact-Sheet-Bundled-Payment-FINAL82311.pdf>.

provided health care to 10.2 million Medicare beneficiaries, nearly double the number of enrollees as in 2003.¹²

12. Generally, however, CMS's payment systems do not reward higher quality care, or punish lower quality care. All providers that meet basic requirements are paid the same regardless of the quality of service provided. To be sure, such issues are not unique to Medicare but confront private payors as well. Indeed, health care policy experts note that current fee-for-service compensation models provide little financial reward for improvements in the quality of health care delivery.¹³

13. Recent changes in U.S. health care law, namely the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act"), seek to improve the quality and reduce the costs of health care services in the U.S. by, among other things, encouraging physicians, hospitals, and other health care providers to become accountable for a patient population through integrated health care delivery systems.¹⁴ One delivery system reform is the Affordable Care Act's Medicare Shared Savings Program (the "Shared Savings Program"), which promotes the formation and operation of Accountable Care Organizations ("ACOs") to serve Medicare fee-for-service beneficiaries.¹⁵ Under this provision, "groups of providers of services and suppliers meeting criteria specified by the [Department of Health and Human Services] Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an [ACO]."¹⁶ An ACO may share in some portion of any savings it creates if the ACO meets certain quality performance standards established by the Secretary of Health and Human Services through CMS. The Affordable Care Act requires an ACO that wishes to participate in the Shared Savings Program to enter into an agreement with CMS for not less than three years.¹⁷

14. Recent commentary suggests that some health care providers are likely to create and participate in ACOs that serve both Medicare beneficiaries and commercially insured patients.¹⁸ The Agencies recognize that ACOs may generate opportunities for health care providers to innovate in both the Medicare and commercial markets and achieve for many other consumers the benefits Congress intended for Medicare beneficiaries through the Shared Savings Program – improved quality of care and lower health care costs. Such integration, however, also can increase market power and could injure competition. Therefore, to maximize and foster opportunities for ACO innovation and better health for patients and to ensure that the antitrust laws are not perceived as a barrier to procompetitive integration, the Agencies recently issued a statement clarifying their enforcement policy regarding collaborations among

¹² See Medicare Advantage Fact Sheet (Apr. 2009), <http://www.kff.org/medicare/upload/2052-12.pdf>.

¹³ Institute of Medicine Workshop Series Summary, "The Healthcare Imperative: Lowering Costs and Improving Outcomes," (2010) at 359, <http://www.iom.edu/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx>.

¹⁴ Health Care and Education Reconciliation Act of 2010, Public Law 111–52, 124 Stat. 1029 (2010); Patient Protection and Affordable Care Act, Public Law 111–48, 124 Stat. 119 (2010).

¹⁵ Patient Protection and Affordable Care Act 3022, 124 Stat. at 395–99.

¹⁶ *Id.* at 395.

¹⁷ *Id.* at 396.

¹⁸ Fed. Trade Comm'n & Dep't of Health and Human Serv., Workshop Regarding Accountable Care Organizations, and Implications Regarding Antitrust, Physician Self-Referral, Anti-Kickback, and Civil Monetary Penalty (CMP) Laws (Oct. 5, 2010).

independent providers that seek to become ACOs in the Shared Savings Program.¹⁹ The Agencies’ policy statement describes (1) the ACOs to which the Policy Statement will apply;²⁰ (2) when the Agencies will apply rule of reason treatment to those ACOs; (3) an antitrust safety zone; and (4) additional antitrust guidance for ACOs that are outside the safety zone, including a voluntary expedited antitrust review process for newly formed ACOs.²¹

2.2. *Private Third-Party Payors*

15. The second largest source of payment for hospital services is payments from private health insurance plans. Private health insurance is obtained primarily through benefits offered by employers, but is also available through other types of groups and through individual purchases from insurance companies. These payors are collectively referred to as third-party payors. Included in this category are employers who self-insure their employees’ medical costs, but hire an insurance company to administer the health insurance benefits, including negotiating prices with hospitals for services covered by the employer’s plan.

16. Third-party payors typically contract directly with hospitals to provide services to the patients covered under the payors’ plan(s), and the prices are negotiated directly between the payor and the hospital.²² The most common payment schemes are per diem rates, per case rates, or discounts-off-charges rates. Under a per diem rate, the third-party payor pays the hospital a fixed price for each day of hospital care without regard to the actual diagnosis of the patient or the resources the hospital uses in the treatment. Under a per case rate, the third-party payor pays the hospital a fixed price for the hospital stay for a particular type of case, regardless of the number of days the patient stays or the resources the hospital uses in the treatment. Under a discount-off-charges rate, also called a percentage-of-charges rate, the third party payor pays a percentage of the hospital’s “charges” for the hospital stay, where the “charges” are the prices the hospital charges for each resource used in treating the patient.

17. In some instances, private payors have copied Medicare’s reimbursement strategies or used Medicare DRGs as a reference price for reimbursement negotiations with hospitals. Thus, some payors negotiate either a specified discount or a specified payment relative to the amount CMS would pay for a

¹⁹ 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. 67,026 (2011).

²⁰ The analytical principles underlying the Policy Statement also would apply to various ACO initiatives undertaken by the Innovation Center within CMS as long as those ACOs are substantially clinically or financially integrated.

²¹ The Policy Statement provides guidance to assist ACOs in determining whether they are likely to present competitive concerns. It does not reflect the full analysis that the Agencies may use in evaluating ACOs or any other transaction or course of conduct.

²² Contracting between hospitals and private payors has sometimes been contentious. Some hospital industry observers claim that hospital systems routinely “terminate then negotiate” for large increases in reimbursement, and use the media to scare the public. *Improving Health Care Report, supra* note 1, Chapter 3, at 31-35. They also state that hospital systems insist that all hospitals in the system be included in a payor network (“all or nothing contracts”), irrespective of whether the payor actually wants to include the entire hospital system. *Id.* Hospital representatives claim that they are protecting their institutions’ interests and that their services had been artificially and unsustainably underpriced in the past. *Id.* These dynamics have played out in several markets during the past few years. Although commentators have noted that particular hospitals and hospital systems seem to have the upper hand in some markets, whether hospitals or health plans have bargaining advantages varies substantially within and among different markets.

specified treatment episode. Outpatient payment provisions, where the hospital does not provide an overnight stay for the patient, are typically structured on a percentage-of-billed charges or a fee-schedule basis.

18. Generally speaking, payors seek to contract with hospitals that contribute to the marketability of their insurance products.²³ Factors that affect marketability include: the price of coverage; the number of hospitals at which care can be provided; the perceived quality, desirability, location, and accessibility of those institutions; and the alternative insurance products that are available in the market. Payors seek to balance the price of the hospital services they must purchase to offer insurance coverage against the desirability of the resulting network to the purchasers of their insurance products. If patients view several hospitals as adequate substitutes for one another, it will be easier for the payor to threaten credibly to exclude one or more of these hospitals. Conversely, if enrollees will drop an insurance plan if their preferred hospital is no longer in its network, the hospital will find it easier to insist on higher reimbursement. These competitive dynamics are illustrated below in Section IV.C.2, which discusses the FTC Administrative Law Judge's recent decision finding that the merger of ProMedica Health System and St. Luke's Hospital in Lucas County (Toledo), Ohio was unlawful, in part, because it increased the hospital system's bargaining leverage in negotiations with payors.

2.2.1. *Consumer Price Sensitivity and Information*

19. The lack of consumer information about the costs of hospital services and lack of incentives for the consumer to choose the most cost-effective hospital makes it more difficult for payors to exclude high-priced, but otherwise desirable hospitals from the payors' health plans. Insured consumers often have only a vague idea of the price of the medical services they receive, and insurance largely insulates them from the financial implications of their medical treatment.²⁴ Consumers who pay the same co-payment, regardless of the price of the treatment they receive, have no reason to inquire into the price of the treatment, or to factor that price into their decisions. Consumers who have co-payments that vary depending on where they receive care will focus on the differing amounts of the co-payment, but not on the total price of the services they receive. Even if consumers become motivated to know the total price of the care they receive, they will find it extremely difficult to obtain that information.²⁵ Proposals to increase consumer price sensitivity must confront this reality, and policy makers must develop strategies to increase the transparency of hospital pricing.²⁶ As discussed below, insurers appear to be using tiering increasingly as one way to deal with this problem.

²³ See generally Gregory Vistnes, "Hospital, Mergers and Two Stage Competition," 67 *Antitrust L. J.* 671, 674 (2000). A marketable network is one that is not too expensive and includes hospitals that enrollees and plan physicians want. Complex rules can make a plan less marketable.

²⁴ Herbert Simon, "A Behavioral Model of Rational Choice," in *MODELS OF MAN* (1957).

²⁵ See Uwe E. Reinhardt, "Can Efficiency in Health Care Be Left to the Market?" 26 *J. Health Pol., Pol'y & L.* 967, 986 (2001) ("[O]ne need only imagine a patient beset by chest or stomach pain in Anytown, USA, as he or she attempts to 'shop around' for a cost-effective resolution to those problems. Only rarely, in a few locations, do American patients have access to even a rudimentary version of the information infrastructure on which the theory of competitive market and the theory of managed care rest. The prices of health services are jealously guarded proprietary information.").

²⁶ Health savings accounts represent a recent attempt to require consumers to bear some of the increased expenses associated with receiving care at a more expensive hospital. A health savings account provides the consumer with a fixed sum of money to pay for the consumer's portion of their health care costs. If, in a given year, the consumer does not use all of the money, the consumer retains the money for future use. Health savings accounts attempt to raise consumer sensitivity to the costs associated with their health care decisions. For this strategy to work effectively, however, consumers need access to good information

2.2.2. *Hospital Tiering – A Competitive Response to Market Conditions*

20. Consumer pressure for broader or open networks has made it more difficult for payors to exclude entire hospital systems from their plans, affecting the bargaining dynamics. In some markets, payors have responded by seeking to “tier” hospitals. Tiering is a payor reimbursement method whereby consumers incur different co-payments (i.e., high or low cost sharing) depending on the hospital at which the consumer chooses to have care provided. Tiering generally does not apply to emergency admissions and may depend upon where routine and specialty services are offered.

21. For payors, tiering offers a potential response to multi-hospital system pressure for inclusion of all system hospitals within a payor network. Tiering allows the payor to maintain a broad network, and include a “must-have” hospital in its plans, but simultaneously creates an incentive for consumers to use lower-cost providers. Some hospitals resist tiering, and with sufficient bargaining power, they can credibly threaten to withdraw from a payor network if they are placed in an unfavorable tier. In some markets, hospital systems have taken pre-emptive steps to negotiate contract language with payors that prohibit tiering. Because tiering is a relatively new development, there are, as yet, no systematic studies available on the prevalence or consequences of this strategy.

3. **Restructuring of the Hospital Industry**

3.1. *Background on the Consolidation Trend*

22. Over the past 30 years, many hospitals have consolidated into multi-hospital systems.²⁷ While in 1979, only about 31 percent of hospitals were part of a multi-hospital system, by 2001 almost 54 percent of hospitals operated as part of a system, with an additional 12.7 percent in looser health care networks. Initially, consolidations involved national systems acquiring hospitals throughout the United States, but recent acquisitions have been more localized.²⁸ Experts predict that in the U.S., the 2010 changes in the health care law, which created incentives for health care providers to establish integrated care organizations (ACOs), and several other factors, including the need for capital to finance facility modernization and the benefits of increased bargaining power, will continue to drive consolidation in the sector.²⁹ Consolidation can take a number of forms. At one end of the spectrum, consolidated hospitals may share a license and have common ownership, report unified financial records, and eliminate duplicative facilities. At the other end, a common governing body may own the consolidated hospitals, but the hospitals maintain separate hospital facilities, retain individual business licenses, and keep separate financial records. A related recent trend is the growth of hospital employment of physicians. Some studies

about the price and quality of the services among which they must choose. Without good information about the actual prices charged by different hospitals, a consumer facing a 25 percent co-payment at one hospital and a 15 percent co-payment at another cannot accurately assess the financial consequences of choosing one hospital over the other.

²⁷ See Vogt, *supra* note 5; Summer, *supra* note 5; Deborah Haas-Wilson, *MANAGED CARE AND MONOPOLY POWER: THE ANTITRUST CHALLENGE* 28 (2003).

²⁸ David Dranove & Richard Lindrooth, “Hospital Consolidation and Costs: Another Look at the Evidence,” 22 *J. Health Econ.* 983, 984 (2003); Alison Evans Cuellar & Paul J. Gertler, “Trends in Hospital Consolidation: The Formation of Local Systems,” 22 *Health Affairs* 77, 80 (Nov./Dec. 2003).

²⁹ See e.g., James C. Robinson, “Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology,” *The American Journal of Managed Care*, 17(6):e241-8 (2011); Summer, *supra* note 5; see also Moody’s Investor Service. Special Comment, “For-Profit Investment in Not-for-Profit Hospitals Signals More Consolidation Ahead” (Apr. 2010), <http://content.hcpro.com/pdf/content/250770.pdf>.

suggest that hospital employment of physicians, including hospitals acquiring independent physician groups, has accelerated in recent years as hospitals aim to increase market share and revenue.³⁰

23. Some observers of the hospital industry assert that hospital consolidations have provided opportunities for hospitals to compete more efficiently, improved the quality of care, and limited duplication of services and administrative expenses.³¹ Others, including many payors, believe that the creation of multi-hospital systems have been motivated by hospitals' desire to gain market power, secure higher reimbursement from payors, and impose other onerous requirements on payors, e.g., "all-or-nothing" contracting.³² The development of hospital networks, through common ownership, or other affiliations among hospitals, may play a significant role in the evolution of hospital markets. If hospital networks do not include significant integration among the member hospitals, for example, if they are simply "virtual networks" with no integration or real common ownership and are formed merely to set prices collectively, they run the risk of being challenged as illegal combinations under the antitrust laws. Most studies of the relationship between competition and hospital prices generally find that increased hospital concentration is associated with increased prices.³³

3.2. *Certificate of Need (CON) Programs – Entry Limitations*

24. A factor influencing the restructuring of the hospital industry has been the presence or absence of certificate of need (CON) laws or regulations in particular states. CON programs, initially adopted when cost-plus reimbursement was the norm, were intended to control costs by restricting provider capital expenditures. State CON programs generally prevent firms from entering certain areas of the health care market unless they can demonstrate to state authorities that there is an unmet need for their services. Upon making such a showing, prospective entrants receive from the state a CON allowing them to proceed.³⁴

3.2.1. *Competitive Concerns Raised by CON Programs*

25. CON regimes prevent new health care entrants from competing without a state-issued certificate of need, which is often difficult to obtain. Their effect is to shield incumbent health care providers from new entrants. As a result, CON programs may actually increase health care costs, as supply is depressed below competitive levels. Moreover, CON programs can retard entry of firms that could provide higher

³⁰ See Ann S. O'Malley, et. al., "Rising Hospital Employment of Physicians: Better Quality, Higher Costs?" Center for Studying Health System Change Issue Brief (Aug. 2011), <http://www.hschange.com/CONTENT/1230/1230.pdf>; Summer, *supra* note 5.

³¹ See Vogt, *supra* note 5; Summer, *supra* note 5.

³² See e.g., Robinson, *supra* note 29; Moody's Investor Service. Special Comment, *supra* note 29

³³ See *infra* Section IV.B. on the FTC's Hospital Merger Retrospective; David Dranove et al., "Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition," 36 J.L. & Econ. 179, 201 (1993) (finding that market concentration in California led to rate increases); Glenn A. Melnick et al., "The Effect of Market Structure and Bargaining Position on Hospital Prices," 11 J. Health Econ. 217 (1992) (finding market concentration appears to increase hospitals' bargaining power with insurers and self-insurers); Ranjan Krishnan, "Market Restructuring and Pricing in the Hospital Industry," 20 J. Health Econ. 213, 215 (2001) (mergers that increase hospital market share in specific hospital services, as measured in 33 DRGs, show a corresponding increase in prices of those services).

³⁴ See John Miles, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES AND PRACTICE § 16:1, at 16-2, 16-5 to 16-6 (2003); James F. Blumstein & Frank A. Sloan, "Health Planning and Regulation Through Certificate of Need: An Overview," 1978 Utah L. Rev. 3; Randall Boybjerg, "The Importance of Incentives, Standards, and Procedures in Certificate of Need," 1978 Utah L. Rev. 83; Clark C. Havighurst, "Regulation of Health Facilities and Services by 'Certificate of Need'", 59 Va. L. Rev. 1143 (1973).

quality services than the incumbents. By protecting incumbents, CON programs likewise can delay the introduction and acceptance of less costly, more innovative treatment methods. Similarly, CON programs that curtail services or facilities may force some consumers to resort to more expensive or less-desirable substitutes, thus increasing costs for patients or third-party payors. Empirical studies confirm that CON programs generally fail to control costs and can actually lead to increased prices.³⁵

3.2.2. *CON and Cost Control*

26. Commentators note that the reason that CON restrictions have been ineffective in controlling costs is that they do not put a stop to supposedly unnecessary expenditures but merely redirect any such expenditures into other areas.³⁶ Thus, a CON rule that restricts capital investment in new beds does nothing to prevent hospitals from adding other kinds of high-tech equipment and using it to compete for consumers.

27. Furthermore, CON programs can provide hospitals with a forum in which to engage in anticompetitive conduct. For example, in 2005, the Justice Department charged two competing West Virginia hospitals with using the state CON program as a mechanism for developing an illegal service allocation agreement, in which one hospital agreed not to offer cardiac surgery in return for the other hospital not offering cancer services.³⁷

28. For all these reasons, the Agencies believe that CON programs are generally not successful in containing health care costs and can pose anticompetitive risks.³⁸ Therefore, the Agencies have urged states with CON programs to reconsider whether the continuation of such programs best serves their citizens' health care needs.³⁹

3.3. *Development of Specialty Hospitals and Ambulatory Surgery Centers*

29. Competition in the U.S. hospital industry is impacted by specialty hospitals and ambulatory surgery centers. Specialty hospitals are facilities that provide inpatient services in a particular medical specialty such as pediatric, rehabilitation, psychiatric, cardiac and orthopedic surgery hospitals.⁴⁰ Single specialty hospitals ("SSHs") may compete with both inpatient and outpatient general hospital surgery

³⁵ See Daniel Sherman, Federal Trade Comm'n, "The Effect of State Certificate-of-Need Laws On Hospital Costs: An Economic Policy Analysis" (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data, that strong CON programs do not lead to lower costs but may actually increase costs); Monica Noether, Federal Trade Comm'n, "Competition Among Hospitals" 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); Keith B. Anderson & David I. Kass, Federal Trade Comm'n, "Certificate of Need Regulation of Entry into Home Health Care: A Multi-Product Cost Function Analysis" (1986) (economic study finding that CON regulation led to higher costs and did little to further economies of scale).

³⁶ *Improving Health Care Report*, *supra* note 1, Chapter 8, at 1-6.

³⁷ Press Release, U.S. Department of Justice, "Justice Department Requires Two West Virginia Hospitals To End Illegal Market-Allocation Agreements" (Mar. 21, 2005) http://www.usdoj.gov/atr/publis/press_releases/2005/208209.htm.

³⁸ See e.g. Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform, "Competition in Health Care and Certificates of Need," (Sept. 15, 2008) <http://www.ftc.gov/os/2008/09/V080018illconlaws.pdf>.

³⁹ *Id.*

⁴⁰ There are still relatively few SSHs. In 2003, the General Accounting Office (GAO) identified 100 existing SSHs with an additional 26 under development.

departments as well as with ambulatory surgery centers. Ambulatory surgery centers (ASCs) perform surgical procedures on patients who do not require an overnight stay in the hospital. Approximately half of ASCs are single specialty facilities,⁴¹ including gastroenterology, orthopedics, or ophthalmology. Many SSHs and ASCs are owned, at least in part, by physicians.

30. Observers have identified a number of market developments that have encouraged the emergence of SSHs and ASCs, including: improved technology; less tightly managed care; the willingness of providers to invest in an SSH or ASC; physicians' desire to provide better, more timely patient care; physicians looking for ways to supplement declining professional fees; and the growth of health care provider entrepreneurs.⁴²

31. Supporters of SSHs and ASCs argue that these facilities can benefit the quality of care patients receive and help to restrain health care costs. Among the asserted benefits of SSHs are better outcomes and important disease management and clinical standards, achieved as a result of focusing on a single area of medical specialty and performing increased volumes of procedures. ASCs require less capital than SSHs, and are generally less difficult to develop because they do not require the facilities or support services needed to offer care twenty-four hours a day, seven days a week. ASCs generally do not have emergency departments, and CON regulations, if they apply at all, often are not as rigorous for ASCs.⁴³

32. Some, however, express concerns about SSHs and ASCs. Critics of SSHs note that some SSHs do not provide emergency departments and thus avoid the higher costs of trauma treatment and indigent care.⁴⁴ Such critics believe this gives SSHs an unfair competitive advantage over 24-hour hospitals with emergency departments.⁴⁵ Other critics of SSHs and ASCs are concerned that SSHs and ASCs siphon off the most profitable procedures and patients, leaving general hospitals with less money to cross-subsidize other socially valuable, but less profitable, care.⁴⁶

33. Others concerned about SSHs and ASCs suggest that physicians with an ownership interest in an SSH or an ASC have an incentive to over-refer patients to those facilities to maximize their income.⁴⁷ The Affordable Care Act of 2010 continues to ban Medicare payments to SSHs, specifically prohibiting the referral of Medicare beneficiaries by physician owners or investors to new physician-owned hospitals or to existing physician-owned hospitals that have expanded their facility capacity beyond their baseline.

⁴¹ The number of ASCs has doubled in the past decade, and they currently total more than 5,000. U.S. Department of Health and Human Services, "Report to Congress: Medicare Ambulatory Surgical Center Value-Based Purchasing Implementation Plan," http://www.cms.gov/ASCPayment/downloads/C_ASC_RTC%202011.pdf.

⁴² *Improving Health Care Report*, *supra* note 1, Chapter 3, at 17-27.

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ A 2003 GAO study analyzed whether SSHs provided care to Medicare and Medicaid patients. The study found that there were modest differences between the percentage of Medicare and Medicaid patients who received treatment at general hospitals and SSHs. U.S. General Accounting Office, GAO-04-167, "Specialty Hospitals: Geographic Locations, Services Provided and Financial Performance" (2003), <http://www.gao.gov/new.items/d04167.pdg>. There were larger differences in the frequency of emergency departments (ED) at SSHs and general hospitals. In particular, 92 percent of general hospitals had an ED, while 72 percent of cardiac hospitals, 50 percent of women's hospitals, 39 percent of surgical hospitals, and 33 percent of orthopedic hospitals had an ED. *Id.*

⁴⁶ *Improving Health Care Report*, *supra* note 1, Chapter 3, at 17-27.

⁴⁷ *Id.*

4. Hospital Merger Analysis

4.1. Overview

34. While the Agencies have wide jurisdiction over anticompetitive conduct in the hospital industry,⁴⁸ most of the cases brought by the Agencies have involved mergers. Because preservation of hospital competition is vital to health care cost containment, both Agencies maintain vigorous enforcement programs to scrutinize hospital mergers for their potential effects on competition. The Agencies have a long history of such scrutiny, which has on occasion led to their challenging particular hospital mergers. Most hospital mergers and acquisitions, however, do not present competitive concerns.

35. The Agencies analyze hospital mergers using the same analytical framework they use for other mergers, following the 2010 Horizontal Merger Guidelines (“Merger Guidelines”). The Merger Guidelines specify that “mergers should not be permitted to create, enhance, or entrench market power or to facilitate its exercise.”⁴⁹ In applying the Merger Guidelines to hospital mergers, particular issues have arisen with respect to the definition of product and geographical markets. In addition, some questions have been raised about whether the non-profit ownership structure of many hospitals should alter the Merger Guidelines analysis.

36. The Agencies prevailed in some early challenges to hospital mergers,⁵⁰ and also obtained a number of consent decrees, allowing multiple hospital mergers to proceed, subject to requirements that certain hospitals be divested.⁵¹ However, in the 1990s, courts rejected the Agencies’ (and state attorneys’ general) attempts to prevent mergers between hospitals that the Agencies claimed would reduce competition.⁵² This string of losses led the FTC to launch its Hospital Merger Retrospective Project.

4.2. FTC Hospital Merger Retrospective Project

37. In April 2002, the Federal Trade Commission announced the Hospital Merger Retrospective Project (HMRP), a joint Bureau of Competition/Bureau of Economics initiative to study consummated hospital mergers “to determine whether particular hospital mergers have led to higher prices.”⁵³ As

⁴⁸ With some minor exceptions, the Federal Trade Commission does not have jurisdiction over the conduct of nonprofit hospitals outside of merger review. The Antitrust Division is not so limited in its jurisdiction.

⁴⁹ U.S. Dep’t of Justice & Federal Trade Comm’n, Horizontal Merger Guidelines § 1 (Aug. 2010) [hereinafter Merger Guidelines], <http://www.ftc.gov/os/2010/08/100819hmg.pdf>.

⁵⁰ See, e.g., *In re Hospital Corp. of Am.*, 106 F.T.C. 361 (1985), *aff’d*, 807 F.2d 1381 (7th Cir. 1986); *American Med. Int’l, Inc.*, 104 F.T.C. 1 (1984), as modified by, 104 F.T.C. 617 (1984) and 107 F.T.C. 310 (1986).

⁵¹ *Columbia/HCA Healthcare Corp./Healthtrust, Inc. - The Hosp. Co.*, 120 F.T.C. 743 (1995) (consent order); *Healthtrust, Inc. - The Hosp. Co./Holy Cross Health Servs. of Utah*, 118 F.T.C. 959 (1994) (consent order); *Columbia Healthcare Corp./HCA-Hosp. Corp. of Am.*, 118 F.T.C. 8 (1994) (consent order).

⁵² *FTC v. Tenet Healthcare Corp.*, 186 F.3d 1045 (8th Cir. 1999); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213 (W.D. Mo. June 9, 1995), *aff’d*, 69 F.3d 260 (8th Cir. 1995); *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057 (N.D. Cal. 2000), *aff’d*, 217 F.3d 846 (9th Cir. 2000), *amended by* 130 F. Supp. 2d 1109 (N.D. Cal. 2001); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 2006), *aff’d per curiam*, 121 F.3d 708 (6th Cir. 1997); *United States v. Mercy Health Servs. & Finley Tri-States Health Group, Inc.*, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997).

⁵³ “Building a Strong Foundation: The FTC Year in Review,” Federal Trade Commission, April 2002, page 9, <http://www.ftc.gov/os/2002/04/ftcyearreview.pdf>.

described by then-FTC Chairman Timothy Muris in a speech given in the Fall of 2002, the HMRP had two objectives: to allow the Commission to “consider bringing enforcement actions against consummated, anticompetitive hospital mergers”⁵⁴ and “to update [the Commission’s] prior assumptions about the consequences of particular transactions and the nature of competitive forces in health care.”⁵⁵ Four consummated hospital mergers were selected for intensive study: the 1998 acquisition of Cape Fear Memorial Hospital by New Hanover Regional Medical Center in Wilmington, North Carolina (New Hanover/Cape Fear); Sutter Health’s 1999 acquisition of Summit Medical Center, which combined Summit in Oakland, California with Sutter’s Alta Bates Medical Center in Berkeley, California (Summit/Alta Bates); Evanston Northwestern Healthcare’s 2000 purchase of Highland Park Hospital in the North Shore suburbs of Chicago (Evanston/Highland Park); and the 2000 merger of Victory Memorial Hospital and Provena St. Therese Medical Center in Waukegan, Illinois (Victory/St. Therese). As discussed below, the Evanston/Highland Park retrospective led to an administrative challenge and the ultimate determination that the acquisition was anti-competitive. The results of all four retrospective studies were published in early 2011.⁵⁶

38. The HMRP led to three important insights about the nature of hospital competition and the competitive effects of hospital mergers that have influenced the Commission’s recent hospital antitrust enforcement.⁵⁷ First, the HMRP illustrated that the methods used by the courts to define geographic markets in past hospital merger challenges can lead to markets that are overly broad, mistakenly implying that some anticompetitive hospital mergers are innocuous. In the hospital merger challenges of the 1980s and 1990s, courts relied on the Elzinga-Hogarty (EH) test to establish the boundaries of hospital geographic markets. The EH test posits that a relevant antitrust geographic market can be defined as an area for which the product flows into and out of the area are sufficiently small. In the context of hospital mergers, the first step of implementing the EH test is to designate a circle or group of zip codes that contain both of the merging hospitals. If most of the patients treated at the hospitals in this area also reside in this area (i.e., the inflows are small) and most of the patients residing in this area seek treatment at hospitals in the area (i.e., the outflows are low), then the area is an EH market. The thresholds used by the courts to define flows that are sufficiently small range from 10 to 25 percent. If either the inflows or outflows exceed the threshold, the market is expanded (usually by adding adjacent zip codes) and the inflows and outflows are recalculated until an area is obtained with inflows and outflows both below the threshold.

39. Some economists have long argued that the use of the EH test in hospital merger cases is inappropriate and leads to geographic markets that are too broad, especially in and around urban areas where the inflows are typically large, as rural and suburban patients seek care at the larger hospitals in the

⁵⁴ *Id.* at 9.

⁵⁵ “Everything Old is New Again: Health Care and Competition in the 21st Century,” prepared remarks of Chairman Timothy Muris before the 7th Annual Competition in Health Care Forum, Chicago, IL, (Nov. 7, 2002), pages 19-20, [hereinafter Muris remarks] <http://www.ftc.gov/speeches/muris/murishealthcarespeech0211.pdf>.

⁵⁶ Deborah Haas-Wilson and Christopher Garmon, “Hospital Mergers and Competitive Effects: Two Retrospective Analyses,” 18 *Int’l J. of the Econ. of Bus.* 17 (2011); Steven Tenn, “The Price Effects of Hospital Mergers: A Case-Study of the Sutter-Summit Transaction,” 18 *Int’l J. of the Econ. of Bus.* 65 (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. of the Econ. of Bus.* 91-101 (2011).

⁵⁷ Orley Ashenfelter, et. al., “Retrospective Analysis of Hospital Mergers,” 18 *Int’l J. of the Econ. of Bus.* 5 (2011).

city.⁵⁸ Courts using the EH test in hospital merger cases have, in some cases, defined geographic markets that are over 100 miles in diameter.⁵⁹ However, before the HMRP, there was little empirical evidence to support the claim that the EH test results in markets that are too broad. The Summit/Alta Bates retrospective found that the post-merger price increase at Summit Medical Center “was among the largest of any comparable hospital in California, indicating this transaction may have been anticompetitive.”⁶⁰ Employing the EH test in this case, the court ruled that the relevant geographic market was the entire San Francisco-Oakland metropolitan statistical area (MSA), implying that there would be sufficient post-merger competition and little risk of a post-merger price increase.⁶¹ The Evanston/Highland Park retrospective found that “relative to other [control] hospitals, the merger between Evanston Northwestern and Highland Park Hospital led to large and statistically significant post-merger price increases.”⁶² Had the EH test been applied in this case, it likely would have resulted in a geographic market of the entire Chicago MSA, implying little risk of a post-merger price increase.⁶³ Thus, the HMRP provided examples of hospital mergers in urban and suburban areas that led to significant post-merger price increases, contradicting the predictions of analyses based on EH-based market definitions. In the Evanston/Highland Park case, the Commission rejected the use of the EH test to define the relevant geographic market.⁶⁴

40. Second, the HMRP illustrated that non-profit hospitals do not necessarily abstain from exercising market power gained from a merger. The significance of a hospital’s institutional form (non-profit versus for-profit) to competition analysis has been a long-disputed issue in hospital merger cases. In antitrust merger analysis the relevant question is not whether non-profit hospitals behave in a manner indistinguishable from for-profit institutions, but whether they would use merger-created market power in ways harmful to consumers. Some courts and analysts have taken the position that even if nonprofit hospitals achieve market power through merger, their long-term public interest missions will prevent them from raising prices above competitive levels. In the Butterworth and Carilion hospital merger challenges,⁶⁵ the courts took this position and ruled for the defendants in both cases due at least in part to the hospitals’ nonprofit designations. These courts found that because of their non-profit designations, and their boards made up of community leaders, the merged hospitals would not pass on supracompetitive price increases to consumers even if the merger resulted in market power for the combined hospitals. In the HMRP, the Summit/Alta Bates and Evanston/Highland Park transactions both involved non-profit hospitals. The evidence gathered there of large price increases after both transactions dispelled the notion that merged non-profit hospitals necessarily refrain from exercising their market power. In this way, the HMRP

⁵⁸ Cory S. Capps, et. al., “Antitrust Policy and Hospital Mergers: Recommendations for a New Approach,” *The Antitrust Bulletin*, 677 (Winter 2002); Gregory J. Werden, “The Limited Relevance of Patient Migration Data in Market Delineation for Hospital Merger Cases,” 8 *J. Health Econ.* 363 (1989).

⁵⁹ *United States v. Carilion Health Systems*, 707 F. Supp. 840 (W.D. Va. 1989), *aff’d*, 892 F.2d 1042 (4th Cir.).

⁶⁰ *Tenn*, *supra* note 56.

⁶¹ *California v. Sutter Health Sys.*, 130 F. Supp. at 1109 (N.D. Cal. 2001).

⁶² Haas-Wilson and Garmon, *supra* note 56.

⁶³ In Evanston, the Commission rejected the Elzinga-Hogarty test for use in geographic market definition. *In the Matter of Evanston Northwestern Healthcare Corp.*, Dkt. No. 9315 (Opinion of the Commission Aug. 2007) [hereinafter Evanston Opinion] at 77.

⁶⁴ *Id.*

⁶⁵ *See Butterworth Health Corp.*, 946 F. Supp. at 1302; *Carilion Health Sys.*, 707 F. Supp. at 849.

supplemented a growing literature that has established that for-profit and non-profit hospitals respond to competitive forces in a similar fashion.⁶⁶

41. Third, the HMRP highlighted that hospital markets and hospital merger effects are complex, requiring a flexible approach to merger enforcement and analytic tools specifically designed for hospital markets. In all of the retrospectives, the estimated post-merger price changes varied across payers, with some receiving large price increases, while others received moderate price increases or even price decreases. In some cases, mergers of closely competing hospitals in relatively isolated geographic areas (e.g., Victory/St. Therese and New Hanover/Cape Fear) resulted in a mixture of price increases and decreases, while mergers between closely competing hospitals in urban and suburban areas (Summit/Alta Bates and Evanston/Highland Park) resulted in significant price increases across most payers. This has led to the development of new tools to analyze hospital mergers that are theoretically based and capture the complexity of hospital markets and the differentiation across hospitals and payers.⁶⁷ For example, one tool that has been used in recent hospital merger investigations is discrete choice modeling. Using hospital discharge data, one can model patient choices as a function of hospital characteristics (e.g., bed size, teaching intensity), patient characteristics (e.g., age, gender, diagnosis), and characteristics specific to the patient-hospital pairing (e.g., the travel time between the patient's residence and the hospital). From these estimates, one can derive a number of statistics that are useful for the analysis of merger effects. For example, one can use the estimated choice probabilities from the model to calculate hypothetical diversion ratios between hospitals to assess whether the hospitals are close competitors. As discussed below, the FTC's Administrative Law Judge in *FTC v. ProMedica Health System* recently relied, at least in part, on diversion analysis to determine which hospitals were close substitutes. One can also use the choice model's estimates to calculate each payer's "Willingness-to-Pay" for each hospital system and other statistics (e.g., patient-weighted Herfindahl-Hirschman Index) that can be used to estimate the effects of hospital mergers.

4.3. *A Summary of the Agencies' Recent Hospital Merger Challenges*

42. A goal of the FTC's HMRP, as discussed above, was to develop new strategies for litigating hospital merger cases.⁶⁸ After a string of losses in the 1990s, the FTC has had recent success in hospital merger litigation with a successful challenge to the consummated Evanston/Highland Park merger, an abandoned transaction, and a successful challenge to a consummated acquisition of outpatient medical clinics.⁶⁹ Three cases filed in 2011 are ongoing.⁷⁰ In this section, we highlight the Evanston/Highland Park case and two of the ongoing cases to illustrate the FTC's use of lessons learned in the HMRP.

⁶⁶ David Dranove and Richard Ludwick, "Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis," 18 J. Health Econ., 87 (1999); Michael Vita and Seth Sacher, "The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study," 49 J. of Indus. Econ. 63 (2001).

⁶⁷ Joseph Farrell, et. al., "Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets," 39 Rev. of Indus. Org. 271 (2011).

⁶⁸ Muris remarks, *supra* note 55.

⁶⁹ In 2008, the Commission challenged a proposed acquisition of Prince William Health System by Inova Health System Foundation, both located in Northern Virginia. The agency alleged that, if consummated, the acquisition would reduce competition for general acute care inpatient hospital services in Northern Virginia, resulting in higher prices, and patients would also lose the benefits of non-price competition. Facing the prospect of an administrative trial, the parties abandoned the transaction. See FTC Press Release, "FTC Approves Order Dismissing Administrative Complaint Against Inova Health System Foundation and Prince William Health System, Inc.," (Jun. 17, 2008) <http://www.ftc.gov/opa/2008/06/inovafyi.shtm>. In July 2009, the FTC issued an administrative complaint challenging Carilion Clinic's 2008 acquisition of an outpatient imaging center and an outpatient surgical

4.3.1. *Evanston Northwestern Healthcare Corporation: Product and Geographic Market Definition, Anticompetitive Effects, Lack of Efficiencies, and Non-profit Status*

43. The first case filed as a result of the HMRP was against a consummated hospital merger in the Chicago suburbs. In 2004, the FTC issued an administrative complaint challenging Evanston Northwestern Healthcare Corporation's ("Evanston") 2000 acquisition of Highland Park Hospital ("Highland Park").⁷¹ Evanston and Highland Park are located in suburbs north of Chicago, Illinois. The FTC alleged that the consummated acquisition eliminated significant competition between the hospitals and allowed Evanston to exercise market power against health care insurance companies and raise prices at least 9 to 10 percent, to the detriment of consumers.⁷² Given that the merger was consummated four years before the Commission brought its complaint, agency staff and its experts were able to gather significant evidence about what happened after the merger.⁷³ After a trial before an agency administrative law judge and an appeal to the full Commission, the Commission found that the merger violated the Clayton Act and "enabled the merged firm to exercise market power"⁷⁴ and raise prices.

44. In Evanston, the complaint alleged and the Commission held that the relevant product market was "acute inpatient hospital services."⁷⁵ The Merger Guidelines provide the framework for defining the relevant product market for hospital services. In hospital merger cases, the product market typically has been defined as a broad group of medical and surgical diagnostic and treatment services for acute medical conditions where the patient must remain in a health care facility for at least 24 hours for recovery or observation.⁷⁶ (In some cases, however, a smaller product market may be alleged, such as the provision of inpatient services for a particular specialty.⁷⁷) The broad grouping generally makes sense because, from the perspectives of payors and patients, inpatient services are complementary and bundled. Even if inpatient hospital prices are increased, patients and payors cannot separate and outsource nursing care, diagnostic tests, and room and board from the other treatments provided as part of a hospital stay.

45. Based on lessons learned in the HMRP, as discussed above, the Commission in the Evanston case determined the relevant geographic market without using the EH test. The Commission noted that according to the Merger Guidelines "the relevant geographic market is a region in which a hypothetical

center in Roanoke, Virginia. Before trial, Carilion agreed to divest both facilities to resolve the FTC's concerns. See FTC Press Release, "Commission Order Restores Competition Eliminated by Carilion Clinic's Acquisition of Two Outpatient Clinics," (Oct. 7, 2009) <http://www.ftc.gov/opa/2009/10/carilion.shtm>.

⁷⁰ *In the Matter of ProMedica Health Sys., Inc.*, Dkt. No. 9346 (Administrative Complaint Jan. 6, 2011) [hereinafter ProMedica Complaint]; *In the Matter of Phoebe Putney Health System, Inc.*, Dkt. No. 9348 (Administrative Complaint Apr. 20, 2011) [hereinafter Phoebe Putney Complaint]; the third ongoing case is the FTC's challenge to a hospital merger in Rockford, IL: *In the Matter of OSF Healthcare Sys.*, Dkt. No. 9349 (Administrative Complaint Nov. 18, 2011) (the related federal case is *FTC v. OSF Healthcare Sys.*, No.11-cv-50344 (Nov. 18, 2011), <http://www.ftc.gov/os/caselist/1110102/111118rockfordcmpt.pdf>).

⁷¹ *In the Matter of Evanston Northwestern Healthcare Corp.*, Dkt. No. 9315 (Complaint Feb. 10, 2004).

⁷² Evanston Opinion, *supra* note 63, at 78.

⁷³ See Haas-Wilson and Garmon, *supra* note 56.

⁷⁴ Evanston Opinion, *supra* note 63, at 5.

⁷⁵ *Id.* at 57.

⁷⁶ In *American Med. Int'l, Inc. and Hospital Corp. of America*, the FTC defined the relevant product market as a group of general acute care hospital services. *American Med. Int'l*, 104 F.T.C. 1, 107 (1984); *In re Hospital Corp. of Am.*, 106 F.T.C. 361 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986).

⁷⁷ ProMedica Complaint, *supra* note 70, at ¶ 12 (alleging a market for "inpatient obstetrical services").

monopolist could ‘profitably impose at least a small but significant and nontransitory increase in price [(“SSNIP”)], holding constant the terms of sale for all products produced elsewhere.’⁷⁸ After finding that the merger enabled Evanston to raise prices by an amount at least equal to a SSNIP, the Commission concluded that the relevant geographic market was “the geographic triangle in which the three [Evanston Northwestern Healthcare] hospitals are located”⁷⁹ and not a larger portion of the Chicago metropolitan area. The Commission also explicitly rejected the EH test for use in geographic market definition.⁸⁰

46. Merging hospitals often claim that their merger will produce significant efficiencies. Claimed efficiencies often include improved quality of care, avoidance of capital expenditures, consolidation of management and operational support jobs, consolidation of specific services to one location (e.g., all cardiac care at Hospital A and all cancer treatment at Hospital B), and reduction of operational costs, such as purchasing and accounting costs.⁸¹ Such efficiencies, if substantiated, are considered and can affect the court’s or the agencies’ decision about the likelihood of the merger being anticompetitive.⁸² In Evanston, the defendants argued that the merger produced efficiencies and other competitive benefits that outweighed the harm to competition. Specifically, the merged hospital claimed that the merger resulted in quality of care improvements.⁸³ The Commission, however, held that the post-merger improvements and expansions of service could and likely would have been made without a merger.⁸⁴ The Commission also found that Evanston provided “little verifiable evidence that the changes it made at Highland Park improved quality of care.”⁸⁵ At trial, the FTC’s expert presented results of a retrospective analysis of quality of care resulting from the Evanston/Highland Park merger. This analysis found little evidence that the merger

⁷⁸ Evanston Opinion, *supra* note 63, at 57, citing FTC & DOJ Horizontal Merger Guidelines (1992 rev.) at § 1.21.

⁷⁹ Evanston Opinion, *supra* note 63, at 78.

⁸⁰ *Id.* at 77.

⁸¹ In several merger cases, hospitals have signed “community commitments” or agreements with state attorneys general, promising not to raise prices for a specified period of time or promising to pass on to consumers a specified amount of money from claimed efficiencies. See *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 149; *Butterworth Health Corp.*, 946 F. Supp. at 1302. Other states also have entered into decrees with merging hospitals that provided for some type of community commitment. See, e.g., *Wisconsin v. Kenosha Hosp. & Med. Ctr.*, 1997-1 Trade Cas. (CCH) ¶ 71,669 (E.D. Wis. 1996) (consent decree); *Pennsylvania v. Capital Health Sys.*, 1995-2 Trade Cas. (CCH) ¶ 71,205 (M.D. Pa. 1995) (consent decree) (court ordered merged hospitals to pass at least 80 percent of the net cost savings to consumers); *Pennsylvania v. Providence Health Sys.*, 1994-1 Trade Cas. (CCH) ¶ 70,603 (M.D. Pa. 1994) (consent decree). Some state attorneys general have signed these agreements in an attempt to translate claimed merger-induced cost savings into actual price reductions to consumers. Community commitments are temporary and do not solve the underlying competitive problem when a hospital merger has increased the likelihood that market power will be exercised. See *Healthcare and Competition Law and Policy Hearings*, March 28, 2003 at 78:16-80:10, <http://www.ftc.gov/ogc/healthcarehearings/030328trans.pdf> (discussing what happened after one community commitment expired). Community commitments represent a regulatory approach to what is, at bottom, a structural market problem – and that problem will remain after the commitment has expired. Therefore, the Agencies do not endorse community commitments as an effective resolution to likely anticompetitive effects from a hospital (or any other) merger.

⁸² See Merger Guidelines, *supra* note 49, at Section 10.

⁸³ *In the Matter of Evanston Northwestern Healthcare Corp.*, Dkt. No. 9315, Pretrial Brief of Respondent Evanston Northwestern Healthcare (Jan. 27, 2005) at 31-32.

⁸⁴ Evanston Opinion, *supra* note 63, at 83.

⁸⁵ *Id.* at 84.

improved quality.⁸⁶ Thus, the Commission held that any quality of care improvements or other efficiencies resulting from the merger did not offset the showing of competitive harm (price increases).⁸⁷

47. The FTC’s case against Evanston also demonstrates that, based on the lessons learned in the HMRP, the agency will not hesitate to challenge an acquisition by a non-profit hospital if the Commission has reason to believe the acquisition will be anticompetitive. In Evanston, the merged hospital system argued that its status as a not-for-profit greatly reduced the potential for anticompetitive harm. Both the ALJ and the Commission rejected this argument, with the Commission holding that “the totality of the record shows that [Evanston’s] non-profit status did not affect its efforts to raise prices after the merger, and we readily agree with the ALJ that [Evanston’s] status as a nonprofit entity does not suffice to rebut complaint counsel’s evidence of anticompetitive effects.”⁸⁸

4.3.2. *ProMedica: Flexible Approach to Merger Effects Analysis*

48. The FTC’s case against ProMedica Health System (“ProMedica”) demonstrates how the agency is utilizing the insight gained through the HMRP that hospital merger effects are complex, requiring a flexible approach to merger enforcement and analytic tools specifically designed for hospital markets. In January 2011, the FTC challenged the consummated acquisition by ProMedica of St. Luke’s Hospital, both of which are located in Lucas County (Toledo), Ohio.⁸⁹ The FTC charged that the merger of ProMedica and St. Luke’s would substantially lessen competition, and the motivation for the acquisition was “to gain enhanced bargaining leverage with health plans and the ability to raise prices for services.”⁹⁰ A federal district court granted a preliminary injunction in March 2011 stopping further integration of the hospitals,⁹¹ and in December 2011, the FTC’s Administrative Law Judge ruled that ProMedica’s acquisition of St. Luke’s Hospital was anticompetitive and ordered that ProMedica divest St. Luke’s.⁹² The ALJ’s Initial Decision has been appealed to the full Commission, which is entitled to de novo review.

49. In ProMedica, the ALJ recognized the interaction and effect of competitive dynamics in several levels of the market for hospital services, which work to promote efficiencies and restraints on prices, as discussed above in Section II.B.⁹³ Specifically, the ALJ found that managed care plans “compete with one

⁸⁶ See Patrick S. Romano and David J. Balan, “A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare,” 18 Int’l J. of the Econ. of Bus. 45 (2011).

⁸⁷ Evanston Opinion, *supra* note 63, at 85.

⁸⁸ *Id.* at 85.

⁸⁹ Prior to the acquisition and during the pendency of the FTC’s investigation, ProMedica entered into a voluntary hold separate agreement with the FTC that restricted ProMedica from making certain changes to St. Luke’s. After investigation, the FTC filed a lawsuit in federal court to preserve the hold separate agreement and enjoin further consolidation while conducting a full trial through its administrative law process.

⁹⁰ ProMedica Complaint, *supra* note 70, at ¶ 1.

⁹¹ See *Federal Trade Comm’n v. ProMedica Health Sys.*, Case No. 3:11CV47 (N.D. Ohio Mar. 29, 2011) (Findings of Fact & Conclusions of Law), <http://www.ftc.gov/os/caselist/1010167/110329promedicafindings.pdf>.

⁹² *In the Matter of ProMedica Health Sys., Inc.*, Dkt. No. 9346 (Initial Decision Dec. 5, 2011) [hereinafter ProMedica Initial Decision].

⁹³ While the federal judge in the U.S. District Court for the Northern District of Ohio reached many of the same conclusions in ordering a preliminary injunction in this matter, this paper focuses on the analysis of the FTC ALJ’s Initial Decision, which was reached after a full administrative trial.

another to be offered by employers in the menu of insurance products that employers offer to their employees.”⁹⁴ “Once included in the employer’s menu of health insurance products, [managed care organizations] compete with one another to attract enrollees.”⁹⁵ Hospitals compete among themselves to be included in plans; once included, hospitals compete for patients from the plan based on quality, location, and other mostly non-price aspects.⁹⁶

50. Using this framework, the ALJ found that “for many patients, St. Luke’s and one of ProMedica’s hospitals are patients’ top two choices for [general acute care] inpatient hospital services” based on the location and other amenities.⁹⁷ The merger eliminated a managed care organization’s option of contracting with St. Luke’s alone. Thus, post-merger, if a managed care organization failed to reach an agreement with ProMedica, the managed care organization would not be able to offer a hospital provider network including one of the local patients’ two top hospital choices. Without top choice hospitals, a managed care plan would lose customers. Thus, the ALJ found that “the [merger] will significantly increase [ProMedica’s] bargaining leverage in negotiations with [managed care organizations] and provide [ProMedica] with sufficient market power to enable it to increase the reimbursement rates it charges . . . for . . . inpatient hospital services.”⁹⁸ Complaint counsel presented diversion analysis,⁹⁹ which the ALJ found supported the conclusion that “St. Luke’s and one or more of the three ProMedica hospitals are close substitutes.”¹⁰⁰ Testimony of managed care officials also supported this conclusion.

51. Finally, the ALJ in ProMedica found that the asserted procompetitive benefits and efficiencies from the transaction, including that the merger would make St. Luke’s financially stronger, were insufficient to outweigh the anticompetitive effects of the merger, and that St. Luke’s was not a “failing firm” under U.S. case law, such that the merger should be allowed to proceed.¹⁰¹

4.3.3. *Phoebe Putney: The State Action Defense*

52. In December 2010, PPHS, a nonprofit corporation and operator of Phoebe Putney Memorial Hospital (“PPMH”), entered into an agreement to acquire control of Palmyra Park Hospital (“Palmyra”), the only competing hospital in Albany, Georgia.¹⁰² The FTC challenged the acquisition, charging that the merger of PPMH and Palmyra under the same operator would constitute a merger to monopoly for inpatient general acute-care hospital services in Albany and its surrounding area, and that even though PPHS is a nonprofit entity, the acquisition “greatly enhances Phoebe Putney’s bargaining position in negotiations with health plans, giving it the unfettered ability to raise reimbursement rates without fear of losing customers.”¹⁰³

⁹⁴ ProMedica Initial Decision, *supra* note 92, at ¶ 237.

⁹⁵ *Id.* at ¶ 238.

⁹⁶ *Id.* at ¶¶ 244 and 245.

⁹⁷ *Id.* at page 162.

⁹⁸ *Id.* at 6.

⁹⁹ See discussion above in section on the HMRP.

¹⁰⁰ *Id.* at 159.

¹⁰¹ *Id.* at 7.

¹⁰² Before the acquisition, Palmyra was owned by a for-profit corporation, HCA, Inc.

¹⁰³ Phoebe Putney Complaint, *supra* note 70, at ¶ 11.

53. The critical issue in the PPHS case is not its nonprofit status but rather its claimed state action defense. Thus, this case illustrates a supply-side factor in the U.S. that threatens to restrain competition between hospitals – the state action defense or state action immunity. PPHS operates PPMH under a lease from the local hospital authority and owner of the facility (“the authority”). PPHS asked the authority to acquire Palmyra, and PPHS agreed to provide the funds the authority needed for the acquisition. The authority agreed to lease Palmyra to PPHS. The FTC sought a preliminary injunction in federal court to enjoin the merger but the defendants argued that the state action doctrine immunized the authority and the planned combination of the two hospitals from antitrust liability. In the U.S., “[t]he doctrine of state-action immunity protects states from liability under federal antitrust laws.”¹⁰⁴ The same protection extends to municipalities or political subdivisions of a state if, “through statutes, the state generally authorizes the political subdivision to perform the challenged action, and [if] through statutes, the state has clearly articulated a state policy authorizing anticompetitive conduct.”¹⁰⁵ The FTC countered that PPHS was the effective acquirer and that the authority was only a “straw man” used to give PPHS control of its competitor. In denying the FTC’s request for a preliminary injunction, the U.S. Court of Appeals for the 11th Circuit ruled in December 2011 that because the state of Georgia granted to local hospital authorities the power to acquire hospitals and to lease hospitals to others to operate, “the legislature must have anticipated that such acquisitions [if they consolidated ownership or operation of competing hospitals and eliminated competition between them] would produce anticompetitive effects.”¹⁰⁶ The FTC is considering its options for appealing this decision.

5. Non-merger Conduct Cases to Protect Competition in Contracting for Hospital Services

54. The DOJ has focused its resources on investigating and challenging conduct by dominant hospitals that prevents entry or expansion by rival hospitals and other health care facilities. In 2011, the DOJ challenged, under Section 2 of the Sherman Act, United Regional Health Care System’s practice of requiring most commercial health insurers to pay significantly higher prices if they contracted with United Regional’s competitors. United Regional provides approximately 90 percent of the inpatient hospital care in Wichita Falls, Texas, which made it necessary for all insurers to have United Regional in their networks in order to sell health insurance in Wichita Falls. Because the penalty for contracting with United Regional’s rivals was so significant, almost all insurers that offered health insurance in Wichita Falls entered into exclusive contracts with United Regional. As a result, competing hospitals and facilities could not obtain contracts with most insurers and were less able to compete, which helped United Regional maintain its monopoly. The DOJ resolved the lawsuit through a settlement that prohibits United Regional from conditioning the prices or discounts that it offers to commercial health insurers on whether those insurers contract with competing health care facilities. To ensure that United Regional can engage in procompetitive discounting, the settlement allows United Regional to offer (a) different prices to different commercial health insurers and (b) incremental volume discounts.

55. The DOJ has also brought cases involving competition in the health insurance market with direct effects on hospitals.

56. In November 2011, the DOJ sued Blue Cross and Blue Shield of Montana (“BCBSMT”) and five hospitals in Montana. The hospitals owned New West Health Services (“New West”), one of only two

¹⁰⁴ *Federal Trade Comm’n v. Phoebe Putney Health Sys.*, D.C. Docket No. 1:11-cv-00058-WLS (11th Cir. Dec. 9, 2011) at 9, [hereinafter *Phoebe Putney 11th Circuit Opinion*] <http://www.ca11.uscourts.gov/opinions/ops/201112906.pdf>.

¹⁰⁵ *Federal Trade Comm’n v. Hosp. Bd. of Dirs. of Lee County*, 38 F.3d 1184, 1187-88 (11th Cir. 1994) (citing *Town of Hallie v. City of Eau Claire*, 471 U.S. 34 (1985)).

¹⁰⁶ *Phoebe Putney 11th Circuit Opinion*, supra note 104, at 13.

significant health insurer competitors to BCBSMT. BCBSMT had agreed to pay \$26.3 million to the hospital defendants in exchange for their agreeing to collectively stop purchasing health insurance for their own employees from New West and instead buy insurance for their employees from BCBSMT exclusively for six years. BCBSMT also agreed to provide the hospital defendants with two seats on BCBSMT's board of directors if the hospitals elected not to compete with BCBSMT in the sale of commercial health insurance. The agreement would likely have caused New West to exit the market for commercial health insurance in Montana.

57. The DOJ settled the case by requiring New West to sell the majority of its commercial health insurance business to a third-party buyer and requiring the five defendant hospital owners to enter into three-year contracts with the acquirer to provide services on terms that are substantially similar to their existing contractual terms with New West. These requirements are important because to compete effectively, health insurers need a network of health care providers at competitive rates.¹⁰⁷

58. In October 2010, the DOJ sued Blue Cross Blue Shield of Michigan (BCBSM) alleging that BCBSM had sought to insulate itself from competition in health insurance markets throughout Michigan by entering into "most favoured nation" agreements ("MFNs") with more than 70 hospitals. These agreements either (1) require hospitals to charge BCBSM's competitors more than what the hospitals charge BCBSM, or (2) mandate that the hospitals charge BCBSM's competitors at least as much as they charge BCBSM, which has caused a number of hospitals to raise their prices to BCBSM's competitors and reduced competition. The DOJ alleged that these agreements likely resulted in Michigan consumers paying higher prices for their health care services and health insurance.

59. BCBSM moved to dismiss the DOJ's complaint on the ground that its conduct was protected by the "state action" doctrine. The DOJ argued that the BCBSM's contracts did not qualify for state action protection because the State of Michigan had not articulated a clear and affirmative policy to allow the anticompetitive MFNs and that the State did not actively supervise the anticompetitive conduct. The court agreed with the DOJ and denied BCBSM's motion to dismiss. The litigation is ongoing.¹⁰⁸

6. Conclusion

60. The hospital industry in the United States continues to evolve, as an aging population and higher-cost technologies put pressure on policy makers to adopt programs to constrain costs while improving quality of hospital services. Recent changes in U.S. health care law are designed to promote efficiencies, improve quality, and restrain further price increases in the provision of services. But, the market for the provision of hospital services is complex, with competitive forces working to promote efficiencies and restrain prices in several levels of the market, including third-party payors (both government and private payors), hospitals, employers who provide insurance benefits for their employees, and consumer/employees/patients. Consolidation at these levels can have anticompetitive effects and result in higher prices and lower quality services. The FTC's Hospital Merger Retrospective project has informed and strengthened the enforcement actions of the U.S. competition agencies. The project provided further evidence that competition can deliver improvements in the quality of care and restraints on prices for hospital services. Recent efforts by the FTC to stop anticompetitive hospital mergers have met with some success, and the U.S. will continue to make the protection and promotion of competition in the hospital market a high priority.

¹⁰⁷ See <http://www.justice.gov/atr/cases/bcbsmnw.html>.

¹⁰⁸ See <http://www.justice.gov/atr/cases/bcbsmfn.html>.