



UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition

May 2, 2016

The Hon. Larry C. Stutts
Alabama State Senate
Alabama State House
11 South Union Street, Suite 735
Montgomery, Al 36130 – 4600

Dear Senator Stutts:

The Federal Trade Commission (“FTC”) Office of Policy Planning, Bureau of Competition, and Bureau of Economics (collectively, the “staff”) appreciate your request for comments on Alabama House Bill 241 / Senate Bill 243 (collectively, the “Bill”).¹ The Bill would permit any public university that operates a school of medicine to form a new type of corporation in Alabama, to be known as an “authority,” in collaboration “with all types of health care providers.”² FTC staff submit this letter to address the Bill’s attempt to exempt authorities, their “collaborative activities,” and their “university affiliates, as well as the public or private entities and individuals with which they collaborate” from the federal antitrust laws.³

If effective, the broad antitrust exemption the Bill purports to provide would immunize anticompetitive mergers, price fixing, boycotts, and a wide variety of other anticompetitive conduct that harms consumers. Many health care provider collaborations can be efficient and beneficial, and no antitrust exemption is needed to permit them from occurring. Indeed, the Bill appears to reflect mistaken beliefs about the antitrust laws and the benefits of competition among health care providers. If enacted, the exemption would not improve patient care, but would likely raise health care costs and decrease access to care. As we discuss below,

- First, the antitrust laws permit health care collaborations that do not harm consumers. As the FTC and its staff have consistently explained, many competitor collaborations – including health care provider collaborations and mergers – can be efficient and procompetitive, and are therefore lawful.
- Second, because the antitrust laws already permit procompetitive health care collaborations, the Bill’s purported “immunization” provision would foster anticompetitive mergers, collective negotiations, and other conduct that would *not* pass muster under the antitrust laws. Hence, the antitrust immunity contemplated by the Bill would likely increase health care costs,

diminish incentives to improve quality, and decrease access to health care services for Alabama consumers.

I. Interest and Experience of the Federal Trade Commission

Congress has charged the Federal Trade Commission (“FTC” or “Commission”) with enforcing the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.⁴ The FTC also enforces Section 7 of the Clayton Act, which prohibits transactions that may substantially lessen competition or tend to create a monopoly.⁵ Competition is at the core of America’s economy,⁶ and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality goods and services, greater access to goods and services, and innovation.⁷ Pursuant to its statutory mandate, the FTC seeks to identify business practices and governmental laws and regulations that may impede competition without also providing countervailing benefits to consumers.

Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,⁸ research,⁹ and advocacy.¹⁰ Of particular relevance, the Commission and its staff have long advocated against federal and state legislative proposals that seek to create antitrust exemptions for collective negotiations by health care providers because such exemptions are likely to harm consumers.¹¹

II. Alabama House Bill 241 / Senate Bill 243

The Bill “would authorize public universities operating schools of medicine to form a new type of public corporation to be called an authority.”¹² The Bill would grant numerous corporate powers, in addition to those generally assigned under Alabama corporate law, to such authorities. These corporations and their affiliates might extend well beyond what are traditionally thought of as academic medical centers, both geographically and in terms of the services they provide. For example, such a corporation would have the power

[t]o acquire, construct, equip, and operate those health care facilities it considers necessary or desirable,¹³ . . . [to] create, establish, acquire, operate, or support subsidiaries and affiliates, either for-profit or nonprofit, to assist an authority in fulfilling its purposes,¹⁴ . . . [and to] participate as a shareholder in a corporation, as a joint venturer in a joint venture, as a general or limited partner in a general or limited partnership, as a member of a nonprofit corporation, or as a member of any other lawful form of business organization, that provides health care *or engages in activities related thereto*.¹⁵

Once established, an authority could accept grants or gifts from any source,¹⁶ and “[t]he state, any university, any governmental entity, and any public corporation [would be] authorized to give, transfer, convey, or sell to any authority . . . with or without

consideration: (1) Any of its health care facilities and other properties, real or personal, and any funds and assets, tangible or intangible, relative to the ownership or operation of any such health care facilities,” among other assets.¹⁷ In addition, the Bill would vest the power of eminent domain in authorities.¹⁸

There appears to be no requirement that all facilities owned or operated by authorities, their subsidiaries, or their affiliates participate directly in medical education, research, or training, or that all such facilities engage directly in the provision of health care to Alabama citizens. Under the terms of the Bill, even the determination of what counts as a “health care facility” would be left to the authority’s discretion.¹⁹

As noted above, the Bill purports to insulate these many and diverse entities, and their conduct, against the safeguards and consumer protections provided by the antitrust laws.²⁰

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

The Bill appears to assume that antitrust laws prohibit efficient health care mergers, acquisitions, and collaborations to the detriment of health care and consumers in Alabama. That assumption is wrong.

Cooperation among competing health care providers, including academic medical centers, often can benefit competition and health care consumers. Many of the Bill’s stated goals—e.g., the promotion of public health and the potential contributions of academic medical centers to it²¹—are not objectionable and frequently result from robust provider competition. Consequently, seeking to immunize the Bill’s proposed corporate authorities, their affiliates, and their subsidiaries from any potential antitrust liability seems unnecessary, and as explained in Part IV below, also likely harmful.

The antitrust laws already recognize that competitor collaborations can be procompetitive. As the FTC and the U.S. Department of Justice (collectively, “the Antitrust Agencies”) have repeatedly explained,²² this position extends to collaborations among competing health care providers. For example, the Antitrust Agencies have stated that “[n]ew arrangements and variations on existing arrangements involving joint activity by health care providers continue to emerge to meet consumers’, purchasers’, and payors’ desire for more efficient delivery of high quality health care services.”²³ More recently, FTC officials have emphasized that

[t]he FTC supports the key aims of health care reform, and . . . recognize[s] that collaborative and innovative arrangements among providers can reduce costs, improve quality, and benefit consumers. But these goals are best achieved when there is healthy competition in provider markets fostering the sort of dynamic, high-quality, and innovative health care that practitioners seek and patients deserve.²⁴

Turning specifically to mergers, the Horizontal Merger Guidelines issued jointly by the Antitrust Agencies recognize that merger-generated efficiencies “may result in lower prices, improved quality, enhanced service, or new products.”²⁵ Those efficiencies are routinely assessed in merger investigations as part of an evaluation of the potential anticompetitive harm stemming from a merger or acquisition. For those reasons, and because many mergers do not threaten competition, the Antitrust Agencies have challenged few of the thousands of health care provider mergers, joint ventures, and other types of collaborations that have occurred in recent years, and have “brought those challenges only after rigorous analysis of market conditions showed that the acquisition was likely to substantially lessen competition.”²⁶ These outcomes confirm that the antitrust laws already consider likely benefits, as well as competitive harms, and therefore already accomplish many of the Bill’s objectives.

Moreover, the goals of antitrust law are consistent with the policy goals of fostering the coordination and integration of health care delivery via collaboration among health care providers through, for example, the formation of Accountable Care Organizations.²⁷ Despite what some health care industry participants have claimed, the antitrust laws do not prohibit the kinds of collaboration necessary to achieve the health care reforms contemplated by the Affordable Care Act and other policy initiatives.²⁸ Specifically, antitrust does not impede Alabama health care providers from forming procompetitive collaborative arrangements that are likely to reduce costs and benefit health care consumers through increased efficiency and improved coordination of care.²⁹

IV. The Purported Antitrust Exemption Poses a Substantial Risk of Consumer Harm

FTC staff understand that Alabama may take particular interest in fostering its academic medical centers. Still, because antitrust law already allows efficient collaborations among health care providers that benefit consumers, the Bill’s exemption provisions would encourage mergers and conduct that likely would *not* pass muster under the antitrust laws because they would tend to reduce competition, raise prices, diminish incentives to improve quality, and provide little or no benefits to consumers.

Even though an “authority” can only be established by a public university that operates a school of medicine, the Bill does not require that the authority be limited to that school of medicine, its academic medical center, or the university community. To the contrary, as noted above, the Bill expressly contemplates that authorities will “collaborate with all types of health care providers,” and that they may “create, establish, acquire, operate, or support subsidiaries and affiliates, either for-profit or nonprofit, to assist an authority in fulfilling its purposes.”³⁰ In fact, the Bill contemplates that a university may incorporate more than one authority,³¹ even if it operates only one academic medical center. Hence, any competitive harm inflicted by such agreements might originate from the loss of competition between two or more *other* hospitals, or other health care providers, and the effects might originate or spread well beyond a teaching hospital and its surrounding community. Any effort to shield such harmful conduct from antitrust

enforcement—including attempts to confer state action immunity—is likely to harm Alabama’s health care consumers, including patients as well as both public and private third-party payors.

In its 2007 report, the congressionally established, bipartisan Antitrust Modernization Commission³² succinctly stated a widely recognized proposition: “[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality and reduced innovation.”³³

Yet, in the face of this proposition, health care providers repeatedly have sought antitrust immunity for various forms of joint conduct, including agreements on the prices they will accept from payors, asserting that immunity for joint bargaining is necessary to “level the playing field” so that providers can create and exercise countervailing market power.³⁴

Here, at least with respect to antitrust treatment of health care providers, we disagree with the Bill’s assertion that “academic medical centers often are at a competitive disadvantage as a result of limitations on their ability to form networks and delivery systems and otherwise collaborate with other health care providers to form joint ventures or other entities with shared ownership.” No such competitive disadvantage is imposed by the federal antitrust laws. If the legislature finds that Alabama’s corporate law, or its university charters, unduly burden the state’s academic medical centers, we respectfully suggest that you seek more targeted, and less competitively harmful, ways to reform those provisions.³⁵

V. Antitrust Exemptions Deprive Consumers of the Substantial Benefits That Competition Provides in Health Care

The U.S. Supreme Court recently reiterated its long-standing position that, “given the antitrust laws’ values of free enterprise and economic competition, ‘state-action immunity is disfavored.’”³⁶ As the Court recognized, this general principle applies with full force in the health care industry, where consumers benefit from vigorous competition, and where anticompetitive conduct can cause significant harm.³⁷ As discussed above, antitrust law permits many forms of procompetitive collaborations among health care providers, and seeks only to protect health care consumers from anticompetitive forms of joint conduct that are likely to harm them. To confer antitrust immunity on provider collaborations, regardless of whether they are procompetitive or anticompetitive, thus would be overbroad and likely to harm consumers.

Empirical evidence on competition in health care markets generally has demonstrated that consumers benefit from lower prices when provider markets are more competitive.³⁸ Retrospective studies of the effects of provider consolidation by FTC staff and independent scholars suggest that, “increases in hospital market concentration lead to

increases in the price of hospital care.”³⁹ Moreover, additional empirical evidence suggests that, “[a]t least for some procedures, hospital concentration reduces quality.”⁴⁰

For example, recent research indicates that “health spending on the privately insured varies by more than a factor of three across the 306 hospital referral regions (HRRs) in the US.”⁴¹ For individual procedures, hospital prices can vary even more. The same study found that, “[h]ospitals’ negotiated transaction prices routinely vary by over a factor of eight or more across the nation and by a factor of three within HRRs.”⁴² Different factors may contribute to this variation but “hospital market structure stands out as one of the most important factors associated with higher prices, even after controlling for costs and clinical quality.”⁴³

Academic medical centers are no less responsive than other health care providers to changes in market structure and conditions, and therefore may respond to changes in market concentration in ways that harm consumers. For example, a retrospective study of a merger involving an academic medical center found that “four of the five commercial insurers experienced large and statistically significant price increases at the merged hospital.”⁴⁴ Moreover, those insurers “were forced to raise their prices by at least 10 percentage points more at the merged hospital relative to other Chicago area hospitals.”⁴⁵ Furthermore, the study found that the relative price increase could not be explained by changes in case mix, patients’ severity of illness, payer mix, or teaching intensity.⁴⁶

Empirical evidence also suggests that greater competition incentivizes providers to become more efficient and innovative. A recent study shows that hospitals faced with a more competitive environment have better management practices.⁴⁷ In sum, ample evidence exists that competition can and does work in health care markets.⁴⁸

The FTC has engaged in significant enforcement efforts to prevent anticompetitive behavior in health care provider markets precisely because consumers benefit from competition and, conversely, are harmed by anticompetitive mergers and conduct.⁴⁹

VI. Conclusion

Competitor collaborations, mergers, and acquisitions can be procompetitive, benefitting patients and payors alike. Interest in such collaboration among health care providers is understandable and, indeed, important. As we have explained both in this comment and in numerous and detailed guidance documents, however, the antitrust laws already permit efficient, pro-consumer collaborations among competing health care providers, and already permit efficient and pro-consumer mergers. The Bill’s apparent attempt to confer antitrust immunity is therefore unnecessary for collaborations that would benefit Alabama’s citizens. If such immunity were conferred, it would prevent antitrust authorities from scrutinizing, moderating, or preventing anticompetitive mergers and conduct that would seriously harm Alabama consumers. In some cases, it also could encourage groups of private health care providers to engage in blatantly anticompetitive conduct.

We appreciate your consideration of these issues.

Respectfully submitted,

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¹ Letter from the Hon. Larry C. Stutts, Alabama State Senate, to the Hon. Edith Ramirez, Chairwoman, Fed. Trade Comm'n (March 10, 2016).

² Alabama House Bill 241 / Senate Bill 243, proposed § 3(b)(2) (the companion bills will be cited hereinafter as Senate Bill 243).

³ *Id.*

⁴ Federal Trade Commission Act, 15 U.S.C. § 45.

⁵ Clayton Act, 15 U.S.C. § 18.

⁶ *Standard Oil Co. v. FTC*, 340 U.S. 231, 248 (1951) (“The heart of our national economic policy long has been faith in the value of competition.”).

⁷ *See Nat'l Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 695 (1978) (The antitrust laws reflect “a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain – quality, service, safety, and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.”).

⁸ *See generally* Fed. Trade Comm'n, An Overview of FTC Antitrust Actions In Health Care Services and Products (Mar. 2013), <https://www.ftc.gov/system/files/attachments/competition-policy-guidance/hcupdaterev.pdf>; *see also* Fed. Trade Comm'n, Competition in the Health Care Marketplace: Formal Commission Actions, <https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care>.

⁹ *See, e.g.*, FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE (“DOJ”), IMPROVING HEALTH CARE:

A DOSE OF COMPETITION (2004), <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf> [hereinafter FTC & DOJ, IMPROVING HEALTH CARE]. The report was based on, among other things, 27 days of formal hearings on competitive issues in health care, an FTC-sponsored workshop, independent research, and the Agencies' enforcement experience.

¹⁰ FTC and staff advocacy may take the form of letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. *See, e.g.*, FTC Staff Letter to the Honorable Theresa W. Conroy, Connecticut House of Representatives, Concerning the Likely Competitive Impact of Connecticut House Bill 6391 on Advance Practice Registered Nurses ("APRNs") (Mar. 2013), <https://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice> (competitive impact of statutorily required "collaborative practice agreements" for nurse practitioners); FTC and DOJ Written Testimony Before the Illinois Task Force on Health Planning Reform Concerning Illinois Certificate of Need Laws (Sept. 2008), <http://www.ftc.gov/os/2008/09/V080018illconlaws.pdf>; Brief of the Fed. Trade Comm'n as Amicus Curiae, *St. Joseph Abbey, et al. v. Castille*, 712 F.3d 215 (5th Cir. 2013) (No. 11-30756) (refuting argument that the policies of FTC funeral rule support restrictions of sort challenged by petitioner); FTC & DOJ, IMPROVING HEALTH CARE, *supra* note 9.

¹¹ *See, e.g.*, FTC Staff Comment Regarding Oregon Senate Bill 231A, Which Includes Language Intended To Provide Federal Antitrust Immunity To Conversations, Information Exchanges, and Agreements Among Participants (Including Competitors) In Oregon's Health Care Markets (May 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-oregon-senate-bill-231a-which-includes-language-intended-provide-federal/150519oregonstaffletter.pdf; FTC Staff Comment to New York State Senator Ranzenhofer and New York State Assemblyman Abinanti Concerning SB 2647 and AB 2888 Authorizing Certain Agreements for the Creation and Operation of a Health Care Delivery System Network (June 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-new-york-state-senator-ranzenhofer-new-york-state-assemblyman-abinanti-concerning/150605nypublichealthletter.pdf; FTC Staff Comment to the Tennessee Department of Health Regarding the Implementation of Laws Relative to Cooperative Agreements and the Granting of Certificates of Public Advantage (Sept. 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-tennessee-department-health-regarding-implementation-laws-relative-cooperative/151015tennesseedoh.pdf; FTC Staff Comment Before the Connecticut General Assembly Labor and Employees Committee Regarding Connecticut House Bill 6431 Concerning Joint Negotiations by Competing Physicians in Cooperative Health Care Arrangements (June 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-connecticut-general-assembly-labor-and-employees-committee-regarding-connecticut/130605conncoopcomment.pdf; FTC Staff Comment to the Hon. Elliott Naishtat Concerning Texas S.B. 8 to Exempt Certified Health Care Collaboratives From the Antitrust Laws (May 2011), <http://www.ftc.gov/os/2011/05/1105texashealthcare.pdf>; FTC Staff Comment to Rep. Tom Emmer of the Minnesota House of Representatives Concerning Minnesota H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009), <http://www.ftc.gov/opp/advocacy/V090003.pdf>; FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008), <http://www.ftc.gov/os/2008/02/V080001homecare.pdf>; FTC Staff Comment Before the Puerto Rico House of Representatives Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-

[independent-practice-association-inc./gripa.pdf](http://www.independent-practice-association-inc./gripa.pdf).

²³ U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *supra* note 22, at 2.

²⁴ Edith Ramirez, *Antitrust Enforcement in Health Care – Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245 (2014), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1408009>. *See also* Deborah L. Feinstein, Dir., Bureau of Competition, Remarks at the Fifth National Accountable Care Organization Summit in Washington, DC: Antitrust Enforcement in Health Care: Proscription, not Prescription, 26 (June 19, 2014), https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf (“We continue to hear claims that antitrust principles are at odds with the mandates of the Affordable Care Act. I believe these arguments misunderstand the focus and intent of federal antitrust enforcement. . . . In the final analysis, our actions make clear the important role of antitrust in health care policy. Ultimately, we believe that the imperatives of developing lower cost, higher quality health care can coexist with continued enforcement of the antitrust laws.”).

²⁵ FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, HORIZONTAL MERGER GUIDELINES, § 10 (2010), <https://www.ftc.gov/tips-advice/competition-guidance>.

²⁶ Feinstein, *supra* note 24, at 9.

²⁷ These widely shared policy goals are central to the Accountable Care Organizations contemplated under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3022, 14 Stat. 119, 395 (“Affordable Care Act”). Ctrs. Medicare & Medicaid Servs., Fast Facts, All Shared Savings Program and Pioneer ACOs Combined (Apr. 2015) (404 shared savings ACOs and 19 Pioneer ACOs with 7.92 million assigned beneficiaries in 49 states plus Washington, DC and Puerto Rico). The FTC has not challenged any of these 423 ACOs. *See also* Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,822 (Nov. 2, 2011) (codified at 42 C.F.R. pt. 425) (“[T]he intent of the Shared Savings Program and the focus of antitrust enforcement are both aimed at ensuring that collaborations between health care providers result in improved coordination of care, lower costs, and higher quality, including through investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”).

²⁸ FTC Staff Comment to the West Virginia House of Delegates Regarding SB 597 and the Competitive Implications of Provisions regarding “Cooperative Agreements” Between – and Possible Exemptions from the Federal Antitrust Laws for – Health Care Providers (Mar. 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-west-virginia-house-delegates-regarding-sb-597-competitive-implications-provisions/160310westvirginia.pdf; FTC Staff Comment Before the Connecticut General Assembly Labor and Employees Committee Regarding Connecticut House Bill 6431 Concerning Joint Negotiations by Competing Physicians in Cooperative Health Care Arrangements (June 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-connecticut-general-assembly-labor-and-employees-committee-regarding-connecticut/130605conncoopcomment.pdf.

²⁹ *See id.*; Feinstein, *supra* note 24. As Feinstein points out, antitrust challenges to mergers involving health care providers of complementary – or “vertical” – services are rare. For example, the FTC has not once “challenged a purely vertical merger involving a hospital and a physician practice.” Feinstein, *supra* note 24, at 8.

³⁰ Alabama Senate Bill 243, § 9(a)(8).

³¹ *Id.* § 4(b).

³² The Antitrust Modernization Commission was created pursuant to the Antitrust Modernization Commission Act of 2002, Pub. L. No. 107-273, §§ 11051-60, 116 Stat. 1856.

³³ ANTITRUST MODERNIZATION COMM’N, REPORT AND RECOMMENDATIONS 335 (2007), http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

³⁴ In general, the Supreme Court has flatly rejected the notion that members of the learned professions should be free from antitrust scrutiny: “The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . nor is the public-service aspect of professional practice controlling in determining whether § 1 includes professions.” *Goldfarb v. Va. State Bar*, 421 U.S. 773, 787 (1975); *see also Nat’l Soc’y of Prof’l Eng’rs v. United States*, 435 U.S. 679, 695 (1978) (Supreme Court rejection of argument that competition itself poses a “potential threat . . . to the public safety”); *FTC v. Indiana Fed’n of Dentists*, 476 U.S. 447 (1986).

³⁵ For example, the legislature might consider whether some of the corporate powers the Bill would vest in the authorities—such as the power of eminent domain—would serve not to level the competitive playing field but further distort it, potentially in ways that are both costly and largely unrelated to academic medicine.

³⁶ *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003, 1010 (2013) (quoting *FTC v. Ticom Title Ins. Co.*, 504 U.S. 621, 636 (1992)); *see also North Carolina State Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101, 1117 (2015) (no state action immunity for dental board that sought to exclude non-dentist competitors in teeth whitening services).

³⁷ *Phoebe Putney*, 133 S. Ct. at 1015 (state legislature’s objective of improving access to affordable health care does not logically suggest contemplation of anticompetitive means, and “restrictions [imposed upon hospital authorities] should be read to suggest more modest aims.”). As the U.S. Court of Appeals for the Fourth Circuit has observed, “[f]orewarned by the [Supreme Court’s] decision in *National Society of Professional Engineers* . . . that it is not the function of a group of professionals to decide that competition is not beneficial in their line of work, we are not inclined to condone anticompetitive conduct upon an incantation of ‘good medical practice.’” *Virginia Acad. of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476, 485 (4th Cir. 1980).

³⁸ *See, e.g., Zack Cooper, Stuart V. Craig, Martin Gaynor, & John Van Reenen, The Price Ain’t Right? Hospital Prices in Health Spending on the Privately Insured*, Nat’l Bureau Econ. Res., NBER Working Paper 21815 (Dec. 2015) (finding tremendous variation in hospital prices, and observing that “hospital prices are positively associated with indicators of hospital market power. Even after conditioning on many demand and cost factors, hospital prices in monopoly markets are 15.3 percent higher than those in markets with four or more hospitals.”); Gautam Gowrisankaran, Aviv Nevo & Robert Town, *Mergers When Prices Are Negotiated: Evidence from the Hospital Industry*, 105 AM. ECON. REV. 172 (2015); Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update*, ROBERT WOOD JOHNSON FOUNDATION: THE SYNTHESIS PROJECT (2012) [hereinafter *Impact of Hospital Consolidation*] (synthesizing research on the impact of hospital mergers on prices, cost, and quality and finding that hospital consolidation generally results in higher prices, hospital competition improves quality of care, and physician-hospital consolidation has not led to either improved quality or reduced costs); Martin Gaynor & Robert J. Town, *Competition in Health Care Markets* (Nat’l Bureau of Econ. Research, Working Paper 17208 (2011) (critical review of empirical and theoretical literature regarding markets in health care services and insurance)).

³⁹ Gaynor & Town, *Impact of Hospital Consolidation*, *supra* note 38, at 1 (citing, e.g., Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 INT’L J. ECON. BUS. 17, 30 (2011) (post-merger review of Agency methods applied to two hospital mergers; data “strongly suggests” that large price increases in challenged merger be attributed to increased market power and bargaining leverage); *see also* Leemore Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*, 52 J. L. & ECON. 523, 544 (2009) (“hospitals increase price by roughly 40 percent following the merger of nearby rivals”); Joseph Farrell et al., *Economics at the FTC: Retrospective Merger Analysis with a Focus on Hospitals*, 35 REV. INDUS. ORG. 369 (2009) (mergers between not-for-profit hospitals can result in substantial anticompetitive price increases); Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, 23 HEALTH AFFAIRS 175, 179 (2004) (“Overall, our results do not support the argument that efficiencies from consolidations among competing hospitals lead to lower prices. Instead, they are broadly consistent with the opposing view that consolidations among competing hospitals lead to higher prices.”)).

⁴⁰ Gaynor & Town, *Impact of Hospital Consolidation*, *supra* note 38, at 3; *see also* Patrick S. Romano & David J. Balan, A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare (Fed. Trade Comm’n Bureau of Econ., Working Paper No. 307, 2010), <https://www.ftc.gov/reports/retrospective-analysis-clinical-quality-effects-acquisition-highland-park-hospital-evanston>.

⁴¹ Cooper et al., *supra* note 38, at 2.

⁴² *Id.* at 33.

⁴³ *Id.*

⁴⁴ Haas-Wilson & Garmon, *supra* note 39, at 27.

⁴⁵ *Id.* at 28.

⁴⁶ *Id.* at 30.

⁴⁷ *See, e.g.*, Nicholas Bloom et al., *The Impact of Competition on Management Quality: Evidence from Public Hospitals*, 82 REV. ECON. STUDIES 457, 457 (2015) (“We find that higher competition results in higher management quality.”).

⁴⁸ Indeed, similar arguments made by engineers and lawyers in defense of anticompetitive agreements on price—that competition fundamentally does not work in certain markets, and in fact is harmful to public policy goals—have been rejected by the courts, and private restraints on competition have been condemned. *See, e.g.*, *FTC v. Superior Court Trial Lawyers Ass’n*, 493 U.S. 411, 424 (1990); *Nat’l Soc’y of Prof’l Eng’rs v. United States*, 435 U.S. 679, 695 (1978).

⁴⁹ *See* note 8 *supra*.