COMPETITION IN HEALTH CARE MARKETS

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Good evening, and many thanks to Bates White, and especially Joe Farrell for inviting me to address you this evening. I am delighted to be part of today's conference.

My remarks tonight will focus on health care and competition. This year represents the FTC's 100th anniversary, and we have much to celebrate when it comes to health care and competition. And I can't think of a more appropriate topic for this conference given the key role economic analysis plays in the FTC's health care enforcement program. In no other area of our work has it proved to be more important to get the economic analysis correct in order to achieve the right result.

The history of our hospital merger program well illustrates this point. After the federal antitrust agencies successfully challenged a number of hospital mergers in the 1980s and early 1990s,[1] we suffered a string of court losses in the mid- and late-1990s, even in cases involving highly concentrated hospital markets.[2] In 2002, the FTC decided to take a step back and examine the reasons for our losses, and whether our analysis of hospital markets was correct.

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[1] *See, e.g.*, FTC v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991); United States v. Rockford Mem'l, 717 F.Supp. 1251, *aff'd*, 898 F.2d 1278 (7th Cir. 1990).

[2] Hosp. Bd. of Directors of Lee County, 38 F.3d 1184 (11th Cir. 1994); FTC v. Freeman Hospital, 69 F.3d 260 (8th Cir. 1995); FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd mem.*, 121 F.3d 708 (6th Cir. 1997); United States v. Mercy Health Servs., 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997); United States v. Long Island Jewish Medical Center, 983 F. Supp. 121 (E.D.N.Y. 1997); FTC v. Tenet Healthcare Corp., 186 F.3d 1045 (8th Cir. 1999). *See also* State of California v. Sutter Health System, 84 F. Supp. 2d 1057 (N.D. Cal. 2000), *aff'd*, 217 F.3d 846 (9th Cir. 2000), *amended by*, 130 F. Supp. 2d 1137 (N.D. Cal. 2001).

We engaged in an in-depth retrospective study, used our 6(b) authority to collect data from hospitals and insurance companies, and held workshops along with DOJ.[3] Cory Capps of Bates and White, and other economists contributed significantly to our understanding as well.[4] This intense period of reflection led to several important papers demonstrating that the consummated mergers stemming from the hospital merger challenges we lost – including those involving non-profits – resulted in anticompetitive effects, particularly increased prices.[5] We also determined that our losses were due in part to the courts' acceptance of faulty economic analysis of geographic markets (through improper reliance on the Elzinga-Hogarty test) and competitive effects (through improper use of critical loss analysis).[6]

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[3] Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study*, 49 J. INDUS. ECON. 63 (2001); *Everything Old is New Again: Health Care and Competition in the 21st Century*, Prepared Remarks of Timothy J. Muris before the 7th Annual Competition in Health Care Forum (Nov. 7, 2002), *available at* http://www.ftc.gov/sites/default/files/documents/public_statements/everything-old-new-again-health-care-and-competition-21st-century/murishealthcarespeech0211.pdf; Press Release, Fed. Trade Comm'n, FTC Chairman Announces Public Hearings on Health Care and Competition Law and Policy to Begin in February 2003 (Nov. 7, 2002), *available at* http://www.ftc.gov/opa/2002/11/murishealthcare.shtm; FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July 2004), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[4] *See* Cory Capps, David Dranove, & Mark Satterthwaite, *Competition and Market Power in Option Demand Markets*, RAND JOURNAL OF ECONOMICS vol. 34, no. 4 (2003), at 737–63; Robert J. Town & Gregory Vistnes, *Hospital Competition in HMO Networks*, JOURNAL OF HEALTH ECONOMICS vol. 20, no. 5 (2001), at 733–53.

[5] Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, Fed. Trade Comm'n Bureau of Economics, Working Paper No. 293, (2008), *available at* http://www.ftc.gov/be/workpapers/wp293.pdf; David J. Balan & Patrick S. Romano, *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 Economics, Working Paper No. 307 (2010), *available at* http://www.ftc.gov/be/workpapers/wp307.pdf; Christopher Garmon & Deborah Haas-Wilson, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 INT'L J. ECON. BUS. 17 (2011); Aileen Thompson, *The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover – Cape Fear Transaction*, 18 INT'L J. ECON. BUS. 91 (2011); Orley Ashenfelter, Daniel Hosken, Michael Vita & Matthew Weinberg, *Retrospective Analysis of Hospital Mergers*, 18 INT'L J. ECON. BUS. 5 (2011).

[6] *See* Cory Capps, David Dranove, Shane Greenstein, & Mark Satterthwaite, *Antitrust Policy and Hospital Mergers: Recommendations for a New Approach*, *Antitrust Bulletin* 47 (Winter 2002): 677-714; Cory Capps, David Dranove, Shane Greenstein, & Mark Satterthwaite, *The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: A Critique and New Approach to Analyzing Hospital Mergers*, NBER Working Paper 8216 (2001). *See also* Cory Capps, *From Rockford to Joplin and Back Again: The Impact of Economics on Hospital Merger Enforcement*, BATES WHITE ECONOMIC CONSULTING (Apr. 2012), *available at* http://html.documation.com/cds/health12/support/pdfs/12-1.pdf; Cory S. Capps, Economic Analysis of Hospital Mergers in the 21st Century, A New Economic Toolkit for Assessing

Our intense retrospective paid off, as it helped us develop a better economic and legal enforcement framework specifically tailored to the unique competitive dynamics of hospital mergers. Using bargaining and "willingness-to-pay" modeling, our new framework more accurately reflects the ways in which hospitals compete.[7] Under this model, if a merger among providers that are close substitutes increases the merged provider's leverage with health plans because of inadequate alternatives, the provider gains the ability to obtain supra-competitive pricing. Using this improved enforcement framework beginning with our *Evanston* case,[8] we now have an impressive string of victories under our belt,[9] including most recently in the Sixth

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Hospital Mergers, Antitrust in Healthcare Conference, ABA and American Health Lawyers Association (May 4, 2012), *available at* http://html.documation.com/cds/health12/support/pdfs/12-1.pdf.

[7] The "willingness-to-pay" model is based on the real life negotiation strategies between hospitals and private insurers, where rates are determined by each party's bargaining leverage. A hospital provider's bargaining leverage depends on the value that it brings to the managed care organizations's (MCO) network. For example, the hospital's value could be based on the hospital's location, or its reputation for quality. The more desirable a hospital is to an MCO's enrollees, the higher the price the MCO is willing to pay to include a hospital in its network. In turn, an MCO's bargaining leverage depends on the number of patients it can offer a hospital provider, and importantly, its ability to "walk-away" and assemble a network without the hospital using alternative hospitals in the geographic market that are acceptable substitutes.

[8] *In the Matter of* Evanston Northwestern Healthcare Corp., Docket No. 9315 (Commission Opinion), Aug. 6, 2007, *available at* http://www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf.

[9] *In the Matter of* Inova Health System Foundation and Prince William Health System, Inc., Docket No. 9326, (Order Dismissing Complaint), 2008, *available at* www.ftc.gov/sites/default/files/documents/cases/2008/06/080617orderdismisscmpt.pdf; *In the Matter of* Reading Health System and Surgical Institute of Reading, Docket No. 9353 (Order Dismissing Complaint), 2012, *available at* http://www.ftc.gov/sites/default/files/documents/cases/2012/12/121207readingsircmpt.pdf; Fed. Trade Comm'n v. OSF Healthcare System and Rockford Health System, No. 3:11-cv-50344 (N.D. Ill. 2012), *available at* www.ftc.gov/sites/default/files/documents/cases/2012/04/120505rockfordmemo.pdf; FTC v. Phoebe Putney Health System, Inc., 568 U.S. ___, 133 S. Ct. 1003, 185 L. Ed. 2d 43 (2013); Fed. Trade Comm'n v. Phoebe Putney Health System, Inc., No. 1:11-CV-00058-WLS (M.D. Ga. 2013), *available at* http://www.ftc.gov/sites/default/files/documents/cases/2013/06/130606phoebestip.pdf; Statement of Bureau of Competition Director Richard Feinstein on announcement by Capella Healthcare that it will abandon its plan to acquire Mercy Hot Springs, June 27, 2013, *available at* http://www.ftc.gov/news-events/press-releases/2013/06/statement-ftc-competition-director-richard-feinstein-todays.

Circuit, where the court upheld our challenge to the merger between ProMedica and St. Luke's in the Toledo, Ohio area.[10]

ProMedica

ProMedica is the first case in 15 years – and the first case since we developed our new enforcement framework – in which a US Court of Appeals has reviewed a Commission's decision to block a hospital merger. As many of you know, the Sixth Circuit's decision in *ProMedica* was an overwhelming victory for the Commission on all counts.

There are a number of important aspects to the Sixth Circuit's decision. Let me mention two of the most notable ones from an economic perspective.

First, the court relied on evidence showing a strong correlation between ProMedica's market share and prices in this market. The court found that before the merger, ProMedica's share of the market was 46.8 percent, followed by the next largest competitor, Mercy, with 28.7 percent, then University of Toledo Medical Center with 13 percent, and finally the smallest, St. Luke's, with 11.5 percent. The court found that ProMedica's prices were on average 32 percent higher than Mercy's, 51 percent higher than UTMC's, and 74 percent higher than St. Luke's.[11] Thus, the higher the market share, the higher the prices.

The court further determined that the higher prices were not explained by higher quality of services or underlying costs, but rather were the result of ProMedica's greater bargaining leverage with health insurance plans.[12] In this respect the court adopted the Commission's use of bargaining modeling and "willingness-to-pay" theory. Using that analysis, the court agreed with

[10] ProMedica Health System, Inc. v. Fed. Trade Comm'n, No. 12-3583 (6th Cir. April 22, 2014). ProMedica filed for rehearing and en banc review on June 3, 2014.

[11] *Id.* at 14.

[12] *Id.* at 3.

the Commission that post-merger, ProMedica would have much greatly enhanced bargaining leverage, because health plans simply could not offer a competitive product without including either ProMedica or St. Luke's in their hospital network.[13]

Second, the court recognized the appropriate role of presumptions in merger analysis as articulated in the 2010 Horizontal Merger Guidelines.[14] The court said it was correct for the Commission to apply a presumption of illegality to a merger in which there was a strong correlation between market share and price, and where the merger would create further concentration in an already highly concentrated market.[15] The court found that this merger increased the Herfindahl-Hirschman Index (HHI) by 1,078 (more than five times the increase necessary to trigger the presumption of illegality) to a total of 4,391 (almost double the 2,500 threshold for a highly concentrated market).[16] Noting that these numbers "blew through [the HHI] barriers in spectacular fashion,"[17] the court said "at some point the Commission is entitled to take seriously the alarm sounded by a merger's HHI data."[18]

I am proud to have authored the Commission's decision in *ProMedica*. And I give enormous credit to former FTC Chairman Tim Muris and Mike Vita from our Bureau of Economics, who recognized fifteen years ago that our hospital merger work had hit an iceberg, and worked very hard to right our health care enforcement ship. The *ProMedica* decision

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[13] *Id.* at 14–15.

[14] U.S. DEPT. OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES (Aug. 19, 2010) § 5.3, *available at* http://www.ftc.gov/os/2010/08/100819hmg.pdf [hereinafter 2010 HORIZONTAL MERGER GUIDELINES].

[15] *ProMedica Health System, Inc.*, No. 12-3583 at 15.

[16] *Id.* at 12.

[17] *Id.*

[18] *Id.* at 15.

demonstrates that, because of the foresight and groundbreaking work of our predecessors, my fellow Commissioners and I can set a clearer path for our hospital merger enforcement work.

Some believe we may be facing a similar challenge today to our work analyzing physician acquisitions and other forms of provider consolidation in light of the policies articulated under the Patient Protection and Affordable Care Act (ACA),[19] arguing that the ACA and antitrust enforcement are at cross purposes.[20] I do not believe that is the case, because the FTC's work and the ACA share the common goals of promoting high quality and cost-effective health care. This is not the first time I and my fellow Commissioners have tried to set aside concerns about the alleged conflict between our antitrust enforcement work and the ACA,[21] and I'm sure it won't be the last.

So let me turn to the relationship between the ACA and antitrust law, and how this issue was addressed in one of our other recent health care enforcement cases.

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[19] Patient Protection and Affordable Care Act, Pub. L. No. 11-48, 124 Stat. 119 (2010) [hereinafter Affordable Care Act].

[20] *See, e.g.*, Connecticut State Medical Society, Testimony in Support of House Bill 6431 An Act Concerning Cooperative Health Care Arrangements, March 5, 2013, *available at* https://www.csms.org/upload/files/2013%20Testimony/HB%206431%20AAC%20Cooperative%20Health%20Care%20Arrangements.pdf; Joe Carlson, Pulled In Two Directions, Providers Pursuing Coordinated Care Confused by Antitrust Actions, Modern Healthcare, December 15, 2012, *available at http://www.modernhealthcare.com/article/20121215/MAGAZINE/312159986;* David Balto, Making Health Reform Work, Accountable Care Organzations and Competition, February 2011, Center for American Progress, *available at* http://www.dcantitrustlaw.com/assets/content/documents/CAP/Making%20Health%20Reform%20Work.pdf.

[21] Remarks of Commissioner Julie Brill at 2013 National Summit on Provider Market Power, Promoting Healthy Competition in Health Care Markets: Antitrust, the ACA, and ACOs (Jun. 11, 2013), *available at* http://www.ftc.gov/public-statements/2013/06/promoting-healthy-competition-health-care-markets-antitrust-aca-and-acos; Remarks of Chairwoman Edith Ramirez at 11th Annual Loyola Antitrust Colloquium, Antitrust, Accountable Care Organizations, and the Promise of Healthcare Reform(Apr. 29, 2011), *available at* http://www.ftc.gov/sites/default/files/documents/public_statements/antitrust-accountable-care-organizations-and-promise-health-care-reform/110429loyolaspeech.pdf*;* Remarks of Commissioner Maureen K. Ohlhausen, before the Connecticut Bar Association, Health Care, Technology, and Health Care Technology: Promoting Competition and Protecting Innovation (Feb. 26, 2014), *available at* http://www.ftc.gov/system/files/documents/public_statements/203081/140226healthcaretechnology_0.pdf.

The Affordable Care Act and Competition Enforcement

Health care in the U.S. is provided by entities operating in markets, and the ACA does nothing to change that. Free market competition is built into the U.S. health care system's DNA today, just as it was 50 years ago.

Most hospitals and doctors are private actors, and roughly 50 percent of health care spending is paid for through commercial insurance. While the other roughly 50 percent of health care spending is publicly financed through Medicare and Medicaid, much of the health care received by beneficiaries of those programs is provided by private hospitals and physicians that operate in markets.[22]

The ACA is structured to operate within those underlying competitive markets. With respect to health care financing, the ACA provides for the creation of state-based health insurance marketplaces.[23] The "exchanges" offer individuals and small employers a range of competing health insurance products that might otherwise be unavailable or unaffordable. This expansion of access enables consumers to be more responsive to the cost and quality of provider networks. The exchanges also encourage greater competition in local insurance markets, driving premiums down for consumers.[24]

With respect to health care delivery, the ACA's Medicare Shared Savings Program encourages groups of providers to form Accountable Care Organizations (ACOs) to work

[22] Martin Gaynor, Competition Policy In Health Care Markets: Navigating The Enforcement And Policy Maze, HEALTH AFFAIRS, May 2014, *available at* http://content.healthaffairs.org/content/early/2014/05/13/hlthaff.2014.0333.full.

[23] Affordable Care Act, *supra* note 19, Section 1322.

[24] *See* Leemore Dafny, Mark Duggan & Subramaniam Ramanarayanan, *Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry*, 102(2) AM. ECON. REV., 1161-85, *available at* http://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.102.2.1161.

together to coordinate care for Medicare fee-for-service beneficiaries.[25] An ACO participating in the Medicare Shared Savings Plan may share in savings they create if the ACO meets certain criteria set out by the Secretary of HHS, including quality performance standards.

Thus, both the ACA's health care financing provisions and the its Medicare Shared Savings Program depend in large part on well-functioning competitive markets in order to provide the intended benefits to consumers. The ACA does not replace the market-based nature of the industry. While it is true that Medicare and Medicaid rates may be set by one payer, the underlying health care providers are still competing in their own health care markets on important non-price factors, such as quality and access. Many of those same providers compete in the private-payer commercial market as well. The ACA aids in this process by incentivizing providers to be creative in health care delivery, providing higher quality, lower cost care, but importantly it doesn't mandate a particular structure.

Antitrust enforcement – including preventing firms from accumulating undue market power through mergers and acquisitions – is therefore just as crucial now as it was before the ACA in ensuring that our health care markets in the U.S. work well. There is a wealth of empirical evidence of the harmful effects of high concentration among health care providers.[26]

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[25] Affordable Care Act, *supra* note 19, at 395 (Section 3022). ACOs have also formed outside the context of the Medicare Shared Savings Program to bring similar care coordination efforts to commercially-insured patients. *See* David Muhlestein, *Continued Growth of Public and Private Accountable Care Organizations* (Feb. 19, 2013), *available at* http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/ (noting that while there are more than 250 Medicare Shared Savings Program ACOs, there are a total of 428 ACOs in 49 states, including private sector, non-Medicare ACOs).

[26] *See, e.g.*, Eduardo Porter, *One Reason Health Insurance Premiums Vary So Much*, N.Y. TIMES (May 15, 2014) (citing research by Leemore Dafny, Christopher Ody & Jonathan Gruber), *available at* http://www.nytimes.com/2014/05/16/upshot/why-health-insurance-premiums-vary-so-much.html; Eduardo Porter, *Health Care's Overlooked Cost Factor*, N.Y. TIMES, June 11, 2013, at B1.

Numerous studies have found that the existence of excess provider market power results in higher prices, lower quality, and less innovation.[27]

Implementation of the ACA and other health care policy changes has coincided with a wave of mergers among hospitals, physicians, and other health care providers.[28] Some providers have pointed to the ACO program as a justification for potentially problematic mergers, complaining that the federal government is "speaking out of both sides of its mouth," with the Medicare program encouraging providers to come together and create organizations that will enable greater collaboration, while the antitrust agencies challenge them.

These contentions are creative, but misguided. First, the ACA neither requires nor encourages providers to merge or otherwise consolidate, but rather encourages providers to create entities that *coordinate* the provision of patient care services. In fact, ACOs may be

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[27] *See, e.g.*, Martin Gaynor et al., *Death by Market Power: Reform, Competition and Patient Outcomes In the National Health Service*, Apr. 30, 2012, *available at* http://www.andrew.cmu.edu/user/mgaynor/Assets/Death_by_Market_Power.pdf; Clark C. Havighurst & Barak Richman, *The Provider-Monopoly Power Problem in Health* Care, 89 OREGON L. REV. 847 (2011); Robert Berenson, Paul Ginsburg, & Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, HEALTH AFFAIRS, Apr. 2010; WILLIAM B. VOGT & ROBERT TOWN, THE ROBERT WOOD JOHNSON FOUND., HOW HAS PROVIDER CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? (2006), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1. Prices for inpatient hospital services in particular have risen dramatically. A study published in the *American Journal of Managed Care* in March of last year found that from 2008 to 2010, inpatient hospital prices increased 8.2 percent per year, with wide variation in price levels. Jeff Lemieux & Teresa Mulligan, *Trends in Inpatient Hospital Prices, 2008-2010*, 19(3) AM. J. MANAG. CARE, e106 (2013). Data show that increasing provider consolidation is one contributor to rising hospital prices. *See* THE ROBERT WOOD JOHNSON FOUND., THE IMPACT OF HOSPITAL CONSOLIDATION—UPDATE (2012), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.
See also James C. Robinson, *Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology*, 17(6) AM. J. MANAG. CARE, e241 (2011), *available at* https://www.blueshieldca.com/sites/make-care-affordable/documents/Hospital-market-concentration-pricing-profitability.pdf.

[28] *See, e.g.*, Provider Mergers and Consolidation Continue at a Ferocious Pace, AHIP Coverage, January 23, 2014, *available at* http://www.ahipcoverage.com/2014/01/23/provider-mergers-and-consolidations-continue-at-a-ferocious-pace/.

formed through contractual arrangements that are well short of a merger, such as a joint venture.[29]

Second, neither the ACA statute nor the implementing regulations express a preference for consolidation *among competing entities*. The ACA final program rule stipulates that CMS will rely on the antitrust agencies to use "their existing enforcement processes for evaluating concerns raised about an ACO's formation or conduct and [to file] antitrust complaints when appropriate."[30] Importantly, CMS can exclude from the Shared Savings Program any ACO that violates the antitrust laws, and CMS has promised to "coordinate closely with the Antitrust Agencies throughout the application process and the operation of the Shared Savings Program to ensure that the implementation of the program does not have a detrimental impact upon competition."[31]

Third, far from being a barrier to procompetitive collaboration envisioned in the ACA, antitrust aligns naturally with the goals of ACOs. By serving as a watchdog against firms accumulating undue market power and engaging in anticompetitive conduct, antitrust promotes market behavior that creates efficiencies and benefits consumers. Antitrust law permits providers to engage in a wide array of legitimate collaborative activities, including ACO arrangements, as well as many mergers and consolidations, so long as the conduct is not likely to

[29] As CMS stated in its final rules: "we do not believe that mergers and acquisitions by ACO providers and suppliers are the only way for an entity to become an ACO. The statute permits ACO participants that form an ACO to use a variety of collaborative organizational structures, including collaborations short of merger. . . . We reject the proposition that an entity under single control, that is an entity formed through a merger, would be more likely to achieve the three-part aim [of the Shared Savings Program]." Dep't of Health & Human Servs., Centers for Medicare & Medicaid Servs., Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 42 C.F.R. § 425 (2011), 76 Fed. Reg. 67,826 (Nov. 2, 2011)[hereinafter CMS Final Rule], at 67,843.

[30] *Id.* at 67,826. *See also* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, STATEMENT OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM, 76 Fed. Reg. 67026, 67030-31 (Oct. 28, 2011); Susan S. DeSanti, *ACO Antitrust Guidelines: Coordination Among Federal Agencies* 1 (Dec. 2011).

[31] CMS Final Rule, *supra* note 29, at 67,842.

harm consumer welfare through higher cost or lowered quality.[32] This is not a new concept for antitrust regulators – we embraced it as far back as 1996.[33] With regard to aggregation of market power – whether through mergers or otherwise – antitrust law uses a scalpel, not a sledgehammer, and carefully analyzes each case to bar only those that on balance threaten to harm consumers.[34]

Now we have a new court decision squarely supporting the view that the ACA and competition law are not in conflict, but aligned. A federal district judge in Idaho upheld our challenge of the acquisition of the Saltzer physician group by the hospital St. Luke's.[35] The parties argued that the merger was justified by the ACA, but the court believed the evidence showed otherwise.

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[32] For a more detailed discussion of the antitrust analysis of such arrangements, *see, e.g.*, Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition to Michael E. Joseph, Esq., McAfee & Taft (Feb. 13, 2013) (concerning Norman PHO), *available at* http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf; Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition to Christi J. Braun, Esq., Ober, Kaler, Grimes & Shriver (Apr. 13, 2009) (concerning TriState Health Partners, Inc.), *available at* http://www.ftc.gov/opa/2009/04/tristate.shtm; Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition to John J. Miles, Esq., Ober, Kaler, Grimes & Shriver (June 18, 2007) (concerning Follow-Up to 2002 MedSouth, Inc. Staff Advisory Opinion), *available at* http://www.ftc.gov/bc/adops/070618medsouth.pdf; Letter from Markus H. Meier, Assistant Director, Bureau of Competition to Christi J. Braun, Esq., and John J. Miles, Esq., Ober, Kaler, Grimes & Shriver (Sept. 17, 2007) (concerning Greater Rochester Independent Practice Association, Inc.), *available at* http://www.ftc.gov/opa/2007/09/clinicalintegration.shtm; Letter from David R. Pender, Acting Assistant Director, Health Care Division, Bureau of Competition to Clifton E. Johnson, Esq., and William H. Thompson, Esq., Hall, Render, Killian, Heath & Lyman (Mar. 28, 2006) (concerning Suburban Health Organization), *available at* http://www.ftc.gov/opa/2006/03/shor31.shtm.

[33] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ENFORCEMENT POLICY IN HEALTH CARE (1996), *available at* http://www.ftc.gov/bc/healthcare//industryguide/policy/hlth3s.pdf.

[34] *See* 2010 HORIZONTAL MERGER GUIDELINES, *supra* note 14.

[35] Federal Trade Commission v. St. Luke's Health System, LTD., Findings of Fact and Conclusions of Law, Case No. 1:13-CV-00116-BLW (D. Idaho Jan. 24. 2014). St. Luke's has appealed the decision to the Ninth Circuit.

St. Luke's/Saltzer

The case began in March 2013, when we filed a joint complaint with the Idaho Attorney General challenging St. Luke's Health System's acquisition of Saltzer Medical Group.[36] The complaint alleged that the merger between Idaho's largest health care system and the state's largest independent, multi-specialty physician practice would be anticompetitive, creating a dominant single provider of adult primary care physicians in the Nampa, Idaho area, with nearly 80 percent of the market. Although the transaction in some respects was vertical – a large hospital system acquiring a physician group – it was also a horizontal merger, consolidating a large majority of physicians and physician groups in what was already the largest health care system in Idaho. Our complaint focused on the horizontal aspect of the case.

After a full trial, in January of this year, the federal district court held that the acquisition violated Section 7 of the Clayton Act and the Idaho Competition Act, and ordered St. Luke's to fully divest itself of Saltzer's physicians and assets.

St. Luke's argued that the acquisition was needed in order for it to lower costs and improve health care quality, citing the ACA.[37] The Commission carefully investigated each of St. Luke's claims, keeping in mind the goals of the ACA as well as the importance of competition to its proper function, and found that St. Luke's – with its 500-plus employed physicians and integrated health care system – already had the ability to achieve significant cost

[36] Complaint for Permanent Injunction, Federal Trade Commission v. St. Luke's Health System, LTD., Case No. 1:13-CV-00116-BLW (D. Idaho Mar. 26, 2013).

[37] FTC trial counsel referred to St. Luke's argument as the "health care reform" defense, or the "give the monopoly a chance" defense, quoting from defense counsel's brief: "Indeed, the procompetitiveness of the Saltzer transaction is underscored by the fact that it accords with, and carries out, the federal policy, reflected in the [ACA], of encouraging large, clinically-integrated physician-hospital networks designed to reduce the overall cost of health care through the precise methods that will be implemented as a consequence of this transaction." Presentation, Federal Trade Commission, Opening Statement: Federal Trade Commission & State of Idaho v. St. Luke's Health System, Ltd. & Saltzer Medical Group, P.A. 73 (Sept. 23, 2013), http://www.ftc.gov/system/files/documents/cases/130923stlukeslides.pdf.

savings and quality improvements without acquiring Saltzer. The district court agreed. St. Luke's was not able to prove that further consolidation would allow it to achieve significant additional cost savings and quality improvements – the evidence just wasn't there.

While the district court applauded St. Luke's for its efforts to improve the delivery of health care and credited St. Luke's with at least intending that the acquisition would improve patient outcomes, the court found that St. Luke's had other ways to achieve the same goals that would not run afoul of the antitrust laws.[38] Importantly, the court found that physicians are committed to improving the quality of healthcare and lowering costs regardless of whether they are employed or independent, and that the committed team – not any specific organizational structure – is the key to integrated medicine.[39]

St. Luke's documents did not help it on this point – one internal St. Luke's document, authored by a St. Luke's board member, stated that "Employing physicians is not achieving better cost, it's achieving better profit."[40] Moreover, St. Luke's Vice President of Payer Relations, who previously worked for Advocate Health, a Chicago-based health care physician group well known for its high-quality care, testified that Advocate Health provided independent

[38] *St. Luke's Health System, LTD.*, 1:13-CV-00116-BLW, at 3. The court found that St. Luke's efficiency claims were not merger specific, citing the 2010 HORIZONTAL MERGER GUIDELINES, *supra* note 14, and F.T.C. v. H.J. Heinz Co., 246 F.3d 708, 722 (D.C. Cir. 2001). *Id.* at 38, 46. St. Luke's argued that broadening the use of its health information technology would improve quality and create efficiencies. But the evidence wasn't there. St. Luke's was in the process of developing an "Affiliate" electronic medical records program to its own "Epic" program that would allow independent physicians to access Epic, thus the court held that the merger was not necessary in order for St. Luke's to achieve efficiencies associated with sharing medical records. *Id.* at 37-38. Moreover, the evidence showed that St. Luke's was years away from having Epic installed at all of its facilities. The Commission also presented evidence that Idaho has a Health Data Exchange that facilitates interaction between medical records across the entire state. Presentation, *supra* note 37, at 69.

[39] *St. Luke's Health System, LTD.*, 1:13-CV-00116-BLW, at 32.

[40] Presentation, *supra* note 37, at 62.

physicians significant financial benefits if they met specific quality metrics; it was not necessary for Advocate Health to employ physicians to improve health care quality.[41]

The economic evidence also belied St. Luke's arguments. St. Luke's argued that its past acquisitions led to lower cost healthcare. The FTC's economic expert, Professor David Dranove, evaluated this claim, and found no supporting evidence. Professor Dranove compared costs to patients of St. Luke's acquired primary care physicians with those of primary care physicians who were not acquired by St. Luke's, and found either no significant spending changes, or an actual increase in total spending.[42] Professor Dranove found that, if anything, the evidence suggested that the acquisition of Saltzer was more likely to result in cost increases.[43]

The Commission's case was bolstered by the fact that there was evidence showing that St. Luke's had already successfully used its market power to increase reimbursements a few years earlier, through enhanced negotiating leverage after acquiring physician groups in a different region in Idaho. In Magic Valley, St. Luke's amassed a large percentage of the area's primary care physicians and was able to successfully exercise market power.[44]

In sum, the *St. Luke's/Saltzer* decision demonstrates that the ACA is not a free pass. Although the ACA encourages integration of health care delivery, there are many mechanisms for achieving this goal. While the FTC doesn't challenge the vast majority of health care provider acquisitions,[45] we will step in to challenge acquisitions that give a firm market power

[41] *Id.* at 67.

[42] *Id.* at 63.

[43] *Id.*

[44] *St. Luke's Health System, LTD.*, 1:13-CV-00116-BLW, at 18.

[45] For example, from 2002 to 2012, the FTC challenged just six hospital mergers out of 970 total hospital merger and acquisition deals, less than one percent of the total transactions. *See* "Hospital Merger and Acquisition Trends,

that creates a serious risk of competitive harm to consumers. The ACA and antitrust enforcement are aligned in the need to achieve this goal.

Thank you.

2002-2012," in presentation by Greg Koonsman, *Analyzing the Health System Market*, VMG HEALTH 24 (Oct. 2013), http://www.vmghealth.com/Downloads/BeckerASCKoonsman2013.pdf.