

Keynote Address of FTC Chairwoman Edith Ramirez
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I want to thank the American Health Lawyers Association and the ABA's Antitrust and Health Law Sections for inviting me to be here. It is a pleasure to be back to share some of the Federal Trade Commission's recent work in the healthcare sector.

When I was here two years ago, I noted that our healthcare markets were undergoing significant and dramatic change with the implementation of the Affordable Care Act and the challenge of providing care to an aging population and the newly insured. My key message then was that antitrust is fully compatible with the aims of healthcare reform – higher quality and innovative health care at lower cost. The message I want to leave you with today is that vigorous enforcement of the antitrust laws is more important than ever.

I. Provider Consolidation

Let me start with the issue of consolidation. I remain very concerned about the rapid rate of consolidation among healthcare providers. The number of hospital transactions continues to rise. In 2015, the number of hospital mergers increased 18% over the prior year and were 70% higher than in 2010.¹ And the rate may even be accelerating. The number of deals rose significantly in the second half of last year.² Transactions involving physician practices – both mergers between independent physicians as well as hospital acquisitions of physician groups –

¹ Ayla Ellison, *Hospital M&A Activity Jumps 70% in 5 Years*, Becker's Hospital Review, Jan. 21, 2016, <http://www.beckershospitalreview.com/hospital-transactions-and-valuation/hospital-m-a-activity-jumps-70-in-5-years-8-findings.html>.

² *Id.*

also continue to increase.³ In addition, we have seen providers increasingly pursue alternatives to traditional mergers such as affiliation arrangements, joint ventures, and partnerships, all of which could also have significant implications for competition.

Most provider mergers are not anticompetitive, but the few that are could cause significant competitive harm. The latest empirical research only heightens these concerns. Last December, for example, our former Bureau of Economics Director, Marty Gaynor, along with several other academics, issued a significant new study that goes beyond prior research because it analyzes not only Medicare data, but also claims data from private insurers.⁴ By drawing from both sources, the study provides a more complete picture of what is driving healthcare provider pricing around the country. It found that the disparity in hospital prices within regions is the primary driver of variation in healthcare spending for the privately insured.

While many factors influence provider prices, the study shows that hospitals that face fewer competitors have substantially higher prices, controlling for quality and other differences. According to the study, hospital prices in monopoly markets are more than 15% higher than those in areas with four or more competitors. It also found that, where hospitals face only one competitor, prices are over 6% higher; where they face two, almost 5% higher.

This can make a big difference in healthcare costs. As Professor Gaynor has explained, the cost of an average inpatient stay at a hospital that faces no competition is almost \$1,900 higher than those where there are at least four competitors, which results in higher premiums that

³ Molly Gamble & Benjy Sachs, *60 Statistics and Thoughts on Healthcare, Hospital and Physician Practice M&A*, Becker's Hospital Review, July 22, 2015, <http://www.beckershospitalreview.com/hospital-transactions-and-valuation/60-statistics-and-thoughts-on-healthcare-hospital-and-physician-practice-m-a.html>.

⁴ Zack Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, The Nat'l Bureau of Economic Research Working Paper 21815 (December 2015), <http://www.nber.org/papers/w21815>.

get passed on to consumers.⁵ Other new studies over the last year have also found a positive correlation between provider concentration and pricing in the form of higher insurance premiums.⁶

Research also shows that competition plays an important role with respect to quality as hospitals compete to attract patients. A recent study of reforms in the English National Health Service found that greater competition for patients among hospitals had a significant impact on clinical quality of care, including lower mortality rates for many procedures.⁷

In short, the latest empirical research continues to consistently find that provider competition results in the greatest price and quality benefits for consumers, justifying the FTC's continued vigilance in healthcare provider markets. And we have been very active.

Late last year, the Commission sued to block three proposed hospital mergers that we allege would lead to increased market power for the merging firms in their local communities.

The first suit, filed in November, challenges a proposed merger between Cabell Huntington Hospital and St. Mary's Medical Center, alleging that the deal would combine the only two providers of inpatient hospital services and two of three providers of outpatient surgery services in the Huntington, West Virginia area.⁸ Our complaint alleges that the combination

⁵ Beth Jones Sanborn, *Huge Variation in Medical Prices as Hospital Monopolies Charge More, Report Says*, Healthcare Finance (Dec. 18, 2015), <http://www.healthcarefinancenews.com/news/huge-variation-medical-prices-hospital-monopolies-charge-more-report-says>.

⁶ See, e.g., Richard Scheffler et al., *Differing Impacts of Market Concentration of Affordable Care Act Marketplace Premiums*, 35 Health Affairs 880 (2015); Erin Trish & Bradley Herring, *How Do Health Insurer Market Concentration and Bargaining Power With Hospitals Affect Health Insurance Premiums?*, 42 J. Health Econ. 104, 112 (2015).

⁷ Martin Gaynor et al., *Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service*, 5 Am. Econ. J. 134 (Nov. 2013); Zack Cooper et al., *Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms*, 121 The Economic J. 228 (2011); see also Nathan Wilson, *Market Structure as a Determinant of Patient Care Quality*, Am. J. of Health Econ. (forthcoming).

⁸ Press Release, Fed. Trade Comm'n, *FTC Challenges Proposed Merger of Two West Virginia Hospitals* (Nov. 6, 2015), <https://www.ftc.gov/news-events/press-releases/2015/11/ftc-challenges-proposed-merger-two-west-virginia-hospitals>.

would result in the parties having at least a 75% market share of inpatient admissions and lead to higher prices and reduced service.

In December, the Commission, joined by the Pennsylvania Attorney General, challenged a proposed merger between Penn State Hershey Hospital and Pinnacle Health System.⁹ We allege that this merger would combine the two largest health systems in the four-county greater Harrisburg area to create a dominant provider for hospital services with a 64% market share.

A week after that, the Commission, together with the Illinois Attorney General, sued to block the proposed \$2.2 billion merger between Advocate Health Care Network, the largest healthcare system in Illinois, and what we allege is a close competitor in the northern suburbs of Chicago, the four-hospital NorthShore University Health System.¹⁰ (NorthShore is the same hospital system that was at issue in the FTC's 2007 *Evanston* case.) We allege that the combined entity would operate a majority of the hospitals and control more than half of the market for general acute care inpatient hospital services in the North Shore area.

All three cases are still ongoing. As many of you are aware, earlier this week, the federal district court in Harrisburg denied our motion for a preliminary injunction to block the Penn State Hershey Hospital/Pinnacle Health System merger pending completion of the FTC's administrative process.¹¹ We are appealing the district court's ruling. While I cannot say very much about the case, I will note that the court's approach to determining the relevant geographic market diverges significantly from that taken by the Commission and other federal courts in

⁹ Press Release, Fed. Trade Comm'n, FTC and Pennsylvania Office of Attorney General Challenge Penn State Hershey Medical Center's Proposed Merger with PinnacleHealth System (Dec. 8, 2015), <https://www.ftc.gov/news-events/press-releases/2015/12/ftc-pennsylvania-office-attorney-general-challenge-penn-state>.

¹⁰ Press Release, Fed. Trade Comm'n, FTC Challenges Proposed Merger of Two Chicago-area Hospital Systems (Dec. 18, 2015), <https://www.ftc.gov/news-events/press-releases/2015/12/ftc-challenges-proposed-merger-two-chicago-area-hospital-systems>.

¹¹ Memorandum Opinion & Order, *FTC v. Penn State Hershey Med. Ctr.*, Civ. A. No. 1:15-cv-2362 (M.D. Pa. May 9, 2016).

recent years in healthcare provider mergers. Specifically, we allege that Harrisburg-area residents typically seek general acute care services close to their homes and that hospitals outside of the Harrisburg area draw very few patients from Harrisburg. Accordingly, we allege that a commercial health plan would struggle to market a network to Harrisburg-area employers and consumers if it did not include hospitals in the area and that it likely would not exclude the merged entity from its network in the face of a price increase.

At the same time that we are seeing see the number of provider combinations rise, I am also concerned that parties are increasingly seeking ways to sidestep antitrust enforcement. One way they have tried to do this is by entering into temporary agreements, often with insurers or state authorities, that purport to address competitive concerns potentially arising from their transaction. The parties in the Cabell case, for instance, entered into seven-year commitments with both the largest payor in the region and the state attorney general, principally consisting of rate caps, in an apparent effort to stave off a challenge by the FTC. Similarly, the parties in the Penn State Hershey matter entered into agreements with certain payors to forestall opposition to the merger.

Generally speaking, we believe these kinds of arrangements fail to replicate the benefits of competition. Many of the agreements we have seen require consistent and active oversight, could be circumvented by the parties, and may reduce incentives to lower costs or innovate. They are also temporary, leaving payors and ultimately consumers vulnerable when they expire. Finally, even if the agreements do partially mitigate some of the price effects of a merger, they fail to account for lost quality competition or innovation.

Another troubling development is the enactment of state legislation – specifically, Certificate of Public Advantage (or COPA) laws – that purport to grant antitrust immunity to certain healthcare provider collaborations.

For example, in March, following our challenge of Cabell’s proposed acquisition of St. Mary’s Hospital, West Virginia enacted legislation establishing a COPA process.¹² Similarly, both Tennessee and Virginia enacted or updated COPA laws in response to a proposed merger between the two dominant health systems in the Tri-cities area of southwest Virginia and northeast Tennessee, Wellmont and Mountain States.¹³ All three states are in the process of reviewing those applications now.

Proponents of these legislative measures claim that FTC enforcement efforts undermine the policy aims of the Affordable Care Act to improve the quality of health care and lower costs by encouraging more coordination between healthcare providers in local communities. In my view, these legislative efforts to immunize combinations from the antitrust laws are misguided and risk harming consumers. We understand that coordination of care has the potential to further key goals of healthcare reform, including encouraging provider collaboration, avoiding duplicative testing, increasing preventive care, and encouraging greater patient follow-up. But procompetitive collaborations are already permissible under the antitrust laws. Consequently, the primary impact of COPA laws may very well be to immunize mergers that will *not* generate substantial efficiencies and therefore would not pass muster under the antitrust laws, likely leading to increased healthcare costs and lower quality and decreased access to care. We have

¹² W. Va. Code §§ 16-29B, 26-29.

¹³ Tamara Rosin, *Proposed Bill to Update Tennessee’s COPA Law Will Impact MSHA, Wellmont Health System Merger*, Becker’s Hospital Review (Apr. 13, 2015) (noting that the bill’s sponsor in the Tennessee Senate indicated that the changes were in direct response to the proposed Mountain States/Wellmont merger), <http://www.beckershospitalreview.com/legal-regulatory-issues/proposed-bill-to-update-tennessee-s-copa-law-will-impact-msha-wellmont-health-system-merger.html>.

submitted comments in New York,¹⁴ Virginia,¹⁵ Tennessee,¹⁶ West Virginia,¹⁷ and Alabama¹⁸ expressing concerns with the potential impact of COPA laws.

I want to emphasize that we take claims of efficiencies seriously. We devote considerable time and resources to evaluating efficiency claims, especially those that are quality-related. Parties, however, have largely failed to present us with even a close case, often providing little substance to back-up their claims. In particular, parties have generally failed to make their case when trying to demonstrate that a merger is necessary to achieve the claimed efficiencies, a requirement the Ninth Circuit emphasized in affirming the FTC's trial victory in the *St. Luke's* case.¹⁹

Parties often assert that their merger will provide the necessary patient volume to allow them to engage in risk-based contracting and population health management. We recognize that health care is increasingly moving in this direction and continue to assess, on a case-by-case basis, whether a merger that enables parties to engage in these and other activities could benefit

¹⁴ Fed. Trade Comm'n Staff Comment to Center for Health Care Policy and Resource Dev., Office of Primary Care and Health Sys. Mgmt., N.Y. State Dep't of Health Re: Certificate of Public Advantage Applications Filed Pursuant to New York Public Health Law, 10 NYCRR, Subpart 83-1 (Apr. 22, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-center-health-care-policy-resource-development-office-primary-care-health-systems/150422newyorkhealth.pdf.

¹⁵ Fed. Trade Comm'n Staff Comment to Va. Dep't of Health, Office of Licensure and Certification Re: Virginia's Rules and Regulations Governing Cooperative Agreements, 12 VAC 5, Chapter 221 (Sept. 17, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-virginia-department-health-regarding-virginias-rules-regulations-governing/151015virginiadoh.pdf.

¹⁶ Fed. Trade Comm'n Staff Comment to Tenn. Dep't of Health Re: Tennessee Rules Implementing Laws Relative to Cooperative Agreements and the Granting of Certificates of Public Advantage Pursuant to the Hospital Cooperation Act of 1993, T.C.A §§ 68-11-1301 through 68-11-1309, Proposed Chapter 1200-38-01 (Sept. 24, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-tennessee-department-health-regarding-implementation-laws-relative-cooperative/151015tennesseedoh.pdf.

¹⁷ Fed. Trade Comm'n Staff Comment to W.Va. House of Delegates Re: Senate Bill 597 (March 9, 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.

¹⁸ Fed. Trade Comm'n Staff Comment Before the Ala. State Senate Re: House Bill 241 and Senate Bill 243 (May 2, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-alabama-state-senate-regarding-alabama-house-bill-241-senate-bill-243/160504commentalabama.pdf.

¹⁹ *Saint Alphonsus Medical Center–Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 791 (9th Cir. 2015).

consumers. Yet there is strong evidence that scale, at least over a certain threshold, is not necessary to engage in those practices. Greater scale can also frequently be achieved through another combination that is not a merger with a close rival.

Additionally, despite parties' frequent claims to the contrary, risk-based contracting does not preclude the exercise of market power. Although it may change some contracting incentives, parties in risk-based arrangements still negotiate over key terms, including the overall medical budget, the amounts subject to sharing, the risk assumed by the hospital, and quality measures and benchmarks.

Parties also frequently claim capital cost avoidance – for instance, that a new bed tower will no longer be needed – as an efficiency. While potentially cognizable, parties have generally failed to account for alternatives that would allow hospitals to address their capacity constraints short of a merger. Moreover, capital cost avoidance claims must be substantiated and credible. In our successful challenge to a hospital merger in Rockford, Illinois, the court did not credit the hospital's capital avoidance claims because it had put the costly expansion plan on hold years before the merger.²⁰ It is also important to note that we would not consider capital cost avoidance that reduces output or consumer choice to be a cognizable efficiency.

In other cases, parties assert that their merger would result in significant quality improvements at one of the merging hospitals. While we might credit that argument when a hospital with documented high quality care proposes to acquire a lower quality hospital and has a sound, concrete plan to improve quality at the weaker hospital, we have rarely been presented with that kind of case.

Instead, many of the mergers we have examined involve two high quality hospitals. And

²⁰ *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1091 (N.D. Ill. 2012).

while parties often claim outcomes can be improved merely through increased volume, the evidence only supports that assertion for a few, highly-complex procedures. For most everything else, research suggests that volume is either largely irrelevant or that thresholds are sufficiently low that most merging hospitals can meet them independently.²¹ Quality improvements can also often be made independently through enhanced training or through a merger or affiliation with an alternative partner that does not raise competitive concerns. Moreover, competition itself is a significant driver of improvements in patient care.

Likewise, for physician group acquisitions, as we demonstrated in the *St. Luke's* case, there is little evidence showing that physician employees are necessary to coordinate care and move away from a fee-for-service model.²² Other arrangements, short of a merger, such as shared access to electronic medical records, would likely achieve the same goals.

Notably, one of our economists reviewed six proposed hospital mergers that the Commission stopped, either through a successful challenge or because the parties abandoned the transaction.²³ In each case, the selling party found an alternative buyer, suggesting that many of the claimed efficiencies were not merger-specific and could be achieved either independently or through an alternative merger or affiliation that would not meaningfully reduce competition.

In sum, given the strong evidence that competition is beneficial to healthcare consumers, providers merging with close rivals should continue to expect that their deals will be closely scrutinized by the FTC.

II. FTC Advocacy

²¹ Thomas C. Tsai & Ashish K. Jha, *Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better?*, *Journal of the Am. Med. Ass'n* 29 (July 2, 2014).

²² *St. Luke's*, 778 F.3d at 791.

²³ David J. Ballan, *Hospital Mergers That Don't Happen*, *New England J. Med. Catalyst* (Mar. 30, 2016), <http://catalyst.nejm.org/hospital-mergers-dont-happen/>.

I now want to turn to the FTC's competition policy and advocacy efforts, which serve as an important complement to our enforcement work.

We continue to advocate against laws and regulations that impede entry or expansion in healthcare provider markets. In addition to a large number of scope of practice advocacies over the past year, we have filed comments encouraging the repeal or reform of certificate of need laws in Virginia and the Carolinas.²⁴ CON laws, in place in more than 35 states, require state approval before a new provider can enter or an existing provider can make certain capital improvements. Our concern is that they needlessly raise the cost of investing in new healthcare services, stifle innovation, and deter entry. They can also shield incumbents from competition that would benefit consumers and lower prices. Moreover, while originally enacted more than forty years ago to control costs, improve quality, and increase access, there is little evidence that CON laws have helped achieve any of those goals.

We have also engaged in advocacy related to emerging forms of healthcare provider competition. Telemedicine is a good example. Technology can enable doctors to monitor, diagnose, and, in some cases, even treat patients without a physical examination. It offers convenience to patients, can lower costs, and may also help alleviate physician shortages.

Telemedicine is a developing and intriguing field with implications for many areas, including healthcare access, quality, and scope of practice issues. Of course, we recognize that

²⁴ Joint Statement of the Fed. Trade Comm'n & Dept. of Justice on Certificate of Need Laws and S.C. House Bill 3250 (Jan. 11, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf; Joint Statement of the Fed. Trade Comm'n & Dept. of Justice to the Virginia Certificate of Need Workgroup (Oct. 26, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-virginia-certificate-public-need-work-group/151026ftc-dojstmtva_copn-1.pdf; Letter from Fed. Trade Comm'n Staff to N.C. Rep. Marilyn W. Avila re House Bill 200 (July 10, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-concurring-comment-commissioner-wright-regarding-north-carolina-house-bill-200/150113nconadv.pdf.

there may be important health and safety concerns raised by the absence of a physical examination. Where regulation is necessary, we encourage policymakers to narrowly tailor those regulations to serve legitimate policy goals without unduly restricting new forms of competition.

In some states, though, incumbent providers, threatened by the increased competition from telehealth providers, may attempt to use the existing regulatory structure to deter new, potentially disruptive entry. For instance, in Texas, the state medical board enacted rules in 2015 severely restricting the availability of telehealth services, prompting an antitrust lawsuit from the largest provider of telemedicine services in the state.²⁵

We will continue to use advocacy and other efforts to encourage competition. The FTC recently filed comments related to state efforts to expand access to telemedicine services in the state of Alaska, which has a long history of physician shortages.²⁶ The legislation would allow doctors licensed in the state, but located outside of Alaska to provide telehealth services to the same extent as physicians physically located in Alaska. By eliminating the “in-state” requirement, we argued that the bill would likely expand the supply of telehealth providers, promote competition, and increase access to safe and cost-effective care. It could also reduce transportation costs for patients, who often have to travel great distances to receive even basic treatment, as well as providers. The bill passed both houses of the Alaska legislature and now awaits the governor’s signature.

The FTC will continue to monitor legislative and policy developments in these areas, and advocate in favor of competition and consumers.

²⁵ Lauren Silverman, *Texas Puts Brakes on Telemedicine – And Teladoc Cries Foul*, Nat’l Pub. Radio (June 2, 2015), www.npr.org/sections/health-shots/2015/06/02/408513139/texas-put-brakes-on-telemedicine-and-teladoc-cries-foul.

²⁶ Letter from Fed. Trade Comm’n Staff to Representative Steve Thompson, Co-Chair, House Finance Committee, Alaska State Legislature re Senate Bill 74 (Mar. 25, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-alaska-state-legislature-regarding-telehealth-provisions-senate-bill-74-which/160328alaskatelehealthcomment.pdf.

III. Other FTC Work

Finally, let me close with a short discussion about other areas of interest and work. While we have focused our enforcement efforts on horizontal mergers between competing healthcare providers, we also hear concerns that provider consolidation in non-overlapping geographic or product markets may also lead to higher prices.²⁷ This is an issue that we are continuing to explore in an effort to determine whether the antitrust laws are implicated.

We are also continuing to examine the competitive impact of electronic health records, including the fact that they may deter patients from switching to alternative providers. The move toward increased consolidation and interoperability among various EHR platforms raises competition issues that we are monitoring.²⁸ Among the questions we are asking is whether a dominant healthcare provider could take advantage of the lack of compatibility among EHR systems to further consolidate their already strong position.

Finally, our Bureau of Economics is conducting research on a variety of important topics related to healthcare provider markets. This includes efforts to hone and refine the tools we frequently use to assess healthcare provider mergers. Our economists have several projects underway investigating the performance of various screening approaches and exploring the accuracy of models examining how patients choose healthcare providers.

They also have a number of research projects analyzing the impact of consolidation, including hospital/physician acquisitions, on healthcare outcomes. Another ongoing study

²⁷ See, e.g., Leemore Dafny et al., *The Price Effects of Cross-Market Hospital Mergers*, Nat'l Bureau of Econ. Research Working Paper 22106 (Mar. 18, 2016), <http://www.nber.org/papers/w22106>; Laurence C. Baker et al., *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, 33 *Health Affairs* 756 (May 2014).

²⁸ See, e.g., Fed. Trade Com'n Staff Comment to the Nat'l Coordinator for Health Info. Tech., Office of the Nat'l Coordinator for Health Info. Tech., U.S. Dep't of Health and Human Servs. Re: Shared Nationwide Interoperability Roadmap DRAFT Version 1.0 (Apr. 3, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-office-national-coordinator-health-information-technology-regarding-its-draft/1504-roadmaphealth.pdf.

examines the frequency with which patients are treated by out-of-network providers when receiving care at in-network facilities, potentially exposing them to significantly higher costs. One concern we have is that an increase in unexpected out-of-network costs could lead to the disfavoring of narrow networks, even though narrow networks are a proven means of lowering provider costs.

All of this work will support our ongoing effort to determine how best to promote competition in healthcare markets and benefit consumers.

IV. Conclusion

Let me close by emphasizing that we will continue to use all of the tools at our disposal to promote the robust competition that underpins healthcare reform, benefiting consumers through lower costs, better outcomes, greater access to care, and more innovation.

Thank you.