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Antitrust Challenges in Hospital Mergers

Navigating FTC-DOJ Guidance and Regulatory Actions Given Conflict Between
ACA Efficiency Mandates and FTC Pro-Competition Oversight

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Hospital Consolidations: Facing Competing Pressures to Merge and Remain Independent

By: Mary K. Marks, New York

July 1, 2012

The past 18 months have been a busy time for the staffers investigating hospital mergers at the Federal Trade Commission (FTC). In December 2011, the U.S. Court of Appeals for the 11th Circuit affirmed a district court's denial of an FTC preliminary injunction motion¹, from which the FTC and Solicitor General in March 2012 filed a petition seeking review by the U.S. Supreme Court (the "*Phoebe* Transaction"). Also in March, the FTC ruled that the 2010 acquisition of control over a rival health system in the Toledo, Ohio, area would have anticompetitive effects and ordered divestiture²; the parties reportedly plan to appeal (the "*ProMedica* Transaction"). In April 2012, the U.S. District Court for the Northern District of Illinois granted the FTC's request for a preliminary injunction against two hospital systems in Rockford, Illinois,³ prompting the parties to abandon their proposed transaction (the "*OSF/Rockford* Transaction").

At issue in each of these challenges was the anticipated consolidation in inpatient general acute care services⁴ sold to commercial health plans and their customers, which the FTC is concerned will result in increased healthcare costs and the reduction of quality and range of choices for local consumers. The hospitals have argued that their consolidation is just what President Obama has ordered under the nation's new health care law,⁵ while the FTC has expressed concern that consolidation in some smaller markets could lead to higher prices and harm consumers.⁶

The federal antitrust agencies, at times joined by the states, have a long history of challenging hospital mergers. After a hiatus in the early 2000s, the FTC has reinvigorated hospital enforcement, obtaining a consent order against an Illinois hospital system,⁷ and convincing a Virginia hospital system to abandon its plans to acquire a competitor,⁸ while allowing a failing Texas hospital to be acquired by the only available purchaser.⁹

¹ *FTC v. Phoebe Putney Health Sys., Inc.*, 1:11-cv-00058-WLS (M.D. GA 2011)

² *FTC v. ProMedica Health Sys., Inc.*, 3:11-cv-00047-DAK (N.D. OH 2011)

³ *FTC v. OSF Healthcare Sys. and Rockford Health Sys.*, 3:11-cv-50344 (N.D. IL 2012)

⁴ The *ProMedica* challenge also involved inpatient obstetric services.

⁵ See <http://www.nytimes.com/2012/04/03/us/in-ohio-ftc-bans-promedica-st-lukes-merger.html>.

⁶ See <http://online.wsj.com/article/SB10001424052702303863404577286071837740832.html> and <http://www.nytimes.com/2011/08/22/us/22health.html>.

⁷ *In the Matter of Evanston Northwestern Healthcare Corp. & ENH Medical Group, Inc.*, FTC Docket No. 9315.

⁸ *In the Matter of Inova Health Sys. Found. & Prince William Health Sys., Inc.*, FTC Docket No. 9326.

⁹ *Scott & White Healthcare/King's Daughters Hosp.*, FTC File No. 091 0084.

With hospital mergers at an all time high,¹⁰ it appears from these developments that antitrust investigations are also likely to increase. However, that is not to say that all hospital mergers are in jeopardy. In 1996, the Department of Justice (DOJ) and FTC issued joint guidance on health care merger enforcement¹¹ (“Hospital Guidance”) that sets forth an antitrust safety zone for smaller, established hospitals providing general acute care services. The Hospital Guidance recognizes that smaller, and in particular rural, hospitals may need to merge with other hospitals in order to achieve certain cost-saving efficiencies. Outside of the Hospital Guidance’s safety zone, hospital mergers are analyzed using the analytical framework of the agencies’ Merger Guidelines, with a focus on balancing the likelihood of the exercise of market power with the likelihood of cost savings to be passed on to consumers.

Similarly, the DOJ and FTC joint statement addressing antitrust issues relating to Accountable Care Organizations (ACOs, “ACO Guidance”)¹² was intended to ensure that health care providers have the antitrust clarity and guidance needed to form pro-competitive ACOs. The ACO Guidance provides an antitrust safety zone for ACOs that are eligible to participate in the Affordable Care Act’s Medicare Shared Savings Program of a 30 percent “combined share” of the “common service” provided by physicians and facilities, with hospitals and ambulatory surgical centers required to be non-exclusive to the ACO to fall within the safety zone, regardless of the primary service area share. The ACO Guidance also highlights conduct that is relatively more likely to raise competitive concerns, including the sharing of competitively sensitive information and certain activities that require extensive fact finding to confirm its anti- or pro-competitive effect.

While all of this guidance is helpful, a recent Government Accounting Office analysis¹³ of how antitrust guidance affects the ability of health care providers to collaborate to improve health care quality concluded that various stakeholders (health care providers, insurance plans, antitrust enforcers and other experts in antitrust law) differ widely on a number of aspects of such guidance, including whether the agencies should permit greater use of exclusive collaborative arrangements and the scope of the various antitrust safety zones. Given the factual specificity required to analyze multi-faceted hospital mergers, it seems safe to say that outside of the safety zones much remains to be debated and hospital merger investigations are not going to diminish any time soon.

The Phoebe Transaction

On April 26, 2011, the FTC filed a complaint in federal court challenging Phoebe Putney’s acquisition of Palmyra, thereby seeking to block the proposed combination of the only two

¹⁰ “Last year, a 10-year high of 86 hospital deals were announced - valued at roughly \$7.94 billion.” <http://www.beckershospitalreview.com/hospital-transactions-and-valuation/hospitals-confused-by-ftcs-increased-merger-scrutiny.html>. See also “Hospital mergers, acquisitions expected to maintain quick pace” <http://www.ama-assn.org/amednews/2012/04/02/bisa0402.htm>.

¹¹ See <http://www.ftc.gov/bc/healthcare/industryguide/policy/statement1.htm>.

¹² Available at <http://www.ftc.gov/opa/2011/10/aco.shtm>.

¹³ “Stakeholders’ Perspectives Differed on the Adequacy of Guidance for Collaboration among Health Care Providers,” available at <http://www.gao.gov/products/GAO-12-291R>.

hospitals in Albany, Georgia. According to the FTC, the merged entity would control 100 percent of the licensed general acute care hospital beds in Dougherty County; even under an expanded geographic market that would represent a market share of approximately 86 percent.¹⁴ Accordingly, the transaction allegedly would “greatly enhance Phoebe Putney’s bargaining position in negotiations with health plans, giving it the unfettered ability to raise reimbursements rates,”¹⁵ which are then passed on to the health plans’ customers - local employers and their employees, who are members of the health plans.

On June 27, 2011, the district court dismissed the FTC’s complaint on the ground that the defendants’ actions were attributed to the Hospital Authority of Albany-Dougherty County (“Authority”), which, as a state actor, is immune from antitrust liability. Because the Authority’s allegedly anticompetitive activities were legally “authorized by the state pursuant to state policy to displace competition with regulation or monopoly public service,”¹⁶ the defendants did not need to argue that the transaction would be pro-competitive or within any of the antitrust safety zones. In December 2011, the Eleventh Circuit upheld the District Court’s decision,¹⁷ and on March 23, 2012, the FTC requested that the U.S. Supreme Court grant *certiorari* to review the state action ruling.¹⁸

The ProMedica Transaction

In January 2011, the FTC, along with the Ohio Attorney General, challenged ProMedica Health System’s August 2010 acquisition of control¹⁹ over St. Luke’s Hospital through a Joinder Agreement, concerned that it would result in higher healthcare costs that would be passed on to employers and employees, and reduced quality and breadth of health care services available to residents in the Toledo area (which is located in Lucas County, Ohio).²⁰ The FTC claimed that the transaction would give ProMedica enhanced bargaining clout and the ability to obtain higher rates for services at St. Luke’s *and* at its other Lucas County hospitals.²¹ According to the commission, the transaction would reduce the number of competitors in general acute-care inpatient hospital services in Lucas County from four to three, with a combined market share of close to 60 percent, and would also reduce the number of competitors in inpatient obstetrical services in Lucas County from three to two, with a combined market share of more than 80 percent.²² On March 29, 2011, the district court granted FTC’s motion for a preliminary injunction and required the hospitals to maintain St. Luke’s as an independent competitor pending completion of the FTC’s investigation.²³

¹⁴ *Phoebe*, Complaint at 5.

¹⁵ *Id.* at 6.

¹⁶ *Phoebe*, Order (M.D. GA 2011) at 32.

¹⁷ *Phoebe*, Order (11Cir. 2011).

¹⁸ *Phoebe*, Petition for Writ of Cert.

¹⁹ The acquisition of control was not subject to the reporting and waiting period requirements of the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended.

²⁰ *ProMedica*, Complaint at 16.

²¹ *ProMedica*, Complaint at 15.

²² *ProMedica*, Complaint at 4.

²³ *ProMedica*, Order (N.D. OH 2011)

After a full administrative trial, on December 5, 2011, the Administrative Law Judge (ALJ) issued an Initial Decision, finding that the transaction reduced the number of competitors in the market for general acute-care inpatient hospital services from four to three and would increase ProMedica's bargaining power with commercial health plans, leading to higher reimbursement rates that would be passed on to the plans' customers (local employers and their employees).²⁴ While the ALJ did not agree with the FTC's definition of inpatient obstetrical services as a separate relevant product market, on the basis of the expected harm to consumers in the general acute-care inpatient hospital services market, he ordered that ProMedica divest St. Luke's to an FTC-approved buyer within 180 days after the final order.²⁵

On March 22, 2012, the FTC upheld most of the ALJ's Initial Decision, ruling that ProMedica's acquisition of St. Luke's was likely to substantially lessen competition and increase prices for general acute-care inpatient hospital services, as well as for inpatient obstetric services sold to commercial health plans in Lucas County.²⁶ The FTC's Opinion defines the relevant market somewhat differently than the ALJ, but the FTC noted that "the outcome of this case is the same whether or not [inpatient obstetrical] services are included in the [general acute-care] inpatient hospital services market... As the ALJ found, regardless of which market definition is used, market shares and concentration levels exceed the thresholds for presumptive illegality provided in the 2010 Horizontal Merger Guidelines and the case law. Respondent does not dispute this."²⁷

The FTC rejected all of ProMedica's arguments that the commercial health plans' countervailing bargaining power, lack of competitive effects evidence post-transaction, likely repositioning by competitors, and St. Luke's questionable financial viability justified upholding the acquisition. Thus, the FTC ordered ProMedica to divest St. Luke's. The parties reportedly are planning to appeal the decision to the Sixth Circuit.²⁸

The OSF/Rockford Transaction

On November 18, 2011 the FTC challenged OSF Healthcare System's proposed acquisition of Rockford Health System, claiming that the transaction would substantially reduce competition for critical health care services in Rockford, Illinois, thereby increasing total health care costs and reducing the quality of care and range of health care choices for employers and residents.²⁹ It was alleged that the combined entities would control 64 percent of the general acute-care inpatient hospital services in the Rockford area and, together with one other competitor, SwedishAmerican, would control 99.5 percent of that market. In addition, the FTC claimed that the combined entities would only face competition from two other primary care physician groups in the Rockford area, and post-transaction, the OSF/Rockford Health System would control over 37 percent of the primary care physician services in the Rockford area and, combined with SwedishAmerican, would control 58 percent of the market.³⁰

²⁴ *In the Matter of ProMedica Health Sys., Inc.*, FTC Docket No. 9346, Initial Decision.

²⁵ *Id.*

²⁶ *ProMedica*, Opinion of the Commission.

²⁷ *Id.* at 26.

²⁸ See <http://www.beckershospitalreview.com/hospital-transactions-and-valuation/promedica-st-lukes-appeal-ftc-ruling.html>.

²⁹ *OSF/Rockland* Complaint at 1.

³⁰ *Id.* at 2.

The FTC's complaint alleged that the combined entities would have a greater ability to raise rates, which would be passed on to consumers either directly or through higher insurance premiums, co-pays, and other out-of-pocket health care expenses. The FTC was also concerned that the two remaining hospitals would have increased incentives and ability to engage in anticompetitive coordinated behavior, and to eliminate beneficial non-price competition that had been happening between the two hospital systems.³¹ In February 2012, the court held an evidentiary hearing on the FTC's motion, in which each side was permitted to present four witnesses.

On April 5, 2012, while noting that the FTC's likelihood of success on its alleged "primary care physician services" market was "distinctly lower" than its claim involving the "general acute-care services" market due to lower concentration levels and lower barriers to entry, the district court nevertheless granted the FTC's request for a preliminary injunction, pending a full administrative trial on the merits.³² The court discounted the defendants' argument that the merger would not allow them to raise prices to supra-competitive levels, which arguments were based on the contentions that SwedishAmerican was a strong competitor and that large health plans could effectively negotiate against the combined entity.³³ The court also declined to find as sufficient the defendants' offer of a stipulation of how the combined entities would deal post-transaction with commercial health plans.³⁴ Shortly thereafter the parties decided to abandon the proposed transaction.

Looking Ahead

Consolidation in the health care industry is a hot topic these days, with the government urging providers to come up with ways to deliver services more effectively *and* challenging them to avoid combinations that have the potential to raise prices or diminish service. Antitrust concerns are a growing area of focus in deciding if, and with whom, to partner in the industry. Given the FTC's recent actions, there is no reason to expect that antitrust scrutiny into these combinations will lessen. In fact, the opposite is probably true. Certainly, providers of general acute-care services that fall outside of the various antitrust safety zones, residing instead in moderately- or highly- concentrated markets as set forth in the 2010 Merger Guidelines, need to factor an FTC challenge into their timing if they plan to combine.

Significantly, if the Supreme Court grants *certiorari* to the FTC on the *Phoebe* transaction, it will be the first merger case accepted by the highest court in decades. Although it is not clear that the case would create new antitrust law in the merger field, depending on the breadth of the court's decision, the implications for hospital mergers could be critical.

³¹ *Id.* at 2-3.

³² *OSF/Rockland Order* (N.D. IL 2012).

³³ *Id.* at 21-25.

³⁴ *Id.* at 26-27.



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The Changing Health Care Sector: Tough New Challenges for Antitrust Enforcers

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The Changing Health Care Sector: Tough New Challenges for Antitrust Enforcers

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I. INTRODUCTION

The past few years have been marked by increased consolidation among health care providers. Hospitals are merging with each other, physician groups are combining to create much larger, often single specialty practices, and hospitals are acquiring or employing an ever-growing number of physicians. Some observers have suggested that the Patient Protection and Affordable Care Act (“PPACA”)² has encouraged this consolidation, and that the Act will prompt even greater consolidation—with adverse competitive effects—as providers form accountable care organizations (“ACOs”), which under the Act have the potential to share savings with the Medicare program but which also will likely negotiate with commercial health plans on behalf of independent providers.³ Is this, then, an example of contradictory government policies that ultimately will make it even more difficult to rely on competition to reduce health care costs and improve quality?

The short answer is “not necessarily,” but changes in the health care sector will require antitrust enforcers and health care regulators to apply more sophisticated approaches to ensure that our reliance on competitive health care markets is well-placed. Some of the health care sector changes are a result of or will be hastened by PPACA, but others would have occurred in any case, even without the passage of federal health care reform.

II. THE CHALLENGES OF RELYING ON COMPETITIVE HEALTH CARE MARKETS

The causes of the market failures that are present in health care markets are well-recognized. An employer-based health insurance system insulates the patient who “consumes” health care services from much of the actual costs of health care, which are paid by employers

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² Patient Protection and Affordable Care Act, Pub. L. 111-48 124 Stat. 119 (2010).

³ See e.g. Statement of Scott Gottlieb, M.D., Resident Fellow, American Enterprise Institute, before the House Committee on the Judiciary Subcommittee on Intellectual Property, Competition and the Internet at Hearing on “Health Care Consolidation and Competition after PPACA” (May 18, 2012), http://www.aei.org/files/2012/05/18/-scott-gottlieb-testimony_094622558298.pdf; Havighurst & Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 872-875 (2011). *But see* Statement of Thomas L. Greaney, Professor of Law, St. Louis University School of Law before the House Committee on the Judiciary Subcommittee on Intellectual Property, Competition and the Internet at Hearing on “Health Care Consolidation and Competition after PPACA” (May 18, 2012), <http://judiciary.house.gov/hearings/Hearings%202012/Greaney%2005182012.pdf> (arguing that PPACA encourages pro-competitive consolidation and is aimed at addressing some of the market failures that have plagued health care competition).

who contract for health care services that are often ordered by physicians who have little financial incentive to assure that care is furnished in the most cost-efficient manner. Because of information asymmetries and the difficulties in measuring health care quality, those who order and receive health care services are often in a poor position to determine the value of the services. Entry barriers, many imposed by the government such as certificate-of-need and licensure, are high. Consumer preference for broad provider networks makes it difficult for health plans to selectively contract. And, in at least some cases, courts have been receptive to the argument that either because of the professional nature of the services, or the non-profit status of a provider, some special consideration may be warranted when applying antitrust laws in the health care sector.⁴

In addition to all of the above, a crucial factor that further complicates application of antitrust to health care is the role of government as the dominant purchaser. In 2009, Medicare and Medicaid accounted for approximately 47 percent of the average hospital's revenue and 29 percent of the average physician's revenue, although this amount varies by geographic location and mix of services.⁵ Moreover, these percentages will rise in the coming years as more baby boomers qualify for Medicare, and Medicaid rolls grow under PPACA, at least in those states that do not opt out of expanded Medicaid coverage.

There are two key implications that flow from the government's—and especially Medicare's—role as the largest purchaser by far of health care services.⁶ First, the incentives embedded in the Medicare payment system have a huge impact on how providers structure and conduct themselves. This is not only because Medicare directly pays for so much of what they do, but also because other payers in both the public and private sphere generally model their payment approaches around the Medicare program. Medicare reimbursement has been largely based on a fee-for-service model that rewards greater utilization, does not incentivize coordination among health care providers, and does not differentiate payment amounts based on quality.⁷ One consequence of this system is that providers generally do not compete on price for Medicare patients; there may be non-price competition on the part of providers to attract patients directly, or to attract physicians who will refer or admit patients, but such competition is hampered by the lack of incentives and useful data that can be used to identify those providers that provide higher value, i.e. better quality or lower cost.

⁴ See e.g. *Federal Trade Commission v. Butterworth Health Corp*, 946 F. Supp. 1285, 1302 (W.D. Mich. 1996) (asserting that “nonprofit hospitals operate differently in highly-concentrated markets than do profit-maximizing firms”).

⁵ See Medical Payment Advisory Commission, June 2011 Data Book, Health Care Spending and the Medicare Program, at 6, available at <http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf> [hereinafter “MedPAC 2011 Data Book”].

⁶ For a more extended discussion of the ways that government, as both purchaser and regulator, affects hospital markets, see Hammer & Sage, *Critical Issues in Hospital Antitrust Law*, 22(6) HEALTH AFFAIRS 88 (Nov/Dec. 2003).

⁷ This discussion applies to the traditional fee-for-service Medicare program. Medicare Advantage, which covers about 27 percent of Medicare beneficiaries, relies on health plans to cover Medicare beneficiaries using managed care approaches that are similar to those used to cover individuals that are privately insured. See M. Gold, et al., *Medicare Advantage 2012 Data Spotlight: Enrollment Market Update*, Kaiser Family Foundation Medicare Coverage, 2012, available at <http://www.kff.org/medicare/upload/8323.pdf>.

Second, the financial bottom line for most health care providers is heavily dependent on what and how Medicare pays. If Medicare payment per service is reduced substantially, providers will more aggressively seek out ways to reduce costs and increase revenues, the latter either by increasing utilization or seeking more revenues from non-Medicare patients.⁸

III. THE PROVIDER SECTOR REACTION TO HEALTH CARE REFORM

PPACA is widely viewed as insurance reform legislation that does little to address underlying health care costs. The law, however, does contain several provisions aimed at planting the seeds for more fundamental changes in Medicare payment policy.

The initiative that has gotten the most attention is the Medicare Shared Savings Program (“MSSP”) whereby providers organized into ACOs can share the savings (and eventually be at risk for a share of excess costs) associated with providing care to a defined set of Medicare beneficiaries, with the level of payment also being affected by aggregate scores on a variety of quality measures. Other provisions of the Act establish a Center for Medicare and Medicaid Innovation with a \$10 billion dollar budget for fiscal years 2011- 2019,⁹ whose goal in part is to experiment with various innovative ways to structure Medicare payment.

These are largely targeted at achieving the same goals of ACOs—*i.e.* to develop ways in which providers will have incentives to work more closely together across different specialties and settings to improve the overall value of the health care services they provide so that patients receive better quality care, including improved preventive and chronic care services, that result in an overall reduction in health care costs. Such initiatives include payment based on “episodes of care” that involves bundling into a single payment all of the costs associated with a procedure or illness, and the use of “patient centered medical homes” that involve greater coordination by, and reimbursement of, primary care physicians of a wide range of services, many of which have traditionally been under-reimbursed or not paid for at all.

Notwithstanding (at least until recently) the uncertainty of whether PPACA would be overturned, and the somewhat limited nature of these initiatives, the provider community generally has embraced the notion that—sooner or later—both Medicare and private health plans are going to adopt payment reforms that will reward efficient, higher quality providers, and punish those who are not. As a result, there has been a tremendous amount of interest in developing ACOs, or ACO-like approaches, and gathering data and exploring ways to integrate across providers. Most of this should be pro-competitive or competitively neutral. For example, the most significant kinds of integration to build a successful ACO involve providers either contracting or merging with providers of complementary services, *i.e.* not involving horizontal agreements or mergers among competitors.

The movement towards ACOs and similar payment reforms might prompt physicians in very small practices to merge to create the scale to invest in infrastructure, such as an IT system, that would be useful in responding to “value-based purchasing” initiatives, but given the large number of small physician practices, there is room for much of this sort of consolidation without

⁸ See MedPAC 2011 Data Book at 84.

⁹ See “Fiscal Year 2013: Budget In Brief, Strengthening Health and Opportunities for All Americans,” U.S. Department of Health and Human Services, *available at* <http://www.hhs.gov/budget/budget-brief-fy2013.pdf>

raising serious market power concerns. The movement towards payment based on value also should further a market for analytic tools to measure quality and efficiency that would help address one of the major market failures that has plagued health care. Under ACO-like arrangements, physicians will use these tools to choose the facilities where they wish to practice and to shift care among themselves so as to reduce overall costs and improve quality scores.

PPACA, and ongoing discussions about reducing the deficit, also have prompted concerns among the provider community about the reductions in Medicare reimbursement generally. For example, Medicare on the average paid only 95 percent of hospital costs in 2009, compared to 112 percent in 1997.¹⁰ With respect to physicians, payments under the Medicare fee schedule in 2010 averaged only 81 percent of private insurer payments for preferred provider organizations across all physician services and geographic areas.¹¹

Concern about large Medicare cuts is prompting some physicians to sell their practices and seek employment by larger health care systems or with much larger physician practices. Similarly, such concerns have caused some health care systems to consolidate so they can have greater access to capital, obtain more financial stability, and reduce costs. Health plans and some observers have asserted that, in addition to these beneficial results, the consolidations also can result in greater market power (or at least “clout”) in dealing with commercial health plans, and the result will be higher commercial health plan negotiated rates; and such increased rates may go to subsidizing shortfalls from Medicare, Medicaid, and other government payers.¹²

IV. TOUGH ISSUES FOR ANTITRUST ENFORCERS

The developments discussed above mean that the healthcare landscape—already a complex one for antitrust enforcement—will likely become even more challenging.

Undoubtedly antitrust enforcers will continue to do what they are doing now—scrutinize provider mergers—both hospitals and physicians—and challenge those that they believe result in undue concentration in well-defined markets with high entry barriers, and which will likely have anticompetitive effects. The most obvious targets are mergers in moderate-sized cities in relatively isolated areas. These will have sufficient population for the agencies to argue that there is enough volume to support the efficient continued operation of the merging providers as independent entities, and where the geographic market for at least a substantial range of services seems well-defined and limited. The recent FTC hospital challenges in Toledo, Ohio; Rockford, Illinois; and Albany, Georgia are examples.

But such matters involve a small percentage of the health care sector. As they branch further afield, antitrust enforcers will face a number of much more difficult issues to assess. These include the following:

¹⁰ Hospital margins under Medicare vary widely, based on location, teaching status, patient mix, and other factors. See MedPAC 2011 Data Book at 77.

¹¹ See “Report to the Congress, Medicare Payment Policy,” Medical Payment Advisory Commission, March 2010, at 105-06, available at http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

¹² See e.g. Berenson, Ginsburg, Christianson, & Yee, *The Growing Power of Some Providers to Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed*, 31(5) HEALTH AFFAIRS 973 (May 2012) available at <http://content.healthaffairs.org/content/31/5/973.abstract>; Havighurst & Richman, *supra* n. 3.

- *Hospital mergers in urban areas.* The Antitrust Division was unsuccessful in its 1997 challenge of the merger of the North Shore Health System and Long Island Jewish Medical Center, as the court rejected the Division’s allegation of an “anchor hospital” product market and found that the merging hospitals competed with numerous other hospitals in Long Island and parts of New York City.¹³ The FTC took a different approach in the Evanston Northwestern/Highland Park Hospital merger, where the Commission ultimately found a geographic market that consisted essentially of just the merging hospitals, notwithstanding the presence of close to 100 hospitals in the Chicago area.¹⁴ But that challenge was based primarily on evidence of anticompetitive effects that had occurred since the merger had closed. Given the length of time needed to obtain such evidence and to litigate a case, the agencies may conclude that because such delays may preclude meaningful relief, absent very unusual circumstances, retrospective challenges are not worth bringing. This means that the agencies, if they wish to mount hospital merger challenges in large urban areas, will need to develop persuasive evidence regarding likely competitive effects, notwithstanding the likely presence of other nearby hospitals.
- *Physician mergers.* The antitrust enforcers have investigated a number of physician mergers, and in recent years have challenged a few, although none have gone to litigation. This likely will become an area of increasing concern as physicians form large single-specialty practices, or hospital systems acquire a large share of physicians in the same specialty. These cases could raise challenging questions regarding geographic and perhaps product market definition, as well as the extent of entry barriers. Because they are likely not to be HSR-reportable, many of these investigations will likely arise post-closing, perhaps in response to efforts by the merged entity to obtain substantial increases in negotiated rates. One response may be that even if rates went up, so did quality and value (i.e. lower unnecessary utilization). Determining whether indeed there has been an increase in “quality-adjusted prices” (or perhaps alternatively total expenditures for a given population over time, taking into account appropriate adjustments) will be a crucial, and difficult, issue.
- *“Cross-market” and vertical mergers.* Many health systems are expanding by acquiring hospitals outside of their service areas, or complementary providers, such as physicians, laboratories, home health agencies, and other entities that do not compete for hospital inpatients. Health plans assert that such acquisitions give the system more bargaining clout and that, after the transaction, the acquired provider often obtains higher rates, and the whole system—which may negotiate on a “take it or leave it all” basis—is able to negotiate more generous rate increases. There may be legitimate reasons for higher post-acquisition rates (e.g. an increase in quality or the use of more skilled negotiators). But even absent such reasons the agencies will face a substantial burden in challenging mergers of entities that do not compete in the same market. Similarly, the agencies likely

¹³ See *U.S. v. Long Island Jewish Medical Center and North Shore Health System Inc.*, 983 F.Supp. 121, 137-140 (E.D. NY 1997).

¹⁴ See *In the Matter of Evanston Northwestern Healthcare Corporation*, F.T.C. No. 9315, at 63-64 (Aug. 2, 2007), available at <http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf>.

will face a high burden if they seek to challenge contracting practices involving tying or bundling unless the system has market power and likely anticompetitive effects can be shown.

- *ACO formation and operation.* As I have described elsewhere,¹⁵ with the publication of the ACO regulations and the DOJ/FTC statement of antitrust enforcement policy regarding ACOs,¹⁶ providers should have a more clearly defined path regarding how to achieve sufficient financial and/or clinical integration to avoid *per se* condemnation. While there still may be some providers who merely wish to jointly negotiate their fees with no real intention of implementing meaningful processes to improve quality or reduce costs, most provider collaborations will involve genuine efforts to improve their so-called “value proposition.” Many of these will not involve sufficient horizontal overlaps to raise serious antitrust concerns. But others may raise issues, particularly where they involve dominant hospitals or “must have” physician groups. Conduct that likely will be scrutinized will raise issues of both potential collusion (*i.e.* involving too large a share of competing providers), as well as foreclosure and exclusion (*i.e.* making it difficult for competitors to form their own ACOs or otherwise compete). Here the Agencies will be faced with difficult, and novel, questions, as they seek to weigh potential adverse effects that likely will be felt primarily in the commercial market (at least with respect to an impact on prices), against the potential for improved care and efficiencies for patients covered by both commercial and government payers.
- *Conduct that prevents health plans from using tiering/steering approaches or disseminating information about provider cost and quality.* Given the preference that consumers have for broad provider networks, many health plans report that they cannot successfully market networks without certain “must have” providers. But plans can promote intra-network competition by using benefit designs that incentivize health plan members to use providers that are lower cost or higher quality—provided that such information is available and the providers do not preclude tiering or steering approaches. While such initiatives have not been widely used by health plans in the past, there is growing interest in them. There may be, of course, legitimate reasons why a provider may oppose the use of tiering or steering, or certain information dissemination—for example, if it involves the use of misleading or inaccurate data. Moreover, it is also not clear that a provider’s insistence that it not be disadvantaged under a steering or tiering approach, by itself, would violate the antitrust laws.

The above list is not exhaustive. And, as noted, some of the conduct which arguably may frustrate efforts to make health care markets more competitive may be difficult or even impossible to challenge successfully under the antitrust laws. It is here that policymakers may conclude that it is necessary to adopt an approach that combines antitrust insight in how

¹⁵ Leibenluft, *The ACO Antitrust Policy Statement: Antitrust Enforcement Meets Regulatory Rulemaking*, ANTITRUST SOURCE (December 2011) available at http://www.americanbar.org/content/dam/aba/publishing/antitrust_source/dec11_leibenluft_12_21f.pdf.

¹⁶ See Final Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011), available at <http://www.ftc.gov/os/fedreg/2011/10/111020aco.pdf>.

competitive markets should function with the tools that can be provided only through a regulatory regime. Indeed, the proposed ACO guidelines can be seen as an example of that approach. Under the proposed guidelines, all MSSP ACOs that met certain thresholds would have been subject to mandatory review.¹⁷

Had this aspect of the proposal been adopted, ACOs that included dominant providers might have found it difficult to survive that mandatory review if they engaged in certain conduct that the agencies indicated should be avoided. These included preventing or discouraging steering or tiering, requiring a purchaser to contract with all hospitals under common ownership, and restricting payers from making available to their enrollees information about providers' cost, quality, efficiency, and performance. In short, the antitrust agencies proposed to use a regulatory "hook" to effectively prevent certain practices that they might have had difficulty challenging as antitrust violations. The final ACO guidelines retain many of these provisions, but in a less restrictive form that does not include any mandatory review.

V. CONCLUSION

Health care antitrust enforcement has never been simple. But if the movement towards consolidation and integration continues, the antitrust agencies will need to address an even more challenging array of issues. This may result in novel challenges in the courts, and also greater coordination between antitrust enforcers and the Centers for Medicare and Medicaid Services and other government agencies to consider how to make health care markets more competitive through regulatory interventions.

¹⁷ See Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 21,894, 21,897-98 (Apr. 19, 2011), *available at* <http://www.justice.gov/os/fedreg/2011/03/110331acofrn.pdf>.