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Health Care Benefits vs. Costs: Are We Making the Right Choices?

Rosa M. Abrantes-Metz (Global Economics Group & New York University)
&
Albert D. Metz (Moody's Investor Services)

Health Care Benefits vs. Costs: Are We Making the Right Choices?

Rosa M. Abrantes-Metz & Albert D. Metz[1]

I. INTRODUCTION

America has a new health care system, which attempts to increase coverage at less cost. There are doubts that it is in fact doing so, but that should not be a surprise to anyone. We have for years pointed out that increasing coverage while lowering prices would not generally be feasible without severe rationing of services. And, in fact, we can now see that to date and for many Americans, not only are our health care options severely restricted but we also pay drastically increased insurance premiums.

In addition, the new health care system may also have undesired effects on much needed innovation, by making "low health care costs" the policy objective. Lowering health care costs is important, and there is certainly room to do so, but the question is at what impact to future benefits? Is it a coincidence that we see pharmaceutical companies reducing staff and planning on moving (further) key operations abroad? And should "lower costs" truly be the goal of policy? After all, one person's "cost" is another person's "revenue," and costs can rise for a number of good, socially desirable reasons.

In this article we argue that, instead, policy should focus on the price per constant quality of health care. There are reasons to think that prices may be inefficient in this market, and there may be policy options that could address that. Allowing for interstate competition between insurance companies would likely reduce premiums and significantly reduce health care costs.

Still, even "reducing price" must be attempted judiciously. Measures discouraging innovation may allow for lower prices in the present but, to the extent they reduce current R&D, they will represent a large social cost in the future. Such measures would include the growing number of cases in which pharmaceutical companies are denied the financial benefits from their patents till expiration. Yes we get cheaper medicines today, no doubt, but how about tomorrow?

II. BENEFITS TO SOCIETY FROM ADDITIONAL HEALTH CARE COSTS

There is a significant amount of literature showing the benefits of health care expenses in different areas. Here we present new evidence from two different and simple empirical comparisons between benefits and costs when comparing the United States against a large group of countries.

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[1] Rosa M. Abrantes-Metz is a Managing Director in the Antitrust, Financial Regulation and Securities practices of Global Economics Group and an Adjunct Associate Professor of Economics at Leonard N. Stern School of Business, New York University (RAbrantes-Metz@globaleconomicsgroup.com). Albert D. Metz is a Managing Director at Moody's Investor Services (Albert.Metz@Moodys.com). The views expressed are the authors' and should not be attributed to the affiliated institutions or their clients.

A. Health Care Expenses and Longevity

We use data from the OECD for health care expenses, GDP, GDP implicit price deflator, population, life expectancy at 65 for both males and females, and life expectancy at birth. Data was available from 1960 to 2005 for the majority of the countries. The 21 countries studied are Australia, Austria, Canada, Czech Republic, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Japan, The Netherlands, Norway, Poland, Portugal, Slovakia, Spain, Sweden, United Kingdom, and the United States. Though it is possible that health care expenses might not incorporate exactly the same components across all of the countries, we expect for the most part that these data are roughly comparable.

We study the effect that real per capita health care expense as a percentage of real per capita GDP has on life expectancy at 65 divided by life expectancy at birth. Some countries might have higher life expectancy at birth due to other factors besides their health care systems (genetics, diet, or cultural lifestyles for example); however, this ratio represents the relative gain or improvement in life expectancy which is more directly due to interventions like health care, and the analysis will relate that to health care expenditures.

It is important to stress that, to the extent we find that higher spending is correlated with longer life expectancy, this would represent only a fraction of the total benefits of health care spending. Much of the benefit of health care is felt in the *quality* of living and not just in the *quantity* of living as captured by life expectancy.

Having observations for all of these countries over time, we estimate a panel regression model with country-specific fixed effects. We estimate two similar regressions by OLS, one for female and one for male life expectancies, using logarithmic transformations of the variables and allowing the interpretation of the coefficients as elasticities.[2]

Table 1 reports the results for female life expectancy in Panel A and male in Panel B. The findings are very similar for the two genders, with Adjusted R^2's of 73.3 and 72.4 percent respectively. The coefficient on real per capita health care expense as a percentage of GDP is positive and statistically significant, meaning that countries with greater health care expenses see greater increases in life expectancy at 65 relative to life expectancy at birth. Specifically, the elasticity of per capita health care expenses as a percentage of GDP is 0.21 for females and 0.23 for males, meaning that an increase of 1 percent in health care expenses will induce an increase of 0.21 percent in the ratio of life expectancy at 65 to life expectancy at birth for females, and 0.23 percent for males.[3]

[2] T-statistics are computed using robust standard errors.

[3] A specification with year specific fixed-effects to control for various structural breaks in particular changes in policies was also run and results are similar.

Table 1 – Benefits of health care expenses to longevity

Panel A

Log level female life expectancy at 65/at birth	
	Coefficient
Constant	-0.92(*)
Health Exp (real, pc, 5 yr growth) - GDP (same)	0.21(*)
Australia	0.03(*)
Austria	-0.04(*)
Canada	0.03(*)
Czech Republic	-0.04(*)
Denmark	-0.04(*)
Finland	-0.02(*)
France	0.03(*)
Germany	-0.07(*)
Iceland	0.02(*)
Ireland	-0.03(*)
Italy	0.05(*)
Japan	0.06(*)
Netherlands	-0.01(*)
Norway	0.02(*)
Poland	0
Portugal	0
Slovakia	-0.02(*)
Spain	0.07(*)
Sweden	-0.01(*)
UK	0.02(*)
US	-0.04(*)
Adjusted R^2	**0.733**
(*) These are statistically significant at 95% confidence level. Data Sources: Bureau of Labor Statistics; Social Security Administration; National Accounts, OECD.	

Panel B

Log level male life expectancy at 65/at birth	
	Coefficient
Constant	-1.01(*)
Health Exp (real, pc, 5 yr growth) - GDP (same)	0.23(*)
Australia	0.03(*)
Austria	-0.03(*)
Canada	0.01(*)
Czech Republic	-0.04(*)
Denmark	-0.05(*)
Finland	-0.03(*)
France	0.03(*)
Germany	-0.08(*)
Iceland	0.06(*)
Ireland	-0.04(*)
Italy	0.04(*)
Japan	0.07(*)
Netherlands	-0.04(*)
Norway	0.01(*)
Poland	0.01(*)
Portugal	0.03(*)
Slovakia	-0.02(*)
Spain	0.09(*)
Sweden	-0.01
UK	0
US	-0.04(*)
Adjusted R^2	**0.724**
(*) These are statistically significant at 95% confidence level. Data Sources: Bureau of Labor Statistics; Social Security Administration; National Accounts, OECD.	

B. Health Care Expenses and Cancer Survival Rates

Our second analysis relates health care expenditures to cancer survival rates. We combine the data from the previous approach with the 5-year cancer survival rates per country contained in Coleman, et al.—the first worldwide population-based study on cancer survival rates on five continents.[4] With the exception of the Czech Republic, Poland, and Slovakia, all of the remaining 18 countries are represented in Coleman, et al.[5]

The 5-year survival rates used in our model are for prostate, breast, colon, and rectal cancers (diagnosed between 1990 and 1994). Though the data are not as current as one might like, Coleman, et al. is the only study to our knowledge collecting and computing these comparable statistics across such a variety of countries.

This simple model estimates how these cancer survival rates across countries correlate with the share of real per capita health care expenses with respect to GDP. We estimate a cross-sectional linear regression model with 108 observations (18 countries by 6 cancer survival rates per country). We regress the 5-year cancer survival rates on per capita health care expenses as a percentage of GDP, allowing the coefficients to vary across colon and rectal, male and female,

[4] M.P. Coleman, et al., *Cancer survival in five continents: a worldwide population-based study,* 9(8) LANCET ONCOL. 730-56 (August, 2008) hereinafter "Coleman, et al."

[5] There are several other countries also studied by Coleman, et al., but we were unable to find compatible national accounts for those and hence have not used them in this analysis. Additionally, for a couple of the 18 countries, survival rates are computed excluding a few geographical regions.

breast and prostate cancers. The results are presented in Table 2. As with the previous approach, we find a positive and statistically significant coefficient on the log of the per capita health care expenses as a share of GDP on the five-year cancer survival rates. The Adjusted R^2 is 66.8 percent.[6]

Table 2

5-Year Cancer Survival Rates
1990-1994 through 1999

	Coefficient
Breast-Women	5.14(*)
Colon-Men	4.76(*)
Colon-Women	4.79(*)
Rectum-Men	4.69(*)
Rectum-Women	4.76(*)
Prostate-Men	4.97(*)
log (Health Care Expense / GDP per capita)	0.31(*)
Adjusted R^2	*0.668*

(*) These are statistically significant at the 95% confidence level.
Note: Health care expenses and GDP are in 1990 levels.

Data Sources: Coleman, M.P., et al, (2008); Social Security Administration; National Accounts; OECD.

It is important to stress that these survival rates are not only a function of the health care system of the country where diagnosis and treatment take place, but also a function of the health care systems in the countries in which the technologies used for these treatments were developed.

The United States takes a leading role in innovation in the health care industry, which directly benefits domestic consumers but also benefits health care systems around the world.[7] The majority of new technologies are developed and tested in the U.S. As Weisbrod [8] shows, the United States is uniquely positioned among OECD countries as not only a high health care consumer, but also as the leading R&D producer or technology provider. More recently and particularly on pharmaceuticals, Abrantes-Metz, Adams, & Metz[9] (2014) (which will also be discussed in section 4) shows that for the drugs reported as undergoing clinical trials from 1989 to 2002, the majority of these were developed in the United States alone and, less often, sometimes simultaneously in the United States and in other countries. These effects have not been considered in this simple analysis.

[6] There is a binding restriction on the sample size in this case. If not, adding country-specific fixed effects would be preferable. A specification including those effects was run and the results do not qualitatively change.

[7] There are several studies comparing the U.S. health care system against others across the world. But such comparisons routinely overlook the fact that innovation in the U.S. contributes to the success of health care systems in other countries. If a fair comparison is to be made, an extra score should be attributed to the innovator countries, including the U.S., for their contributions to all other health care systems across the world.

[8] Burton A. Weisbrod, *The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment*, 29(2) J. ECON. LIT. 523-552 (June 1991).

[9] R.Abrantes-Metz, C. Adams, & A, Metz, *Determinants of Pharmaceutical Review, Sucess and Duration*, (2014) hereinafter "Abrantes-Metz, et al."

III. REDUCTION IN HEALTH CARE COSTS OR TOTAL EXPENDITURES AS THE POLICY OBJECTIVE

Health care spending per capita in the United States has been increasing as a percentage of GDP and has roughly tripled as a share of GDP over the past forty years, reaching almost 15 percent in 2005, with projections to exceed 19 percent by 2019. Furthermore, the United States spends more on health care per capita than other industrialized countries.[10] While such rapid growth is widely seen as a cause for great concern, much of the discussion on cost growth fails to address whether "more rather than less" health care expenditure is necessarily bad. For example, a 2008 report by the Congressional Budget Office ("CBO") seems to interpret the higher U.S. spending as intrinsically bad, implying that the marginal benefit of one additional unit of health care expense is zero. At the very least, the CBO seems to imply that the marginal benefit from one additional unit of health care is lower than its marginal cost, and hence should not be pursued.

What is important to address is if Americans are "getting more for higher spending." If the marginal benefit of spending is less than the marginal cost, then there is no social gain to spending more. But if benefits exceed costs on the margin, then increasing costs are not, in and of themselves, "bad." This of course would not mean that cost growth cannot and should not be slowed down, and that there aren't inefficiencies in the system or other markets such as insurance which should become more competitive in order to allow a slowdown in health care costs. But even granting all of that, if marginal benefits exceed marginal costs, society's net gain from increased expenditures will be positive.

Having provided such empirical evidence in the previous section, we focus instead on whether "total costs" is the appropriate way to measure value to society in this industry. In our view, *total expenditures* or *total costs* is a poor metric for policymakers. It is easy to imagine good, positive changes that every consumer of health care would welcome but that increase—not decrease—total costs. And it is easy to imagine policies which are designed to curb costs but which result in less (and less effective) health care for all.

We must be very careful to distinguish *costs* from *prices*. Prices inform the relative expense of one item or procedure over another. It is perfectly reasonable to lament the high *price* of health care. Most people would prefer to face lower prices than higher, and most of us would welcome a general decline in the price of health care since that would mean, all else equal, that more people could more easily afford more of it.

Costs, on the other hand, are total expenditures—the total dollars spent. Cost is *price* times *quantity*. If the price of an aspirin is $1, many might feel that this is too high since some can't afford it. When we buy 10 aspirins, the total cost becomes $10. But if the price *falls* to $0.75 and we then buy 20 (either because some of us buy more than we did before, or because new people are able to afford it for the first time), the total cost *rises* to $15. Once we realize that a

[10] CBO (2008); Referring to the CBO's comparison, these countries are Luxembourg, Norway, Switzerland, Austria, Iceland, Belgium, France, Canada, Germany, Australia, The Netherlands, Denmark, Sweden, United Kingdom, Italy, Japan; CBO (2008), Table 1, page 5.

decline in price could lead to an increase in total expenditures, we are forced to question whether *expenditure* is a useful metric for policy.

In fact the two goals—reducing costs and increasing coverage—are generally incompatible. Suppose we decide that it is socially unacceptable to have so many uninsured people. We take the most direct route and subsidize their purchase of health insurance. This has the immediate effect of raising costs, since we now have more social dollars chasing the same amount of health care. It will also have the effect of raising prices, since initially there are no more doctors, nurses, or hospital beds than there were before the subsidies began. Prices—including salaries to doctors and nurses—are likely to rise, and this will over time lead to more people entering the health care industry and thus a greater supply and consumption of "health care." The policy will succeed—we will see an increase in coverage—but only through the mechanisms of *higher* prices and *higher* costs.[11]

If policy makers decide that rises in price and cost are undesirable and prohibit those increases through price controls and the like, an increase in actual coverage might not materialize. With more dollars chasing the same amount of health care, but with prices not *permitted* to rise due to controls, new providers of health care are not likely to enter the industry and there will be no effective increase in coverage. The end result would be rationing.

Roughly speaking, if we have $10 chasing 10 apples, the price will settle at $1 per apple. If we subsidize apple consumption and have $20 chasing 10 apples, the price will be bid up, but that will induce more people to grow more apples, so we may, for example, end up with 16 apples available at $1.25 each—a greater consumption of apples yes, but at a higher price and greater total cost. If we prohibit the price of apples from rising, then we will have $20 chasing 10 apples at $1 per apple—so there will not be enough apples to go around. There will be "apple rationing." This same logic applies to the market for any "widget," including health care.

As illustrated with our aspirin example above, it is easy to imagine a drop in *price* leading to increased *costs* by inducing a more-than-offsetting increase in consumption. This is the first indication that cost can be a poor metric for discussing health care reform. Consider now a second example: new products. Suppose a pharmaceutical breakthrough leads to a treatment for a condition that was previously untreatable. People now spend money on something which literally didn't exist before. "Health care costs" therefore rise. But no one is worse off than before the breakthrough, and many people are better off. Shouldn't this be a welcome development?

Finally, consider a third example: better products. Imagine a new medical procedure doubles the 5-year survival rate for a heart transplant, but costs 50 percent more than the old procedure. Many rational consumers prefer the newer, better, more expensive procedure. "Health care costs" again rise. But by what rationale would this seem socially undesirable?

[11] This analysis is abstracting from the fact that prices might be originally inflated due to market power by insurance companies. As in any other market, the road to a decrease in market power is competition, which can be attained by allowing the purchase of insurance plans across states. If it is true that prices are inflated due to such absence of competition, then it is possible to increase coverage and decrease prices through measures that eliminate protections to insurance companies.

This illustrates a very subtle point even about *price*. We must always ask, "the price of *what*?" In this last example the simple answer is "the price of a heart transplant," and that price went up. That seems "bad" until we realize that the new heart transplant is really very different from the old. *The expected survival rate doubled*. The price *per expected year of survival* actually went down. If something is better, it is not necessarily bad that it has a higher price. What we really need is a largely hypothetical "constant quality price." It seems more appropriate to evaluate proposals on the level of this constant quality price. Is it not almost tautological that anything that lowers the price per unit of quality is socially desirable, even if it leads to an increase in the total "cost" of health care as conventionally measured?

An important study addressing this question is that by Lucarelli & Nicholson,[12] in which the authors build a quality-adjusted price index for colorectal cancer drugs. Given that the average price of treating this type of cancer with chemotherapy increased from about $100 in 1993 to $36,000 in 2005, due largely to the approval and widespread use of five new drugs between 1996 and 2004, the authors question whether the substantial increase in spending has been worth it. They construct a price index for colorectal cancer drugs that takes quality into account of each drug on the market and the value that oncologists place on the drug quality. It is shown that a naïve price index, which makes no adjustments for the changing attributes of drugs in the market, greatly overstates the true price increase. By contrast, when quality is taken into account through a hedonic price index and quality-adjusted indexes, the authors find that prices have in fact remained fairly constant over the 13-year period studied. The new treatment may be 360 times as expensive, but it appears to be about 360 times as effective too.

There is reason to think that prices are unnecessarily inflated in health care, and addressing these inefficient prices will as a corollary lead, *ceteris paribus*, to reduced costs. The growth in insurance markets over the last several decades and the consequent reduction in patient cost sharing over time may have contributed to inappropriately high prices. Consumers may not be as well informed about their options in health care as they are in other markets. Evaluating quality is difficult, and prices are not usually posted so that consumers can make their choices with full information.[13] Finally, it is likely that the absence of competition by insurance companies across states may contribute to inflated prices as well.[14]

Arguments for lowering health care costs today are typically based on a premise that consumer surplus generated by the use of a particular technological advancement will increase if its price decreases. Of course this ignores the production side and the returns to those who invest in research and development. When evaluating such a policy, one must keep both static and dynamic efficiencies in mind. In order to have better technology in the future, firms must invest in R&D today, and hence prices charged today must generate sufficient revenues to offset these investments. Only then can new and better technologies be delivered in the future and thereby

[12] C. Lucarelli & S. Nicholson, *A Quality-Adjusted Price Index for Colorectal Cancer Drugs*, National Bureau of Economic Research Working Paper No. 15174 (2009).

[13] Cutler has also pointed the relevance of potentially inflated factor prices in the growth of health care expenses, *see* David M. Cutler, *The Incidence of Adverse Medical Outcomes Under Prospective Payment*, 63(1) ECONOMETRICA, 29-50 (January, 1995).

[14] J. Cochrane, *Health-Status Insurance: How Markets Can Provide Health Security*, Policy Analysis No. 633, Cato Institute (2009).

increase future social welfare. This trade-off between static/short-run efficiency (that we might lower costs *today* and transfer social surplus from producers to consumers *today*) and dynamic/long-run efficiency (that we will have less innovation *tomorrow* and thus lower-than-otherwise social surplus *tomorrow*) must be carefully balanced in any policy discussion.

Jena & Philipson[15] show that consumer surplus is a poor guide for dynamic welfare in situations when new technologies involve costly R&D. Consider the rationale behind the patent system. The extent to which the net total social value of a new drug is captured by producers in the form of profit determines the level of R&D and hence dynamic efficiency. The reason patents are in place is precisely to transfer consumer surplus to producer surplus in the short-run so that efficient dynamic decisions on R&D can be made, thus enhancing consumer surplus in the long-run. Jena & Philipson argue that since patents are socially beneficial despite lowering consumer surplus in a static analysis, optimal policy in general cannot focus only on consumer surplus. The authors also present a theoretical model and find that, in order to promote dynamic efficiency, the optimal policy is to encourage the sort of "costly innovation" in the long-run that will allow for further increases in consumer surplus in the future.

Jena & Philipson demonstrate this point in the context of HIV/AIDS medications. Under the existing U.S. system, innovators involved in the development of HIV/AIDS medications in the late 1980's were capable of appropriating surplus from their breakthroughs. Jena & Philipson estimate that consumer and producer surpluses from these drugs amounted to $1.33 trillion and $63 billion, respectively. This means that the producer kept 5 percent of the total net social surplus from these socially important breakthroughs. If producers are not able to keep even 5 percent, they are likely to develop fewer important drugs, and the loss to consumers and the society as a whole will far outweigh whatever savings may be realized in the short-run.

IV. CONCLUDING REMARKS

It has been argued that the United States spends more on health care as a percentage of its GDP than any other industrialized country, and that presumably is inherently bad. We show empirical evidence that more spending in the United States has in fact been correlated with higher benefits.

We argue that much of the debate over health care reform in the United States has been focused solely on short-run (even static) analysis without consideration for longer-term efficiencies. It is important to keep in mind that it is today's costly innovation that allows for better quality health care tomorrow. Imposing policies that punish innovation as a way to reduce costs can lead to lower costs today, but it may not be true that they will lead to lower costs tomorrow—particularly if cost is measured in units of quality care. Indeed, we argue that "total health care expenditures" is not the relevant metric for policymakers, but rather that the *price* of one unit of constant quality health care is a more appropriate concept. Unfortunately to our knowledge such measures have yet to be appropriately developed.

[15] A. Jena & T. Philipson, *Innovation and Technology Adoption in Health Care Markets*, American Enterprise Institute for Public Policy Research (2008).

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Patient Outcomes vs. Competition: Squaring the Circle in *FTC v. St. Lukes*

Kent Bernard
Fordham University School of Law

Patient Outcomes vs. Competition: Squaring the Circle in *FTC v. St. Lukes*

Kent Bernard[1]

I. INTRODUCTION

Whether the District Court decision in *FTC v. St. Luke's*[2] is a significant step in the evolution of the application of antitrust law to health care, or whether it is merely a "one off" resulting from the tactical decisions of the parties of how to litigate the case, remains to be seen. What is clear, however, is that the way in which antitrust and health care law function together, and how the seemingly competing priorities of the laws are to be harmonized, is a debate that is just beginning.

The premises driving health care reform reflect a different view of what should take place in the marketplace than the view assumed by traditional antitrust law. For now, the way that we as a society pay for health care serves to reinforce the traditional antitrust approach. But if the changes envisioned by the health care reform laws actually come to pass, antitrust may have to make a major adjustment.

II. AN OUTLINE OF THE PROBLEM

Traditionally, antitrust law treated hospital and physician group mergers the same way it treated any other kind of merger. So if a merger was likely to give the parties the power to raise prices, that merger should be blocked. It is a simple paradigm—more competing players means lower prices.[3] But health care, because of the way the society pays for it, is a weird marketplace. Sometimes, having more providers leads to higher overall costs, since there is a push to over-utilize facilities and equipment that is fed by the payment for services (more accurately, payment for each service) model. For years, governments and private payers have been trying to get a grip on the problem of proliferating providers and overuse.[4]

The law establishing the special status of Accountable Care Organizations ("ACOs")[5] came from a different starting point on costs and benefits than the standard premises underlying

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[1] Adjunct Professor, Fordham University School of Law, J.D. 1975, University of Pennsylvania; B.A. 1972 Colgate University.

[2] FTC v. St. Luke's Health System, Case No. 1:13-CV-00116-BLW (D. Idaho January 214, 2014), *available at* http://www.ftc.gov/system/files/documents/cases/140124stlukesfindings.pdf . The decision and other filings are collected at http://www.ftc.gov/enforcement/cases-proceedings/121-0069/st-lukes-health-system-ltd-saltzer-medical-group-pa .

[3] *See*, e.g., DOJ and FTC 2010 Horizontal Merger Guidelines, Section 6 (2010), *available at* http://www.justice.gov/atr/public/guidelines/hmg-2010.html#6 .

[4] *See*, e.g., national Conference of State Legislatures, Certificate of Need, State Health Laws and Programs, *available at* http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

[5] Patient Protection and Affordable Care Act, "Public Law 111–148". 111th United States Congress. Washington, D.C.: United States Government Printing Office (March 23, 2010).

Section 7. In the world of the ACO an organization is responsible for a patient's total health care and should be paid either on a per capita basis, or in some other way that rewards overall good outcomes. The focus is to be on patient care. And while, when the law was passed it was hoped that this emphasis would lead to lower costs (and is expected to in the long term) quality of care should still be the driver.[6] But while the ACOs look to this new model of care, the payment structure has remained based on payment for individual services. In fact, for something as significant as the ACO, the actual legislative mandate creating it is very terse.[7]

The result seems to be that an organization created by mergers to execute the vision under the Affordable Care law runs into an issue with economic incentives as dealt with under existing law. While mergers, such as St. Lukes and others, may be undertaken in an effort to provide better care, the parties are paid without regard to that end. And for that reason, mergers such as the one at issue here lead in some cases to higher prices, as is eloquently argued by three academic economists in their letter to Massachusetts State Judge Janet Sanders arguing against approval of proposed acquisitions by Partners Healthcare, a major healthcare provider in Massachusetts.[8]

III. THE ST. LUKE'S CASE

The Court in the *St. Luke's* case tried to bridge this gap between the goals of the ACOs and the mandates of classical antitrust. The U.S. Federal Trade Commission ("FTC"), together with the Idaho Attorney General, sued to block St. Luke's Health System, Ltd. from acquiring an Idaho independent, multi-specialty physician practice group, Saltzer Medical Group P.A. The suit alleged that the combination of St. Luke's and Saltzer would give it the market power in the market for primary care physicians ("PCPs") in Nampa, Idaho and surrounding areas, such that it could demand higher rates from payers, ultimately leading to higher costs for health care consumers. 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.[9]

The problem with the case from a precedential standpoint is that the decision seems to have been driven by a couple of tactical decisions by the parties. First, the FTC did not challenge the acquisition on vertical grounds (a hospital acquiring a physical practice), but rather on the horizontal theory that this was the coming together of two physician practice groups. While this

[6] The concept of managed care is not new to ACOs. Health Maintenance Organizations (HMOs) have been around for years. *See* Suzanne Felt-List, *How HMOs Structure Primary Care Delivery*, 4(4) MANAGED CARE QUARTERLY 96-105 (1996); *available at* http://www.aspenpublishers.com/books/kongstvedt/Readings/Chapter%2012/MCQ%204-4.p96-105.pdf. What is new is push for such organizations in the federal statute that substantially changes the healthcare insurance and payment landscape.

[7] Text related to Accountable Care Organizations is found in two sections totaling eight pages, out of 974 total pages of the law. *See* http://www.dmhc.ca.gov/Portals/0/AboutDMHC/FSSB/ACO_Provisions-IHA.pdf .

[8] Letter of July 21, 2014 to The Honorable Janet Sanders from Leemore Dafny, David Dranove, & Lawrence Baker, *see* Robert Weisman, *Experts call on judge to block Partners' hospital takeovers*, BOSTON GLOBE (July 24, 2014), *available at* http://www.bostonglobe.com/business/2014/07/24/outside-antitrust-experts-call-massachusetts-judge-block-partners-hospital-takeovers/cqMDcyBaFXpUVTNjixTJEO/story.html, (hereinafter "Partners Letter").

[9] FTC v. St. Luke's Finding of Fact and Conclusions of Law, *supra* note 2. Private parties brought a vertical case, but the Court did not rule on it given the result in the FTC action.

made for a more traditional analysis (and an easier case for the FTC), it did not provide much help with the legal rules for creating Accountable Care Organizations to cover the medical spectrum.

Second, the only fact question that seemed to be at issue was whether Nampa, Idaho (and surrounding areas) was the proper geographic market in which to evaluate the merger. So the case came down to a question whether the acquisition substantially lessened competition in the market for primary care medical services in and around Nampa, Idaho. Once phrased that way, the outcome was not really in doubt. Given the market share in the defined primary care physician market after the acquisition (some 80 percent), higher prices could almost certainly be presumed to be the outcome.[10]

From a macro perspective this presumed outcome also highlights a second, related problem: How much higher do prices have to be in order to create an antitrust issue? Section 7 applies to "any line of commerce in any section of the country."[11] Primary care physician services may indeed constitute a product market, at least for now. But primary care physician services make up only about 11 percent of the cost of health insurance premiums.[12] This means that a 10 percent increase in the price for PCP—assuming that all of it is passed along as a premium increase—would raise premiums to patients by about 1 percent.

In contrast to the FTC's traditional antitrust argument, St. Luke's argued the policies of the Affordable Care Act. What makes this especially intriguing is that the Court was very sympathetic to that argument:

> Among the experts, there is a rough consensus on a solution to the cost and quality concerns nationwide. They advocate moving away from our present fee-for-service health insurance reimbursement system that rewards providers, not for keeping their patients healthy, but for billing high volumes of expensive medical procedures. A far better system would focus on maintaining a patient's health and quality of life, rewarding successful patient outcomes and innovation, and encouraging less expensive means of providing critical medical care. Such a system would move the focus of health care back to the patient, where it belongs.
>
> In fact, there is a broad if slow movement to such a system. It will require a major shift away from our fragmented delivery system and toward a more integrated system where primary care physicians supervise the work of a team of specialists, all committed to a common goal of improving a patient's health.
>
> St. Luke's saw this major shift coming some time ago. And they are to be complimented on their foresight and vision. They started purchasing independent physician groups to assemble a team committed to practicing integrated medicine in a system where compensation depended on patient outcomes. "[13]

The Court then went on to praise St. Luke's, but then to unwind the transaction:

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[10] As a side note, I always tell my students that whoever defines the market, wins the case. This decision seems to further support that thesis.

[11] Clayton Act Section 7, 15 U.S.C. Section 18.

[12] *See* McCann & Vorasi, *Antitrust Treatment of Physician-Hospital Integration Post FTC v. St. Luke's*, 28 (3) ANTITRUST, 75, 77 and note 40 (Summer 2014) and sources cited therein.

[13] FTC v. St. Luke's, *supra* note 2, Memorandum Decision and Order at p.2. The Court goes into this in some detail in its Findings of Fact Nos. 161-177.

> The Acquisition was intended by St. Luke's and Saltzer primarily to improve patient outcomes. The Court is convinced that it would have that effect if left intact, and St. Luke's is to be applauded for its efforts to improve the delivery of health care in the Treasure Valley. But there are other ways to achieve the same effect that do not run afoul of the antitrust laws and do not run such a risk of increased costs.[14]

What the Court found is that there may be other ways to improve patient outcomes, and since St. Luke's couldn't prove this particular path was the only viable one, then it had not chosen the least restrictive alternative. The fact that there were independent groups experimenting with risk-based contracting was viewed as evidence that this integration was not "necessary." Of course, it is difficult to prove that a new structure is more effective than the existing one if you are never allowed to put the new one into place. Also, how can we determine if the alternative means would improve care as much as the challenged one? Finally, how do we weigh quality of care against cost? Are improved patient outcomes worth a 1 percent premium increase? How do we decide?

The FTC considers improved quality of care to be an "efficiency," which it would have to somehow weigh against the costs of the merger. However, the agency has not found it necessary to actually do such a weighing, because it has always found that the quality improvements were speculative.[15]

We have to recognize that, as the Partner's Healthcare letter referred to above argues, under the current reimbursement method—even if the more integrated structure produces better patient outcomes—if it concentrates the seller side of the health care market, it may result in higher prices. But the stated goal of an ACO is described primarily in terms of patient outcomes; cost comes second:

> Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.
>
> The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
>
> When an ACO succeeds both in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.[16]

IV. SQUARING THE CIRCLE

The Court in the *St. Luke's* case seemed to believe that unless the merging parties could show that the merger was practically indispensable to attain the benefits, then because of the possible effect on costs the merger should not be allowed. In effect, the Court required the parties

[14] *Id.* at 3.

[15] Speech of Deborah Feinstein, Director, Bureau of Competition, Federal Trade Commission, *Antitrust Enforcement in Healthcare: Proscription, Not Prescription*, at 11 (June 19, 2014), *available at* .http://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf

[16] CMS Fact Sheet on ACOs, *available at* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/

to show that the merger was the least restrictive alternative to achieving the benefits. But there is an underlying premise to that argument that we need to consider here. That premise is that the good resulting from the merger can be measured in the same terms as the harm. As stated in the 2010 Horizontal Merger Guidelines, the issue is whether the efficiencies would be sufficient to reverse the merger's "potential harm to customers in the relevant market, e.g., by preventing price increases in that market."[17]

Traditionally, arguments that sought to justify conduct that may have an adverse economic effect, but realize a non-economic benefit, have been rejected.[18] But in the health care field, and specifically under the Affordable Care Act, we have a federal law—of arguably equal standing with the antitrust laws—that promotes a value distinct from price competition. So while in the past it may have been fruitless to argue that better quality of care should outweigh an increase in prices, now there is a statutory basis to at least evaluate that claim.

The Court held in this case that if you are arguing better quality of care in the face of a potentially higher price, you need to show that there is no less restrictive way to reach that goal. But the Affordable Care Act may be read to argue just the reverse—if you can increase the quality of care, it is up to someone attacking the arrangement to demonstrate that there is a better way to reach the goal at a lower cost.

IV. CONCLUSION

Right now we have a system caught in a paradox. We want to encourage integrated provision of health care services, to improve outcomes and (hopefully) eventually reduce costs. But we pay for it on a basis that rewards having multiple providers and multiple services. And money drives conduct.

The argument for allowing transactions such as the one at issue in this case is one based on long-term cost savings. Even if there is a cost increase at first, there will (or may be) savings in the long run in terms of healthier people who need fewer medical services. Since those savings cannot be proven up front, burden of proof is critical.

Perhaps the last lesson here is that facts are always important. At the beginning of its findings of fact, the court stated "In Idaho, the quality of our health care is outstanding, but we pay substantially more than the national average for that quality."[19] In that context, a transaction that purported to increase quality but might also increase costs seems to be mis-targeted. It is as if you had a car that you thought was of excellent quality but cost too much to run, and I offered you a car of even higher quality but also a higher cost of operation. The transaction at issue here may well have been perceived, at least at some level, as offering a benefit that people didn't want at a cost that they also didn't want. That can be a hard thing to sell, in any forum.

[17] 2010 Horizontal Merger Guidelines, *supra* note 3, Section 10.
[18] *See* Wright & Ginsburg, *The Goals of Antitrust: Welfare Trumps Choice*, 81 FORDHAM L. REV. 2405 (2013).
[19] FTC v. St. Luke's Finding of Fact and Conclusions of Law, *supra* note 2, at 2.

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Redefining Care and Competition Models in Health Care

Kenneth W. Field
Jones Day

Redefining Care and Competition Models in Health Care

Kenneth W. Field[1]

Believe it or not, antitrust enforcers, health system executives, and the drafters of the Affordable Care Act ("ACA") all have the same goals in mind. Everyone involved seeks to ensure and increase access to high-quality, low-cost care for patients.

The ACA incentivizes providers to shift from traditional fee-for-service models to population health management models designed to improve patient outcomes and slow the growth of health care costs. Health system executives are busy designing new delivery platforms to accomplish those goals by collaborating and consolidating with other providers to drive down costs and more fully integrate care across the continuum. Meanwhile, antitrust enforcers are actively policing this consolidation, believing that competition remains the best way to reduce costs and improve care for patients. The apparent conflict between incentives to collaborate and staunch antitrust enforcement has drawn more commentary and complaints than any other issue in antitrust for years. But much of the writing misses both the important common ground and the true areas of disagreement.

Antitrust enforcement with regard to hospital mergers and other provider consolidation often focuses today on so-called first-stage competition, that is competition among providers to be included in health plan networks. The analysis considers what alternative providers are available to a health plan and its members in a local area and how any proposed consolidation might alter the relative bargaining positions of the providers and the commercial health plans in that area. The key question is whether a given transaction may increase the bargaining power of the post-merger entity such that it could demand higher reimbursement rates from commercial payers post-merger.

Under the *Horizontal Merger Guidelines*, any transaction that significantly increases concentration in a properly defined market is presumed to increase market power and therefore may tend to substantially lessen competition in violation of Section 7 of the Clayton Act. As a result, any combination of providers with significant market shares in a local area risks being challenged by the Federal Trade Commission and state enforcers.

The *Guidelines* also outline important defenses with which parties to a merger can rebut the presumption of competitive harm. The so-called efficiencies defense is the most important defense for purposes of this discussion. Parties can rebut the *Guidelines*' presumption of harm

[1] Ken Field is a former Federal Trade Commission attorney and is now Of Counsel in Jones Day's Washington, D.C., office. During his six years at the FTC, he worked on health care matters, among others, as a member of the Bureau of Competition's front office before serving as Lead Attorney on the FTC's investigation and successful litigated challenge of OSF Healthcare System's attempted acquisition of Rockford Health System in Rockford, Illinois. Mr. Field now advises health systems and other clients throughout the United States regarding antitrust issues. Contact: kfield@jonesday.com.

with a credible showing that the proposed transaction will generate sufficient cost and quality improvements to offset any lost competition. Importantly, the parties must show that the transaction is necessary to achieve the purported efficiencies, that is that the parties could not realize the same benefits without the transaction at issue. These elements, especially the merger specificity requirement of the efficiencies defense, are the source of much conflict and confusion today.

The first principle of the ACA, and of all modern health reform, is that more collaborative and fully integrated models of care will reduce costs and improve quality and access. Health system executives understand the imperative for change but frequently conclude that they cannot make the transition alone. The systems instead seek out partners to help expand their scope, share expertise, and pool financial resources to afford the investments required to succeed in the new paradigm. Consistent with their understanding of the ACA, health systems favor those combinations with the largest potential to drive cost savings, and create operational and clinical synergies. The presumption that collaboration, integration, and consolidation drives cost savings and generates efficiencies is seen as a fundamental tenet of the ACA.

According to the FTC's departing head economist Dr. Martin Gaynor, however, "[t]he research on cost reductions from hospital mergers shows basically no evidence of cost savings from hospital mergers." As a result, Dr. Gaynor is "fairly skeptical" of claims that consolidation will generate meaningful efficiencies. It is this skepticism that is most frustrating to health systems as they respond to the ACA's incentives to collaborate in pursuit of cost saving and synergies. The recent decision in *FTC v. St. Luke's Health System* supports the FTC view, however, and serves to validate and embolden that skepticism. As a result, health systems today face an increasingly high burden to produce case specific facts and evidence when trying to defend a transaction through the efficiencies defense.

While these competing takes on efficiencies have generated costly litigation and countless pages of commentary, focusing on the narrow efficiencies defense ignores potential common ground that deserves further development and discussion. The FTC and other antitrust enforcers begin with the foundational assumption that competition provides the strongest and most important incentive for cost savings and innovation. Their enforcement actions in health care matters—as in other industries—challenge transactions the agencies believe will reduce or eliminate that beneficial competition. This is the source of perhaps the greatest disconnect between the agencies and health system executives today.

Health systems are undertaking dramatic and wrenching transformation to become more competitive in new markets, not to eliminate competition in existing markets. For example, providers are collaborating to create their own products on the health exchanges in direct competition with existing commercial health plans. The systems increasingly see a future in which survival depends on their ability to deliver value, bear risk, and manage patients' health over a much broader geographic area and in competition with regional networks—a marked shift away from the traditional fee-for-service models that rewarded them for increasing utilization and volumes at the expense of other local providers. For that reason, providers complain that the FTC is applying outdated analytics in evaluating transactions motivated by the ACA.

However, the ACA final rules explicitly rely on the antitrust agencies to use "their existing enforcement processes for evaluating [antitrust] concerns… and [to file] antitrust complaints when appropriate." What is more, the vast majority of care is today still provided and reimbursed under traditional models. Accordingly, parties are unlikely to persuade the FTC, fresh off its recent victories, that it is applying the wrong analytical framework.

As regional networks grow, and as risk-sharing and value-based platforms begin to account for more care episodes, parties to consolidation should be able to develop additional evidence that the nature of competition has truly changed. Once parties' own documents show the systems are constrained not by crosstown rivals but instead by regional or super regional networks or other new models, antitrust analysis will follow.

The fundamental question will remain however, whether or not a proposed transaction will change the relative bargaining power of the providers and payers. The answer will turn on the availability of alternatives to the merged entity, just as it does today. Providers genuinely believe they are moving into a period of increased competition even from more distant competitors, and they are investing and reorganizing and consolidating in response to that perceived threat. The task now is to show that to be true.

Although antitrust analysis is prospective, it will be extremely difficult to convince the enforcers to ignore what they view as real and immediate harm to existing competition and instead analyze the potential effect of transactions with regard only to an as yet unrealized future state. In the meantime, parties to transactions must focus on showing that they are reacting to the changing competitive forces and that their transaction will increase—not reduce—competition in ways that serve the shared goal of increasing access for patients to high-quality, low-cost care.

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The Evolution of Efficiencies and Treatment of Quality of Care Defenses in Light of Changing Health Care Industry Dynamics

Dionne Lomax & Helen Kim
Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C.

The Evolution of Efficiencies and Treatment of Quality of Care Defenses in Light of Changing Health Care Industry Dynamics

Dionne Lomax & Helen Kim[1]

I. INTRODUCTION

The consolidation of health care markets and the impact of this consolidation on prices, costs, and quality, has been a hotly debated topic in the health care industry. Hospitals across the country are merging and acquiring physician practices faster than they have in decades. These dynamic changes in the nation's health care delivery systems have been prompted, in part, by the implementation of the Patient Protection and Affordable Care Act[2] ("ACA"), which seeks, among other things, to promote higher quality, lower cost health care by encouraging increased coordination of care among health care providers through the creation of Accountable Care Organizations ("ACOs").[3]

One premise of the ACA is that the restructuring of the health care industry through coordinated care and integration should enable providers to cut costs and improve quality in ways that benefit patients. However, antitrust enforcement officials are quick to remind providers that the ACA does not change the fact that provider collaborations remain subject to the antitrust laws. Thus, providers must ensure that their new health care delivery systems do not enhance or create market power or otherwise harm consumers.

Efficiencies are frequently a significant part of the business rationale for hospital mergers and other provider collaborations and are an area of increased focus in health care antitrust litigation. However, receiving credit for the efficiency-enhancing aspects of a combination in a merger review is often difficult. By the Federal Trade Commission's ("FTC") own account, "efficiencies are most likely to make a difference in merger analysis when likely adverse competitive effects, absent the efficiencies, are not great."[4] Moreover, in a recent speech, Debbie Feinstein, Director of the FTC's Bureau of Competition, made clear that although the FTC will consider merger-specific efficiencies to balance concerns of market power, the agency is increasingly taking a more stringent approach to how these defenses outweigh competitive harm.

This is particularly evident when analyzing the FTC's treatment of quality improvement claims in some of its most recent cases. As noted by Director Feinstein, while the agencies

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[1] Dionne Lomax is a member, and Helen Kim is an associate, in Mintz Levin's antitrust and trade regulation practice in Washington, D.C.

[2] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

[3] A network of doctors, hospitals, and other health care providers who come together to provide coordinated high-quality care to a group of patients and are held accountable for the cost and quality of the full continuum of care delivered to those patients.

[4] *See* U.S. Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines § 5.3 (2010), *available at* http://ftc.gov/os/2010/08/100819hmg.pdf.

"expect and encourage parties to provide … concrete evidence to support quality claims,"[5] there is an outstanding question regarding the extent to which quality improvement claims can be demonstrated with the specificity required to satisfy the FTC's efficiencies standard as they weigh the competitive implications of a transaction. Indeed, the FTC acknowledges the complexities involved in assessing quality improvement claims, stating:

> [I]t is more difficult to determine how best to balance a possible price increase on the one hand and a quality improvement on the other hand. To date, however, that is not something we have found necessary to do. In the handful of transactions we have challenged, we have determined that the quality improvements were speculative, not substantiated and/or the merger was not necessary to achieve them.[6]

As such, merging parties have had difficulty prevailing on quality improvement defenses. The most recent debate in this regard is the FTC and Idaho Attorney General's 2013 challenge of St. Luke Health System's ("St. Luke's") acquisition of Saltzer Medical Group ("Saltzer"), where efficiencies are a significant component of the parties' defense.

II. *FTC V. ST. LUKE'S HEALTH SYSTEM*

In *FTC v. St. Luke's Health System*, the first fully litigated challenge by the FTC to a hospital acquisition of physician practices,[7] the parties claimed that St. Luke's acquisition of Saltzer would generate substantial efficiencies. They argued that factors such as—(1) shared use of St. Luke's information technology, including electronic medical records; (2) aligned incentives to enable clinically integrated, value-based patient care; (3) expansion of access for the poor and uninsured; and (4) management of population health—were consistent with the objectives of federal health reform legislation.

Although the district court credited the defendants' efficiencies defenses, acknowledging that the merging parties entered into the transaction "primarily to improve patient outcomes" and health care quality, and even stated the merger "would have that effect if left intact," it ultimately concluded that the efficiencies were not "merger-specific" and that St. Luke's could achieve the same efficiencies without fully merging with Saltzer and employing its physicians.[8] The district court held that employment is not necessary to achieve the claimed efficiencies, citing examples of other health systems that had achieved high-quality, low-cost care using independent physician practices. The court also noted that the promised benefits of integration were in an "experimental stage" with the payback, if any, a decade away. As a result, the court ordered St. Luke's to divest the Saltzer assets and permanently enjoined the acquisition.[9]

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[5] Deborah L. Feinstein, Director, Bureau of Competition, Fed. Trade Comm'n, Remarks at the Fifth National Accountable Care Organization Summit, *Antitrust Enforcement in Health Care: Proscription, Not Prescription*, June 19, 2014.

[6] *Id*. at 11.

[7] *St. Alphonsus Medical Center – Nampa, Inc. v. St. Luke's Health System, Ltd.,* Findings of Fact and Conclusions of Law, No. 12-0560, Dkt. No. 464 (D. Idaho Jan. 24, 2014), appeal dktd., No. 14-35173 (9th Cir. filed Mar. 7, 2014).

[8] *Id*. at 3.

[9] The court found that St. Luke's efficiencies defense could not overcome the presumption of illegality created by its dominant market share, a figure the court determined to be 80 percent of the primary care physicians in the

On appeal to the Ninth Circuit,[10] St. Luke's contended that the FTC placed an "impossible" burden on merging parties to prove efficiencies, and argued that the district court wrongly decided that the parties could have raised the quality of health care without an affiliation.[11] Appellants dismissed the FTC's examples of where benefits of integrated care were achieved without a tight affiliation of physicians and instances of improved healthcare without employed physicians, arguing that such other arrangements did not answer the question relevant to the St. Luke's case: "The facts in *this* case do not support the notion that *these parties* could achieve these benefits in the *same timeframe* by some other means."[12] Appellants pointed to the court's finding that previous attempts at a looser affiliation by Saltzer physicians had failed, and asserted that "[o]nly this transaction—which allowed St. Luke's and Saltzer to share technological infrastructure, sophisticated analytics, all patient information, resources for community outreach, and both upside and downside accountability for patient outcomes—could achieve those benefits."[13]

The FTC argued that the district court correctly held that the deal would have anticompetitive effects. Noting that the Ninth Circuit "has not yet accepted a claim that a presumptively unlawful acquisition can be justified because it allows greater efficiency of operation,"[14] the FTC rejected St. Luke's argument that the merger would create efficiencies in health care and thus reduce prices and improve care. They said that those effects could just as easily be achieved through competition, and thus argued that the case was a "poor candidate" for validating an efficiency defense under the Clayton Act.

According to the FTC, appellants' asserted efficiencies cannot "salvage an acquisition held to be anticompetitive…If the Court considers St. Luke's efficiency defense, it should affirm the district court's application of the strict, two-part analysis that the D.C. Circuit used in *Heinz;*"[15] meaning the court must first "undertake a rigorous analysis of the kinds of efficiencies being urged… in order to ensure that those 'efficiencies' represent more than mere speculation and promises about post-merger behavior." The court must then assess whether the asserted efficiencies are merger-specific. The FTC sought strong appellate support for the district court's conclusions that the efficiencies advanced by St. Luke's—a) enabling the parties to move away from "fee-from-service" toward "risk-based care;" b) allowing the parties to provide "integrated" rather than "fragmented" care, thus improving the quality of care; and c) allowing the better use of electronic medical records and data analytical tools—were not merger-specific.

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relevant area, and that no court has found (without being reversed) that efficiencies were enough to save an otherwise illegal merger.

[10] The Ninth Circuit stayed the District Court's order of divestiture and the appeal is on an expedited schedule. *St. Alphonsus Medical Center – Nampa, Inc. v. St. Luke's Health System, Ltd.,* Order Granting Motion to Stay, No. 12-0560, Dkt. No. 510 (D. Idaho Jun. 25, 2014).

[11] *Alphonsus Medical Center – Nampa, Inc. v. St. Luke's Health System, Ltd*., Reply Brief of Appellants St. Luke's Health System, Ltd, et al., No. 14-35173 (9th Cir. Sep. 2, 2014), at 26.

[12] *Id.* at 22-24.

[13] *Id.* at 23.

[14] *Alphonsus Medical Center – Nampa, Inc. v. St. Luke's Health System, Ltd*., Answering Brief for Plaintiffs Federal Trade Commission and the State of Idaho, No. 14-35173 (9th Cir. Aug. 13, 2014), at 4.

[15] *Id.* at 47-48.

The St. Luke's case raises a number of interesting issues and questions in the minds of antitrust practitioners. Some argue that the FTC's merger challenge is misguided because this case is precisely the type of provider collaboration the ACA promotes and that such consolidation is precisely what the industry needs in order to provide a higher level of care to patients and combat rising health care costs. In addition, the FTC is attempting to persuade the Ninth Circuit to adopt the very stringent efficiency defense standard articulated in *Heinz,* where the D.C. Circuit held that the high market concentration levels in the case required, "in rebuttal, proof of extraordinary efficiencies."[16]

This approach to the efficiencies analysis and treatment of the parties' quality of care defense leaves some unanswered questions regarding the type of quality of care defenses the FTC would find acceptable. The D.C. Circuit did not define the term "extraordinary" so it remains unclear what level of efficiencies satisfy that standard. If this more restrictive efficiencies defense standard is applied to future transactions, what type of quality of care efficiencies would be viewed as "extraordinary" and more importantly, how can parties demonstrate such efficiencies with the precision required to satisfy the standard?

If the FTC prevails, it will be the first time on the appellate level in the health care context that the very stringent efficiency defense standard articulated in *Heinz* is adopted. However, this strict efficiency defense standard is one that the Commission previously embraced when assessing quality of care defenses in the *Evanston* case.

III. *IN THE MATTER OF EVANSTON NORTHWESTERN HEALTHCARE CORPORATION*

The FTC's case challenging Evanston Northwestern Healthcare's ("Evanston") acquisition of Highland Park Hospital ("Highland Park") was a result of the FTC's retrospective review of hospital mergers announced by then-FTC Commissioner Tim Muris in 2002. Two years after the retrospective review was initiated, and four years after the transaction closed, the FTC issued a three-count administrative complaint alleging that Evanston's acquisition of Highland Park violated the antitrust laws.

ENH argued that the merger produced significant quality improvements and presented evidence that it spent over $120 million post-merger to make improvements and expand services at Highland Park in 16 areas. The Commission disagreed, stating that Evanston failed to rebut complaint counsel's showing of anticompetitive effects,[17] and finding that the quality improvements asserted by ENH should not be credited as benefits of the merger because Highland Park could have made similar improvements without a merger. It cited evidence that Highland Park had plans in place to improve its quality and had already begun to make a number of the improvements that ENH attributed to the merger (e.g., developing a cardiac surgery program in affiliation with Evanston or another hospital). Further, "ENH produced little verifiable evidence that the changes it made at Highland Park improved quality of care,"[18] such as

[16] *FTC v. H.J. Heinz Co. and Milnot Holding Corp.*, 246 F.3d 708, 720 (D.C. Cir. 2001) (finding that the claimed efficiencies in a merger between two of the only three baby food producers were not large enough to meet the standard when measured across the merged firm's total output and cost structure).

[17] *In the Matter of Evanston Nw. Healthcare Corp.*, Opinion of the Commission at 83, FTC Docket No. 9315 (Aug. 6, 2007), *available at* http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf.

[18] *Id.*

failing to "produce data to substantiate its assessments of quality at Highland Park, even though the record shows that ENH routinely tracks numerous quality indicators as part of its quality improvement program."[19] According to the Commission:

> Given the particular circumstances of this case—the fact that the merger has already been consummated, many of the claimed improvements were implemented years ago, and ENH routinely tracks numerous quality indicators—ENH could have produced more concrete evidence than it did to substantiate its claims that the changes it made at Highland Park improved the quality of care. As the court emphasized in *Heinz*, "a rigorous analysis" is required to ensure that defendant's claims of offsetting procompetitive benefits "represent more than mere speculation." The dearth of verifiable evidence here is all the more reason for us to find that ENH has failed to satisfy its burden to prove "extraordinary" procompetitive benefits, offsetting complaint counsel's showing of competitive harm."[20]

IV. *IN THE MATTER OF OSF HEALTHCARE SYSTEM AND ROCKFORD HEALTH SYSTEM:*

In a 2012 case involving Illinois health systems, the FTC's complaint alleged that OSF Healthcare's proposed acquisition of Rockford Health System would substantially reduce competition among hospitals and primary care physicians in Rockford, Illinois.[21] In opposition to the FTC's request for a preliminary injunction, the defendants argued that the proposed merger would lead to improved quality of care and provide other benefits to the Rockford community, such as allowing the merged entity to develop "Centers of Excellence"[22] and increasing defendants' ability to attract and recruit specialists and subspecialists. The FTC contested defendants' claims, arguing that they were unsubstantiated, speculative, and not merger-specific.[23]

The court agreed. Granting the FTC's request for a preliminary injunction, the court held that the claimed efficiencies failed to outweigh the potential harm to consumers from the presumptively anticompetitive merger. The court explained that proof of "extraordinary efficiencies" would be required in the face of high concentration levels and observed that: (1) conflicting evidence from experts made it unclear whether increased quantity of procedures would lead to improved quality of care; (2) it was unclear that defendants would be able to develop "Centers of Excellence" as a result of the merger and possible that the designation could be achieved independent of the merger; and (3) the argument that the merger would enable the parties to recruit specialists and subspecialists was belied by their history of successfully recruiting specialty physicians.

V. A FRAMEWORK FOR QUALITY IMPROVEMENT CLAIMS

As these decisions highlight, the FTC and the courts require parties to provide evidence of quality improvement efficiencies that are significant, detailed, and merger-specific in order to rebut a presumption of anticompetitive effects from a transaction. These cases also demonstrate

[19] *Id.* at 84.

[20] *Id.* at 85 (citations omitted) (emphasis added).

[21] *In the Matter of OSF Healthcare Sys. and Rockford Health Sys., FTC Docket No. 9349 (Apr. 13, 2012).*

[22] *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1088 (D. Ill. 2012).

[23] *Id.* at 1089.

that providing such clinical quality evidence to the government's satisfaction is often an uphill battle for merging parties. It is clear that the FTC is skeptical of a hospital merger's ability to reduce costs and improve quality. In fact, in a recent interview, Director Feinstein stated that when providers seek to merge, their goal is not only to improve care and reduce costs, but also to "get increased leverage" in negotiations with health plans and employers.[24]

In the face of an agency that appears predisposed to assume a transaction is unlikely to yield significant pro-competitive benefits, citing health care reform and the desire to meet its cost reduction and quality improvement goals as the impetus for a transaction cannot be relied on as the primary defense to what may be viewed as an otherwise unlawful transaction. Rather, parties must provide concrete facts and evidence that substantiate their ability to realize significant quality improvements.

There is a conceptual framework that parties can apply when presenting quality improvement claims that may help parties demonstrate that their efficiency claims are credible, merger-specific, and likely to occur. These include, but are not limited to, the following:

- Analyze the potential for clinical quality improvements as soon as practicable and in as much detail as permissible under the antitrust laws. Develop and solidify concrete steps for the implementation of as many of the quality improvement plans as possible and adopt the plans as part of the deal analysis.[25] When efficiencies are not considered or used by the parties' boards as part of discussions regarding proposed transactions, the agencies and the courts do not view them as credible evidence of legitimate efficiencies.
- Provide evidence regarding the comparative quality of the merging parties and demonstrate that the clinically superior party is able to transfer its clinical expertise to the acquired entity with specific details explaining precisely how the acquiring entity will improve the quality metrics of the acquired party and how the new methods will benefit patients through improved quality of care. According to the FTC economists who analyzed the quality metrics in the *Evanston* matter, the likelihood of realizing "an improvement as a result of clinical superiority is greater if there are specific quality-improving measures that have been adopted by the acquiring system and for which there are concrete, documented plans to export them following the merger."[26]
- Provide evidence that the acquiring firm has a track record of increasing clinical quality by showing the firm has successfully improved quality after previous acquisitions. Such evidence could help persuade the government that clinical quality is likely to improve post-merger in the pending transaction. According to Commissioner Maureen

[24] Robert Pear, *FTC Wary of Mergers by Hospitals*, N.Y.TIMES, Sep. 17, 2014, *available at* http://www.nytimes.com/2014/09/18/business/ftc-wary-of-mergers-by-hospitals-.html? ("They say they need better rates, so they will have more money to invest in their facilities… When you strip that down, it's basically just saying, 'We want a price increase.'")

[25] Jeffrey Perry & Richard Cunningham, *Effective Defenses of Hospital Mergers in Concentrated Markets*, 27 (2) ANTITRUST 43 (Spring 2013) (noting that the existence of an implementation plan adopted as part of the deal analysis helps to reinforce quality claims).

[26] Patrick Romano & David Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18(1) INT'L J. OF THE ECON. OF BUSINESS, 60 [hereinafter "Romano & Balan"].

Ohlhausen, "[o]ne of the things we fear most is that parties will offer these potential efficiencies and then we go back and look at previous acquisitions or integrations and the promised quality failed to materialize."[27]

- Analyze quality improvement plans previously considered by the acquired entity and explain how the proposed transaction will provide more robust results. This should also include providing an explanation as to why any previous plans contemplated by the acquired firm could not have been successfully implemented absent the proposed transaction and/or could not have achieved the level of quality that would only be possible through the merger.
- Demonstrate that certain quality-improving investments that may not have been made at the acquired entity pre-merger are now worthwhile given the acquiring party's new lower cost of capital that will be realized from the transaction (e.g., the merger may make additional investment in quality-improving pieces of equipment with high fixed costs more feasible for a larger health system than for an independent hospital or smaller health system).[28]
- Demonstrate the ability to improve clinical outcomes for certain surgical procedures that exhibit a volume-outcome relationship in which repetition of the procedure generates better clinical outcomes. By consolidating such procedures at fewer hospitals, or by sending experienced personnel from one hospital to another, a system can theoretically extend the benefits of scale enjoyed by a high-volume acquiring hospital to the acquired hospital.[29]
- Provide evidence that demonstrates how the merger will enhance the parties' incentives to innovate and improve the quality of care.
- Use contemporaneous ordinary course documents from the merging parties to demonstrate the likelihood of improving quality and to show that the key drivers of the deal include the desire to improve clinical quality and reduce the cost of health care.

VI. CONCLUSION

Substantiating quality of care efficiencies will remain critically important for merging parties in future transactions, but the FTC's rather stringent approach to assessing quality of care defenses creates uncertainties regarding the type and magnitude of quality of care efficiencies that the FTC will find acceptable.

In a recent speech, the Director of the Bureau of Economics, Martin Gaynor, acknowledged the challenges presented in evaluating efficiency claims in health care, "both because efficiency is multi-faceted (because of the importance of quality), and because there's so much activity and ferment in health care organizations."[30] According to Gaynor, health care

[27] *See, A Discussion with FTC Commissioner Maureen K. Ohlhausen*, ANTITRUST HEALTH CARE CHRON., 3 (Nov. 2013).

[28] Romano & Balan, *supra* note 26 at 48.

[29] *Id.*

[30] Martin Gaynor, Director, Bureau of Economics, Federal Trade Comm'n, Remarks, *Efficiencies Analysis: False Dichotomies, Modeling and Applications to Health Care*, Aug. 3, 2014, *available at*

provides the FTC with the opportunity to advance its modeling and measurement of efficiencies, because "there are a lot of data in health care, and there is a great deal of work being done to develop new and better measures of quality and to try to understand organizational factors."[31] As the FTC continues to develop new ways to measure and assess quality, hopefully their analyses of clinical quality efficiencies will evolve in a way that helps parties gain greater acceptance for their quality claims to the benefit of all interested parties.

http://www.ftc.gov/system/files/documents/public_statements/574751/140619efficienciesanalysis.pdf ("health care provides us with the challenge and the opportunity to advance our modeling and measurement of efficiencies, but most importantly our understanding of how to assess and incorporate them into economic analysis of antitrust issues.")

[31] *Id.*

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Is the Affordable Care Act the Catalyst to Merger Efficiency Reform?

George L. Paul & Andrew K. Mann
White & Case LLP

Is the Affordable Care Act the Catalyst to Merger Efficiency Reform?

George L. Paul & Andrew K. Mann[1]

I. INTRODUCTION

Recently, the Obama Administration has reshaped the healthcare industry and encouraged collaborations among competitors as a way to drive skyrocketing costs down and improve the efficiency of the delivery of healthcare to Americans. But are the Administration's own competition watchdogs standing in the way of these efficiencies?

Tensions between reducing costs and protecting competition are increasingly ramping up for companies seeking to adjust to a constantly shifting competitive landscape created under new federal healthcare reform legislation—the Patient Protection and Affordable Care Act ("ACA")[2]—increasing deal uncertainty for parties attempting new collaborations. Going forward, parties will continue to face uncertainty about how the industry will respond to collaborations, including how competition will be affected, and a lack of clarity about how the agencies will weigh the potentially substantial benefits of proposed collaborations against the potential effect such collaborations will have on a constantly shifting competitive landscape.

This is occurring as the healthcare industry remains one of the largest and fastest-growing sectors in the U.S. economy. It makes up approximately one-fifth of the U.S. GDP, which makes it almost the size of the entire economy of the United Kingdom. According to economists in the Office of the Actuary at the Centers for Medicare and Medicaid Services ("CMS"), healthcare spending is projected to grow at an annual average rate of 5.8 percent through 2020, which is just over 1.0 percent higher than the projected growth rate of U.S. GDP. By 2020, healthcare spending is projected to exceed $4.5 trillion.

II. THE ACA, COLLABORATION, AND ANTITRUST

On March 23, 2010, President Obama signed the ACA into law. The purpose of the ACA was to: (i) increase the quality and affordability of health insurance, (ii) lower the uninsured rate by expanding public and private insurance coverage, and (iii) reduce the costs of healthcare for individuals and the government by shifting the system towards quality over quantity through increased competition, regulation, and incentives to streamline the delivery of healthcare. The ACA introduced a number of provisions and tools to achieve these purposes. The Act's primary tool to reduce costs and improve healthcare outcomes, however, is the promotion of collaboration among hospitals, doctors, and other healthcare professionals.

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[1] George Paul is a partner in White & Case's Washington, D.C. office where he advises clients on a range of international competition issues, including litigation, merger clearances, and criminal defense. Andrew Mann is an associate in the same office.

[2] Pub. L. No. 11-48, 124 Stat. 119 (2010).

Accordingly, at an unprecedented pace, healthcare organizations—both hospitals and physicians—are consolidating to create larger hospital systems with broader service reach and greater efficiencies. This consolidation is manifesting itself on two fronts: Individual hospitals are merging with other local hospitals or larger regional or national hospital systems, and physician groups are joining the payroll of hospitals. From 2009 to 2012, there were 314 hospital mergers in the United States.

In general, the purpose of the federal antitrust laws is "to protect the process of competition for the benefit of consumers, making sure there are strong incentives for businesses to operate efficiently, keep prices down and keep quality up."[3]

At first blush, the stated purpose of the ACA and the federal antitrust laws appear consistent and at least are directionally pointed the same way. Yet there is a tension between the two. On one hand, the clear directive of the ACA is to reduce costs and collaborate more. On the other hand, the Federal Trade Commission ("FTC") is charged with ensuring that such collaborations do not substantially lessen competition among hospitals and physician groups. So, reducing costs should reduce price and increase access to health care. However, reducing competition could encourage hospitals or physicians to pocket the cost savings and not pass them on. As a result, while collaborations have increased, so has FTC enforcement in healthcare. Indeed, the greatest area of competition enforcement from 2009 to 2012 for the FTC was in healthcare (32 percent), and healthcare and pharmaceuticals combined (46 percent) amounted to almost half of all FTC enforcement activity.[4]

Multiple senior leaders at the FTC have tried to assuage this tension. Commissioner Julie Brill recently stated, "the FTC's work and the ACA share the common goals of promoting high-quality and cost-effective health care."[5] FTC Bureau of Competition Director, Deborah Feinstein, stated that it is "critical to recognize that the integration of care provided to patients is fully compatible with core antitrust principles. . . . [and] there is no tension between rigorous antitrust enforcement and bona fide efforts to coordinate care, so long as those efforts do not result in the accumulation of market power."[6] Chairwoman Edith Ramirez explained that "[a]ntitrust enforcers recognized that provider collaboration represents an innovative way to seek to lower healthcare costs and improve the quality of care. We, of course, do not want to stand in the way of those goals. At the same time, we want to ensure that the financial savings and improved

[3] Fed. Trade Comm'n, The Antitrust Laws, http://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws.

[4] Fed. Trade Comm'n, Annual Highlights: Stats & Data, http://www.ftc.gov/reports/annual-highlights-2013 (2013).

[5] Julie Brill, Commissioner, Fed. Trade Comm'n, Keynote Address at the Hal White Antitrust Conference, *Competition in Health Care Markets*, at 6 (June 9, 2014), *available at* http://www.ftc.gov/system/files/documents/public_statements/314861/140609halwhite.pdf.

[6] Deborah L. Feinstein, Director Bureau of Competition, Fed. Trade Comm'n, Fifth National Accountable Care Organization Summit, *Antitrust Enforcement in Health Care: Proscription, not Prescription*, at 2 (June 19, 2014), *available at* http://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf.

patient outcomes that could result from these collaborative efforts are not lost because of increased provider concentration and coordination."[7]

Unfortunately, many antitrust practitioners believe that the antitrust laws and antitrust enforcers continue to "stand in the way" of innovative collaborations that likely will lower healthcare costs and improve the quality of care. But why?

III. THE IMPORTANCE OF CONSIDERING EFFICIENCES IN MERGER REVIEWS

Perhaps the largest reason for this skepticism is the current way efficiencies are considered in the merger review process. Not unique to healthcare merger analysis, but for merger analysis generally, the FTC and the Department of Justice Antitrust Division (the "Agencies") typically consider efficiencies in a silo, placing whatever weight the efficiencies are given on a scale towards the end of the overall review to see which way the balance tips. The Agencies pay close attention to cost savings and, where parties are able to demonstrate substantial merger-specific cost savings, it may help address concerns over concentration levels or a potential lessening of competition.

However, for the most part, the Agencies are skeptical of efficiency claims in a merger. Indeed, the *2010 Horizontal Merger Guidelines* ("*HMG*") clearly acknowledge this cynicism: "Projections of efficiencies may be viewed with skepticism, particularly when generated outside the usual business planning process."[8] Furthermore, parties have a high burden when presenting cost saving and efficiency claims:

> [I]t is incumbent upon the merging firms to substantiate efficiency claims so that the Agencies can verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific.[9]

Additionally, the Agencies currently only consider efficiencies specific to the narrowly defined relevant antitrust markets. Part of the tension that manifests itself in the healthcare context, but in other contexts as well (such as airlines), is that consumers in these industries are part of much larger markets than the narrowly defined antitrust markets.

At least two senior leaders at the FTC have recently provided support for increased attention regarding the scope of efficiencies in merger analysis.

Commissioner Joshua Wright believes that the FTC "should advocate that courts adopt an approach to efficiencies analysis that considers the competitive benefits from a merger that are outside the relevant product market."[10] Interestingly, this notion is not necessarily novel. Buried

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[7] Edith Ramirez, Chairwoman, Fed. Trade Comm'n, Keynote Address at 11th Annual Loyola Antitrust Colloquium, *Antitrust, Accountable Care Organizations, and the Promise of Health Care Reform*, at 2 (April 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.

[8] U.S. Dept. of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* (Aug. 19, 2010) § 10 [hereinafter 2010 Horizontal Merger Guidelines].

[9] *Id.*

[10] Joshua D. Wright, Commissioner, Fed. Trade Comm'n, 2013 Georgetown Global Antitrust Symposium Dinner: *The FTC's Role in Shaping Antitrust Doctrine: Recent Successes and Future Targets*, at 18 (Sept. 24, 2013),

in a footnote in the *HMG*, for the first time Agencies appear to recognize that there are instances where a transaction could cause anticompetitive effects in one market that would be offset by substantial efficiencies in another:

> The Agencies normally assess competition in each relevant market affected by a merger independently and normally will challenge the merger if it is likely to be anticompetitive in any relevant market. In some cases, however, the Agencies in their prosecutorial discretion will consider efficiencies not strictly in the relevant market, but so inextricably linked with it that a partial divestiture or other remedy could not feasibly eliminate the anticompetitive effect in the relevant market without sacrificing the efficiencies in the other market(s). Inextricably linked efficiencies are most likely to make a difference when they are great and the likely anticompetitive effect in the relevant market(s) is small, so the merger is likely to benefit customers overall.[11]

Commissioner Wright supports this direction and points out that "doing so would take the important step of updating current merger doctrine with respect to efficiencies analysis so that it is consistent with the modern trend in favor of analyzing actual competitive effects rather than adopting simplified and potentially misleading proxies for harm."[12]

Including out-of-market efficiencies in the merger review analysis makes sense, particularly since included in the 2010 *HMG* was an endorsement to an approach that generally will result in narrowly defined relevant product markets. Unfortunately, as Commissioner Wright points out, narrowly defined product markets "inevitably lead to the atomization of classes of consumers whereby a market may be defined by picking a harmed consumer and defining a relevant market around that individual."[13] Merging companies seeking government antitrust clearance have consistently included out-of-network efficiencies in their arguments.

In the St. Luke's Health System/Saltzer Medical Group merger (which the FTC, the Idaho Attorney General, and a handful of private party participants successfully challenged in the Federal District Court for the District of Idaho), St. Luke's argued out-of-market efficiencies:

- "St. Luke's is in the process of transforming the delivery of healthcare by offering the population of southern Idaho clinically integrated, risk-based care."[14]
- St. Luke's "transaction with Saltzer will permit the affiliated entities to achieve integrated care—particularly in Canyon County—faster and more effectively than could happen if the transaction had not happened or were unwound."[15]

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available at http://www.ftc.gov/sites/default/files/documents/public_statements/ftc%E2%80%99s-role-shaping-antitrust-doctrine-recent-successes-and-future-targets/130924globalantitrustsymposium.pdf.

[11] 2010 *Horizontal Merger Guidelines* § 10, n.14.

[12] Joshua D. Wright, Commissioner, Fed. Trade Comm'n, 2013 Georgetown Global Antitrust Symposium Dinner: *The FTC's Role in Shaping Antitrust Doctrine: Recent Successes and Future Targets*, at 18 (Sept. 24, 2013), *available at* http://www.ftc.gov/sites/default/files/documents/public_statements/ftc%E2%80%99s-role-shaping-antitrust-doctrine-recent-successes-and-future-targets/130924globalantitrustsymposium.pdf.

[13] *Id.* at 19-20.

[14] Pretrial Memorandum, Federal Trade Commission v. St. Luke's Health System, Ltd., Case No. 1:12-CV-00560-BLW-REB, at 12 (D. Idaho Sept. 10, 2013).

In the American Airlines/US Airways merger challenged by the U.S. Department of Justice in the Federal District Court for the District of Columbia, the airlines also claimed out-of-market efficiencies:

- The merged airlines "would generate enormous direct consumer benefit, most significantly by creating a unified network affording a vastly expanded array of flight options for travelers—taking more passengers where they want to go when they want to go there."[16]
- The models "routinely used by the airlines in their businesses demonstrate that these positive network effects" of "a unified network" would "attract millions of additional passengers to the merged airline" and that methods used by the government "conservatively demonstrate that the value of these consumer benefits would exceed $500,000,000 every year, net of any fare effects."[17]

Unfortunately, neither the St. Luke's/Saltzer merger (appeal pending) nor the American/US Airways merger (deal settled) provided any movement in terms of out-of-market efficiency analysis. Nevertheless, there is still hope for efficiency reform.

On top of the support from Commissioner Wright for updating current merger doctrine with respect to efficiencies analysis, FTC Bureau of Economics Director, Martin Gaynor, recently encouraged economists to "devote more attention to the modeling of efficiencies." As part of this encouragement, Mr. Gaynor asked economists to "step back . . . and consider what the goal of economic analysis of an antitrust matter is. The question that we're really asking is whether a merger or some type of conduct makes consumers better off."[18]

IV. CONCLUSION

Due to the large number of merger transactions that have occurred, the healthcare industry is teed up to provide enough data points to really move the needle in terms of analyzing out-of-market efficiencies. Any developments in this arena, however, will have implications outside the healthcare context.

Uniquely, the healthcare industry is in a period of tremendous and constant flux. Under the ACA, we see a period of unprecedented innovation and reform—providers are repositioning themselves in the marketplace, and healthcare providers and plans are consolidating, all in an effort to walk a fine line between improving access to high-quality care and containing costs. As pioneers in navigating this new landscape, both companies and the Agencies are attempting to adjust.

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[15] *Id.* at 17.

[16] Answer to Amended Complaint, *United States v. US Airways Group*, Case No. 1:13-CV-01236-CKK, at 2 (D.D.C. Sept. 10, 2013).

[17] *Id.*

[18] Martin Gaynor, Director Bureau of Economics, Fed. Trade Comm'n, 2014 Annual Conference of the American Antitrust Institute, *Efficiencies Analysis: False Dichotomies, Modeling, and Applications to Health Care*, at 1 (Aug. 3, 2014), *available at* http://www.ftc.gov/system/files/documents/public_statements/574751/140619efficienciesanalysis.pdf.

For the Agencies, it will mean closely examining their traditional view of efficiencies and likely broadening both the scope of efficiencies considered and the ability of claimed efficiencies to overcome perceived threats to competition. For companies, these shifts mean unfortunate deal uncertainty and the need for both careful analysis of strategic options and understanding of the competitive responses likely to occur going forward.

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Integrating to Enhance Value and Quality vs. Preserving Competition to Maintain Lower Prices

J. Mark Waxman
Foley & Lardner LLP

Integrating to Enhance Value and Quality vs. Preserving Competition to Maintain Lower Prices

J. Mark Waxman[1]

I. INTRODUCTION

The Affordable Care Act ("ACA"), the Triple Aim (targeting enhanced quality and patient satisfaction, engaging in population health, and reducing per capita costs), and the need for capital and infrastructure to change from a fee-based system of care to a value- and results-based system are all driving providers to consider merging and consolidating health care systems, as never before. Those merging believe that only by engaging consumers across a larger and financially integrated platform, and eliminating the inefficiencies of fragmentation, can the necessary efficiencies and quality enhancement really occur in a sustained way.

On the other hand, concerns exist that consolidation to achieve these goals is not necessary, and may well come at the expense of the consumers or those who arrange for their care—the employer and health plan community. Forefront in this concern is the Federal Trade Commission ("FTC"), recently described as "a lonely but powerful voice" suggesting that "consumers may be victimized."[2]

Unfortunately, there is no bright line to indicate where the balance lies between the desire for efficiency and population health management and the need to retain a competitive environment as a check on pricing decisions. Instead, this debate often plays through the application of the provisions of the Clayton Act,[3] which on a market-by-market basis looks to whether the effect of the proposed acquisition will "substantially" lessen competition or "tend" to create a monopoly. Unfortunately, while in many instances it is unnecessary, all too often the answer to this question plays out through the expensive and often frustrating prism of litigation. This Article explores two high profile transactions where the balance is being examined and, in both cases, the examination is taking case through the courts.

II. NAMPA, IDAHO AND THE ST. LUKE'S HEALTH SYSTEM

In Nampa, Idaho, a community initially homesteaded in 1885 and currently with a population under 90,000, has three hospitals in the area, although only one actually within the city. There are also a number of physician groups, although one group (the Saltzer Medical Group) includes 80 percent of the critical primary care physicians in Nampa. One of the hospital systems in the area (St. Luke's Health System) acquired Saltzer as a part of its approach to assemble a team "committed to practicing integrated medicine in a system where compensation depended on patient outcomes," which in turn was found to make it the dominant provider in the area for primary care, thereby giving it "significant bargaining leverage" over the health

[1] J. Mark Waxman is Partner at Foley and Lardner LLP where he is former chair of the Health Care Industry Team, and a member of the Government Enforcement, Compliance & White Collar Defense and Antitrust Practices.

[2] Robert Pear, *F.T.C Wary of Mergers by Hospitals*, NEW YORK TIMES (Sept. 17, 2014).

[3] Clayton Act , Section 7 [15 USC 18]).

plans.[4] This set of facts led the FTC (as well as a number of competitors) to attack the acquisition and seek a divestiture, claiming that the acquisition ran afoul of the Clayton Act by substantially lessening competition.

Following a bench trial early this year, the Court determined that a divestiture was required. The Court's decision reflects the challenge in the market place. First, the Court found that the purposes of the acquisition were to improve patient care, access to quality, and enhance services—not to reduce competition or create a path to a monopoly. The physicians and the hospital involved did not believe a looser affiliation would lead to the necessary level of integration to achieve the desired goals. Yet, it was also true that they recognized the benefits of increased leverage.

Second, the Court found that the resulting market share would create a dominant bargaining position, and although the merging entities were "to be applauded" for their efforts to improve patient care delivery, the Court believed there were other ways to achieve the same effect that did not run the same degree of risk that there would be increased costs as a result. Because the Court found that the transaction would have anticompetitive effects, the transaction would need to be unwound.

The matter is now on appeal, where the argument with respect to the balance between efficiencies and the benefits of integrated delivery against the challenge of a potential for lessening competition will again play out.

III. BOSTON, MASSACHUSETTS AND THE PARTNERS HEALTH CARE SYSTEM

The Partners Health Care System is the largest hospital system in the greater Boston area. Anchored by two of the highest quality institutions in the United States, and formed in response to managed care pressures in the 1990's, it has been a national leader in many health care endeavors, and is one of the largest employers in the State. Over time, it has been growing, and most recently sought to acquire three suburban hospital systems (inclusive of a number of groups of affiliated physicians) with which it has had clinical relationships for many years.

Recognizing that such a large transaction was bound to be heavily scrutinized, Partners worked hard to approach the transaction from the standpoint of the benefits it was bringing: (i) enhanced quality, (ii) the need to move to population health, and (iii) the overall health care benefits it could bring to the delivery system in the areas served by the enhanced system and, in particular, the local communities involved.

Concerned about rising costs, Massachusetts had created the Health Policy Commission ("HPC") to provide public information and analysis with respect to material health care transactions. The work informs and supplements the overall enforcement and oversight authority of the Attorney General in State-based matters. Both the Attorney General and the HPC carefully reviewed the proposed acquisitions and concluded that it was possible that the transactions would lead to higher prices, and it would be necessary and appropriate to address the potentially adverse competitive impacts.

[4] Memorandum Decision and Order, Saint Alphonsus Medical Center et al. v. St. Lukes Health System Ltd. , Case No. 1:13-CV-00116-BLW, Dist. Idaho, January 24, 2014.

In this case, however, rather than address the transaction as one requiring divestiture (a "structural" remedy), the approach taken was to pursue a resolution through controls on future behavior (a "behavioral" remedy), couched in terms of a settlement agreement and consent decree to a complaint. The proposed future constraints seek to address concerns over future growth with respect to hospitals or physicians within the Partners system, pricing restraints, contracting restraints, and other limitations. This resolution is currently being reviewed through the pending approval of the settlement court proceedings, where the determination will be based on whether the settlement is "fair, just and equitable."

As might be expected, the settlement proposal has attracted a great deal of commentary across the affected area, with comments adverse to the resolution filed by insurance carriers as well as competitors. In addition, economists and others with an interest in antitrust issues in health care have weighed in, focusing on whether behavioral as opposed to structural restraints can really be effective. A final resolution awaits further judicial proceedings. They may result in a modification of the settlement terms, approval, rejection, or even potentially formal court hearings at which evidence may be taken prior to a final resolution.

IV. LOOKING FORWARD

Resolving access, quality, efficiency and population health goals of consolidation, as they must be balanced against the benefits of competition and as played out through the judicial system through the application of the Clayton Act (or like State legislation), is clearly a long and expensive process. The alternative, however, is a return to or rebirth of a more regulatory approach, with either pricing and M&A controls applied administratively through something akin to a certificate of need or a public utility model. At the moment, while there is some activity by states in allowing "cooperative activity" subject to active State oversight[5] neither approach finds uniform support across the various States and the Federal governments. As a result, the uncertainly in just where the lines and the balance may be struck will continue to be a burden on the system.

[5] For example in New York, as the result of the enactment of Art. 29-F of the Public Health Law is pursuing this through Certificates of Public Advantage