



CALIFORNIA HEALTHCARE FOUNDATION

**Antitrust Principles and
Integrated Health Care:**
Implications for Consumers and
Health Care Organizations

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Introduction

In recent years, there has been an increasing trend toward consolidation of hospitals and hospital systems. This trend has been motivated by market forces and reinforced by incentives toward integration included in the Affordable Care Act (ACA), both of which emphasize coordinated care for better patient outcomes, cost control, and improved quality. The trend has also been encouraged by a desire among hospitals for greater bargaining power with insurers, which is often achieved through consolidation.

Consolidation increases concentration, however, and thus may enhance market power by the consolidated entities. Consequent reduction in the number of competitors may result in higher costs, higher prices, and fewer or poorer services. Under federal antitrust laws, government regulatory agencies have long monitored consolidations in many industries, including hospital consolidations and other such integrative health care arrangements, in order to protect consumer interests against the effects of such enhanced, concentrated market power.

Given the trend toward market integration, this report is intended to help California health care stakeholders better understand the role of antitrust enforcement in ensuring affordable, quality health care. In particular, it highlights specific antitrust enforcement issues that are critical during this time of increasing health care consolidation that includes not only hospitals but also health plans and providers. The report discusses these issues in the context of hospital consolidations, which include traditional transactions such as mergers, acquisitions, and joint ventures, as well as more creative arrangements, such as joint operating agreements and clinical affiliations with nonhospital providers. (For simplicity, throughout this report, the term “transaction” will be used to refer to any of these arrangements, unless a specific model is being discussed. See the appendix for a brief description of the most common types of transactions). The report also reviews the role of the ACA in fueling the trend toward health care integration, including payment reform initiatives promoting integration, and the development of physician-hospital organizations (PHOs) and accountable care organizations (ACOs).

Regardless of the consolidation approach used, health care entities must ensure that the transaction falls within the parameters of antitrust law. There is a certain

amount of inherent tension between the goals of integration and the assumptions that underlie a traditional competitive health care marketplace; keeping this tension in mind is an important part of appropriate antitrust compliance and enforcement in this marketplace. This tension was recently on display in Idaho, where the federal government alleged that a hospital’s acquisition of a physicians’ group would substantially lessen local competition for health care services, in violation of antitrust law. In January 2014, a federal court agreed and ordered divestiture of the affiliation between the hospital and the medical group. This report’s review of this key recent decision reveals some of the issues health care organizations face as they look toward greater integration, including the impact on cost and quality when health care becomes heavily integrated. (A companion technical brief, *Evaluating the Effects of Hospital Consolidation: How Sensitive Is the Econometric Model?*, discusses the econometric model used to evaluate competitive effects in health care cases.)

Incentives Driving Health Care Integration

Forces Driving Integration

Pre-ACA Market Forces

Over the past several decades, consolidation of individual hospitals into multihospital systems has given these systems greater leverage in contract negotiations with insurers across multiple markets. This leverage, exercised primarily to gain higher reimbursement rates, stems from the fact that insurers rely on these systems to ensure a strong and consistent provider network.¹ In California, eight large systems comprise 40% of the state’s general acute care hospitals and hospital beds.² These large, dominant hospital systems claim that their ability to command higher reimbursements allows them to pass on savings to consumers and to invest in improving treatment outcomes. However, there is some evidence to the contrary, that the absence of competitive pressures tends instead to produce organizational slack, weaker accountability for performance, and lower-quality care. (See Hospital Integration: Helping or Harming, below.)

A corollary of this trend toward consolidation is that many stand-alone hospitals are struggling financially

and being forced to find partners to survive. A typical example in California is Doctors Medical Center (DMC), one of two hospitals in Richmond, which sees the bulk of Richmond's patients. A patient payer mix that is heavily uninsured or underinsured is one of several reasons that this independent hospital has been financially struggling for nearly a decade and is seeking a partner. The hospital filed for bankruptcy in 2006 and had been operating with an annual deficit of around \$18 million, according to an October 2014 *Contra Costa Times* report.³ In the fall of 2014, the State of California allocated \$3 million in state funds to help prop up the hospital, and the City of Richmond has promised to allocate millions in the future so that DMC can continue to operate.⁴ This scenario is typical of many public hospitals and independent hospitals around the nation whose patient populations are predominantly vulnerable and underinsured and who would have few alternatives for care if the hospital were to close.

ACA Payment Reform Initiatives

Passage of the ACA created financial incentives and mandates for increased levels of coordination among providers, payers, and employers, intended to improve quality of care and make the overall health care system more efficient. For example, the ACA includes mandates for new demonstration projects to test the effects of innovative, more integrated approaches to delivery of and payment for health care services. These innovations include:

- ▶ **Bundled payment.** A single payment for a “bundle” of related services during an episode of care rather than separate payments for each service. This is intended to encourage better-coordinated and more efficient care and to eliminate ineffective and unnecessary treatment. Having all related services provided by a single, integrated operating entity helps control the costs associated with the episode of care, which benefits payers whether public or private. For its part, the coordinated provider team is financially rewarded if they can treat the episode of care more efficiently.
- ▶ **Accountable care organization (ACO).** An integrated network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients with the intent of limiting unnecessary spending and improving care.

- ▶ **Patient-centered medical home (PCMH).** A team-based model of care led by a personal physician who provides continuous and coordinated care, throughout a patient's lifetime, to maximize health outcomes. This includes the provision of preventive services, treatment of acute and chronic illnesses, and assistance with end-of-life issues. The PCMH care model promotes improved access and communication, care coordination and integration, and care quality and safety.⁵ Because it is team-based, this model encourages integration of providers to achieve its goals.

Other provisions of the ACA also have created financial incentives for integration. For example, significant increased costs to an independent medical practice brought on by the ACA mandate to install electronic record-keeping can make remaining independent less attractive. Another example of ACA-created pressure on independent physician practices is a reimbursement mechanism that allows outpatient procedures to be better compensated when they are performed inside a hospital-owned practice or a physician-owned facility versus an independent physician's office.

These and other recent health care reforms attempt to grapple with the recognition that silos in health care delivery, a lack of coordination of health information, and a general disaggregation in the health care market often create barriers to efficiency, misaligned incentives, and poorly coordinated utilization. However, increased coordination in many cases has been pursued through, or resulted in, increased market consolidation. This, in turn, has led to concerns that, in some markets, less competition between health care providers results in a significant reduction in or elimination of consumer choice as well as higher prices. As former Secretary of the Department of Health and Human Services Kathleen Sebelius phrased it, “There is a tight balance between a coordinated care strategy and a monopoly.”⁶ This balance is discussed in the following section.

Hospital Integration: Helping or Harming?

According to traditional, basic economic theory, vigorous competition among businesses of nearly all kinds, including health care, makes for strong and effective markets that work for consumers. Competition benefits consumers by forcing each seller to maximize the value it offers — the best product or service at the lowest price — in order to motivate consumers to use its business rather

than another. However, markets do not always operate according to this theory: Competitors have financial incentives to collude on price, divide customers and markets, and refuse to deal except on specified terms. Also, some people argue that traditional market dynamics are particularly inapplicable in the health care market because health care consumers are often unable to evaluate the quality of a health care provider before service is delivered, and are not easily able to compare providers or services based on price.

Nonetheless, consolidated health care delivery systems can potentially benefit consumers through increased efficiency and/or higher quality. Thus the merger of various providers and health care organizations, which then offer a more coordinated team approach, has the potential to provide more efficient health care delivery, which can ultimately benefit the consumer or patient.

On the other hand, if competition is eliminated through consolidation and a single health care provider becomes the dominant or exclusive provider in a geographic area, it has an opportunity to restrict its services and to charge higher prices — to insurance companies and other payers, and ultimately to consumers — than it would with greater competition. (See Figure 1.) The antitrust laws discussed in this report are designed to prevent that from happening.

Research on whether consolidations help or harm consumers is inconclusive. On one hand, several studies have suggested that hospital prices for patients in concentrated markets were significantly higher after merger or other consolidation transactions. A recent

study evaluated the association between hospital market concentration and prices for commercially insured patients and found that hospitals in concentrated markets charged \$4,561 to \$13,690 more per patient for a subset of procedures than hospitals in non-concentrated markets.⁷ Several other authors have demonstrated that in post-1990s hospital mergers, a significant portion of the increase in hospital rates was due to the mergers.⁸ Further, a 2015 study found that, counter to the theoretical claim of integrated delivery network (IDN) operating efficiency, IDNs' flagship hospital services appeared to be more expensive, both on a cost-per-case and on a total-cost-of-care basis, than the services of their most significant in-market competitors. Additionally, the flagship facilities of IDNs that operate health plans or have significant capitated revenues are more expensive per case (Medicare case-mix adjusted) than their in-market competitors.⁹ This literature does not conclusively demonstrate that consolidation is the only factor leading to increased costs, but it does show that concentration in some hospital markets is a factor associated with higher prices for both payers and patients.

Other research, however, has suggested that some kinds of consolidation in one area of health care can help mitigate the adverse effects of consolidation in another area. A study on how hospital and health plan market consolidation interact suggests that the hospital market power in areas where there have been hospital consolidations may be tempered if there has been a parallel shift to increased insurance consolidation, assuming that there is neither a hospital nor an insurance monopoly and that the two markets remain competitive.¹⁰

Figure 1. How Increased Provider Leverage Means Higher Costs to Consumers



Source: Demonstratives for the testimony of Professor David Dranove, *FTC & State of Idaho v. St. Luke's Health System & Saltzer Medical Group*, No. 1:13-cv-00116, October 2, 2013.

It should be emphasized here that focusing exclusively on price overlooks the importance of the services offered and the quality of care, both also critical to the interests of the consumer. Notably, a critique rebutting the statistical methods used in a 2010 report on health care by the Massachusetts Attorney General concludes that some hospitals may receive higher reimbursement because these hospitals provide higher quality or better services, rather than because of price leverage. The authors argue that through consolidation, hospitals have an opportunity to improve services, enhance quality, and expand output of highly demanded services and that, consequently, patients are willing to pay more because they believe they will get better care.¹¹ In accordance with this idea, a 2010 paper posited that if a hospital has superior practices to that of the pre-merged firm that was comparatively less effective, the acquiring system can achieve positive quality improvements based on three measures: clinical superiority, economies of scale, and financial resources. For a detailed review of the current literature evaluating the impact of concentration on cost and quality, see Balto et al.¹²

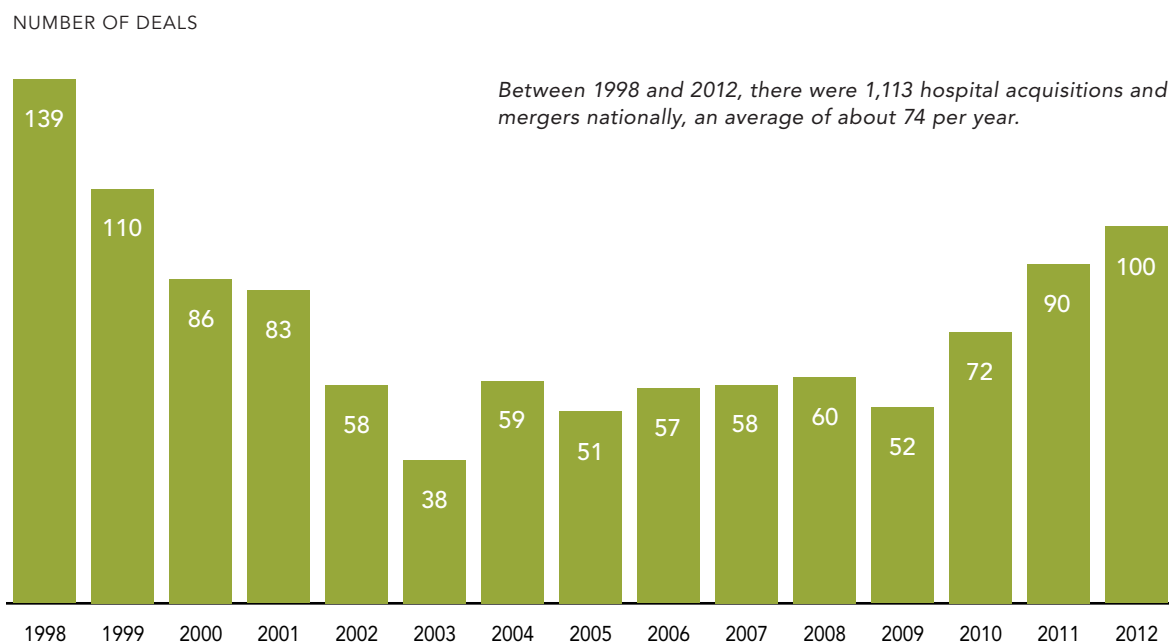
Recent History of Consolidation

Hospital Consolidations Nationally

The pace of hospital consolidation nationally over the past several years has risen sharply after a period of relative quiet, almost reaching levels not seen since the late 1990s.¹³ (See Figure 2.) One hypothesis for the recent prevalence of consolidations is that hospitals were responding to reform provisions of the ACA that promoted increased care coordination. Many hospitals claim that such consolidations will improve quality and reduce costs through greater standardization of care, more negotiating leverage with suppliers, and bigger investments to bolster providers' ability to communicate and to coordinate care.¹⁴

Most of these more recent consolidations manifested themselves in larger regional and national health care systems.¹⁵ In 2013, Ascension Health, the nation's second-largest health system by revenue, acquired regional health systems in Kansas, Oklahoma, and Wisconsin, adding nearly \$4 billion in revenue and 32 hospitals to the St. Louis-based system's portfolio, ending 2013 with patient revenue of \$15.3 billion.¹⁶ Trinity Health, based

Figure 2. Hospital Mergers Nationally, 1998 to 2012



Source: American Hospital Association, "Trends Affecting Hospitals and Health Systems," *Trendwatch Chartbook 2012*, www.aha.org.

in Michigan, and Catholic Health East (CHE), based in Pennsylvania, merged in 2013 to create the behemoth CHE Trinity Health, with more than \$12 billion in operating revenue, making it the fourth-largest health system in the country.¹⁷

The recent spate of integration transactions, spurred in part by ACA incentives, has included not only hospital consolidations but also consolidations among a range of health care providers. With both ACA and market incentives for greater coordination among various provider types, hospitals are exploring ways to integrate with physicians, health plans, behavioral health organizations, and other health care organizations that can contribute to greater continuity of care. Post-acute care organizations and services in particular are increasingly affiliated with hospitals: In 2011, 60% of hospitals offered home health services, 37% had skilled nursing facilities, 62% owned hospice services, and 15% provided assisted living options in various ownership structures or other affiliations.¹⁸ Based on a 2013 *Modern Healthcare*

survey, doctors directly employed by health care systems increased 39% from the previous year, to roughly 67,600 physicians. This may have been a reflection of physician efforts to strengthen their position as local players and of hospitals' desire to have a more integrated and coordinated care structure, to lower costs and increase reimbursement and profits.¹⁹

Hospital Consolidations in California

There is no single, comprehensive official list of hospital mergers and other hospital consolidation transactions in California. However, considerable health system integration activity in the state can be tracked through media reports and through hospital transactions reviewed by the California Attorney General (CA-AG), as shown in Table 1. Most of the cases presented in Table 1 were reviewed by the CA-AG's Charitable Trusts Section, since they involved a sale or conversion of a public benefit corporation to for-profit status. Consequently, the focus of those reviews was on continued availability and access to health care services to the community more than on

Table 1. Hospital Transactions Reviewed by the California Attorney General, 2012 to 2014

YEAR OF MERGER/ AFFILIATION ANNOUNCEMENT	HOSPITAL AND CONSOLIDATING ENTITY	ACTION TAKEN BY REGULATORY AGENCY
2012	St. Rose Hospital (Hayward) and Alecto Healthcare	Conditionally approved
2012	Hoag Memorial Hospital Presbyterian affiliation with St. Joseph Health	Conditionally approved
2012	Dignity Health's acquisition of US Healthworks medical group	N/A
2012	Verdugo Hills Hospital affiliation with USC	Conditionally approved
2013	John Muir Health / San Ramon Regional Health Center joint venture	Closed without action
2013	UCSF / Oakland Children's Hospital merger	Closed without action
2013	Emanuel Medical Center acquisition by Tenet Health	Conditionally approved
2013	Victor Valley Community Hospital sale to Prime Healthcare	Rejected
2013	Mission Community Hospital acquisition by Deanco Healthcare	Approved
2014	Lodi Memorial Hospital acquisition by Adventist Health	Decision pending
2014	O'Connor Hospital (proposed Daughters of Charity sale to Prime)	Approved with conditions / Prime backed away from purchase
2014	Seaton Medical Center - Daly City (proposed Daughters of Charity sale to Prime)	Approved with conditions / Prime backed away from purchase
2014	Saint Louise Regional Hospital (proposed Daughters of Charity sale to Prime)	Approved with conditions / Prime backed away from purchase

Source: Office of the California Attorney General, correspondence January 22, 2015, and March 27, 2015.

the competitive effects of the transaction. The CA-AG Antitrust Law Section may also weigh in before the CA-AG makes a final public decision, but the Antitrust Section's analysis is not always public. Not every hospital transaction is required to be reviewed by the CA-AG, so Table 1 is not a complete list of all activity in the state for 2012 to 2014.

Approval of a transaction by the Charitable Trusts Section often includes conditions that must be met by the consolidating entities in order to preserve services, particularly for vulnerable populations. Because of such conditions, transactions that are reviewed and approved are not necessarily consummated. For example, in March 2015, after approval of the merger of Prime Healthcare (Prime) with the three Daughters of Charity hospitals, Prime decided not to go forward, citing conditions on Prime attached by the CA-AG and described by Prime as "so burdensome and restrictive" they would make it impossible for Prime to make needed changes.²⁰

Hospitals are facing a need to invest heavily in electronic health records and other IT capabilities and to redesign care delivery models to respond to ACA-inspired value-based reimbursements, as well as a myriad of other financial pressures. Staying independent and financially viable is therefore becoming increasingly difficult for stand-alone hospitals and is a strong incentive for many of them to explore partnerships of some kind. Of the California hospital mergers reviewed by the CA-AG in 2013 and 2014, all but one involved a hospital that was financially struggling and, arguably, at risk of near-term if not imminent closure.

Antitrust law permits a specific "failing firm" defense which, if certain conditions are met, may be raised during litigation. However, while media reports and public documents indicate that the hospitals involved in recent reviews by the CA-AG were financially struggling, none of them was assessed using the "failing firm" criteria. Also, few if any hospitals in transactions subject to Federal Trade Commission (FTC) investigation in recent years have met the failing firm defense.²¹ Nonetheless, in several nonpublic hospital FTC merger investigations, the very poor financial condition of one of the parties was part of the reason why the agency did not challenge the merger.²² Similarly, the financial viability of a hospital may be taken into consideration by the CA-AG in cases where the hospital is vital to the health of the community but

is struggling financially and seeking to partner so it can continue to serve the community.

Hospital/Physician Group Transactions

In addition to hospital-with-hospital mergers, hospitals have also been involved in transactions that align them with physician groups and other provider organizations. One such prominent transaction, not reviewed by any regulatory agency, was the July 2014 merger of three San Diego physician groups to create a physician network to partner with Scripps Health hospital network. This collaboration was touted as providing a countywide network of high-quality physicians across a wide range of specialties as well as a broad primary care network.²³

Another physician group/hospital consolidation occurred in April 2014 when the Santa Rosa-based Redwood Regional Medical Group, one of the most established and largest physician-owned groups in the North Bay,

California Law Restricts Employment Structures Between Hospitals and Physician Groups

While in many states, hospitals integrate with physicians through direct employment of physicians or physician groups, the State of California's legal prohibition of the direct employment of physicians by entities other than professional corporations has historically limited the state's hospitals from this type of integration. However, hospitals and health systems in the state have increasingly turned to medical foundations and other mechanisms for formal alignment with physician groups that allows them to achieve many of the same benefits of direct employment.²⁴

Payers, too, have increasingly aligned with providers in management and administrative arrangements. In some instances, this has taken the form of an accountable care organization (ACO) or other shared-risk model between payers and provider groups. In other cases, payers have actually acquired physician organizations or invested in their management companies. Among insurers with significant enrollment in California, UnitedHealth Group and WellPoint (Anthem Blue Cross of California) have developed acquisition strategies to form stronger relationships with physician practices.²⁵

agreed to merge a majority of its operations into St. Joseph Health's Annadel Medical Group, a fast-growing group in the North Bay and part of St. Joseph Health's physician foundation, St. Joseph Heritage Healthcare. (St. Joseph Health also operates several hospitals in Northern California.) The merger was an effort to expand the areas of specialization offered by the system and to allow the Redwood Group, which specialized in oncology and radiation, to partner with a larger entity, which includes hospitals, for greater stability.

Insurance Company/Hospitals Transactions

In September 2014, in a partnership touted as the first of its kind, Anthem Blue Cross, a large California health insurance company, teamed up with seven hospital groups to create a new network in Los Angeles and Orange Counties. Anthem Blue Cross Vivity was created through the integration of Anthem Blue Cross with Cedars-Sinai, Good Samaritan Hospital, Huntington Memorial Hospital, MemorialCare Health System, PIH Health, Torrance Memorial Medical Center, and the UCLA Health System.²⁶

Positioned to offer a competitive product to the Kaiser Permanente system, the new health plan's goal is to have a price point similar to, or lower than, Kaiser's. The plan's partners will all share in the profits and losses from the joint venture.²⁷ In contrast to the usual model, in which insurers have carried most of the financial risk and tried to squeeze hospitals for lower prices or omit them from the network, this approach is collaborative in both care and financial risks and rewards.

ACO Activity

ACOs are based on integration of multiple providers to address population health issues, and operate in both public and private insurance spheres. As of May 2013, California ranked first in the nation in the number of commercial ACO contracting arrangements, with at least 14.²⁸ Most are led by large physician groups, but there is an increasing trend toward hospitals taking a more predominant role.²⁹ As vehicles for promoting population-based care and value-based models, ACOs can compete regionally with Kaiser Permanente, which already implements the integrated care model. It remains to be seen, however, how these organizations and others can achieve an appropriate balance between market power and efficiencies, and how such clinical integration can be encouraged while avoiding excessive antitrust risk, as discussed in the following sections.

Health Care, Antitrust Law, and the Role of Regulatory Agencies

Importance to Consumers of Antitrust Law

The primary purpose of antitrust law is to protect consumer welfare through low prices, high quality, efficiency, innovation, and choice.³⁰ Specific antitrust laws protect consumers by prohibiting either sellers or buyers from engaging in conduct that would unduly reduce competition in the marketplace.

Antitrust enforcement in health care is particularly important in controlling costs, which is vital not only to individual consumers but also to the viability of the economy. Bankruptcies resulting from unpaid medical bills were estimated at nearly 2 million nationally in 2013, making health care the number one cause of such filings, outpacing credit card debt and unpaid mortgages.³¹ The unit price for health care services is higher in the United States than in any other industrialized nation, yet this high cost does not result in "notably superior" care, according to a study from The Commonwealth Fund.³²

Federal and State Antitrust Laws Applied to Health Care Entities

Three major federal antitrust laws — the Sherman Antitrust Act, the Clayton Act, and the Federal Trade Commission Act — are used by both the state and federal government to review the effects on competition from health care entity conduct and consolidations. In addition, the Hart-Scott-Rodino Act sometimes requires larger entities to provide the federal government with advance notice of their intentions to consolidate. California also has its own state antitrust law, the Cartwright Act.

Possible violations of these antitrust laws are analyzed using either the "per se rule" or the "rule of reason." The former refers to an inherent violation of the law where the conduct is illegal on its face, without the need to precisely measure its effects on the marketplace or other circumstances. For example, if two physicians in different practices were to agree to coordinate the fees they each charge for certain procedures in their respective independent practices, this would be a per se violation

since it would clearly violate the letter of the law prohibiting collusion. Under the rule of reason, on the other hand, the circumstances in which the action was committed or the transaction completed must be considered, with enforcement authorities examining the details of the action or transaction to measure whether and how much it might interfere with competition.³³

Sherman Antitrust Act

Sections 1 and 2 of the Sherman Antitrust Act are often used to review, and in some cases to take enforcement action against, anticompetitive conduct engaged in by health care entities.³⁴ Section 1 prohibits “contracts, combinations, and conspiracies in restraint of trade” — anticompetitive agreements between entities. Section 2 prohibits conduct by a single company, or sometimes two or more companies working together, to sabotage competition in order to gain or keep a monopoly. Section 2 does not prohibit a single firm from controlling the market for a product or service merely because its product or service is superior to others, but only when it does so by suppressing competition through anticompetitive conduct. Neither is Section 2 violated simply when one firm’s vigorous competition to provide better quality and service and lower prices takes sales away from its less efficient competitors.

The Sherman Act carries both civil and criminal penalties, although in recent times criminal prosecution has been reserved for only the most blatant forms of anticompetitive agreements that are “per se” violations of Section 1. The United States Department of Justice (DOJ) is the only agency within the federal government empowered to bring criminal prosecutions under the Sherman Act. State attorneys general may also bring civil actions for conduct violating the Sherman Act, under authority given to them in the Clayton Act. (See The Role of Regulatory Agencies, below.)

Clayton Act

The Clayton Act is a civil statute (carrying no criminal penalties, unlike the Sherman Act).³⁵ Section 7 of the Clayton Act prohibits mergers or acquisitions where the effect “may be substantially to lessen competition, or to tend to create a monopoly.” Other parts of the Clayton Act give state attorneys general the authority to enforce the antitrust laws, and permit consumers and other private parties harmed by antitrust violations to bring their own actions.³⁶

Federal Trade Commission Act

The Federal Trade Commission Act (FTCA) prohibits unfair methods of competition in interstate commerce and provides for civil remedies but carries no criminal penalties.³⁷ It also created the FTC to police violations of the act. Section 5 of the FTCA prohibits “unfair methods of competition” and “unfair or deceptive acts or practices in commerce” and gives the FTC broad powers to cope with new threats to the competitive free market.³⁸ The prohibition against unfair methods of competition covers the same conduct as the prohibitions in the Sherman Act, and may go further.

Hart-Scott-Rodino Act

The Hart-Scott-Rodino (HSR) Act established the federal premerger notification program, which provides the FTC and DOJ with advance information about larger proposed mergers and acquisitions before they are finalized.³⁹ The HSR Act requires parties to notify the FTC and DOJ when a proposed transaction such as a merger or asset acquisition meets specified dollar thresholds (unless an exemption applies). Most commonly, a filing is required if both the value of the transacting parties based on sales or assets (the “size of person” test) and the transaction itself (the “size of transaction” test) are above specific threshold dollar values. It is important to note that many health care consolidations do not meet the monetary thresholds for HSR reporting, and therefore the consolidating parties are not required to report in advance to the regulatory agencies. However, even if the parties are not required to report based on HSR requirements, the transaction is still fully subject to antitrust scrutiny and enforcement if it raises concerns about harm to competition.

Cartwright Act

The Cartwright Act, similar but not identical to the federal Sherman Act, is California’s principal antitrust state law available to the CA-AG.⁴⁰ It covers certain types of anticompetitive actions, such as price fixing and market division schemes, which are agreements between competitors to divide markets, products, customers, or territories among themselves (e.g., one hospital agrees to focus on bypass surgery while the other will focus on orthopedics). However, the act does not specifically cover mergers, and the state does not have a separate merger statute equivalent to the federal Clayton Act, so most mergers are reviewed under federal merger laws.

The Role of Regulatory Agencies in Antitrust Enforcement

The trend toward incentives and market motivation that has led to increased integration has raised increasing concerns regarding reduced competition and its potential to harm consumers, who often struggle to find and pay for medical care even under the best of conditions. So, in an effort to protect health care consumers, antitrust enforcement agencies must assess the harm a transaction or conduct may cause to competition and consumers.

Enforcement can occur at either the state or federal level. In the merger context, the state and federal regulatory agencies examine whether a particular consolidation of health care entities will result in increased market power for the resulting entity that it can use to increase the cost of care or cut corners on quality and choice without being held in check by competition. The agencies also examine whether the consolidation will make it easier and more likely that the consolidated entity and other remaining market participants will coordinate to reduce output or increase prices, e.g., an agreement or understanding among hospitals to maintain a minimum cost of services when negotiating with insurers.

Federal Enforcement Agencies

The DOJ's Antitrust Division and the FTC both enforce federal antitrust law. Both agencies enforce Section 7 of the Clayton Act. The DOJ enforces the Sherman Act, while the FTC enforces the FTC Act, which generally covers the same prohibited conduct as the Sherman Act.⁴¹ Each agency has developed expertise in particular industries or markets, where it generally takes the lead. In health care, the FTC tends to take the lead on matters involving providers, while the DOJ leads on matters involving insurers.⁴² But both agencies may and do review proposed actions or transactions and investigate conduct regardless of the nature of the health care entity. It should also be noted that most antitrust enforcement actions are civil, but when the conduct is a blatant, per se violation of the Sherman Act, the individuals and businesses involved may also be criminally prosecuted by the DOJ.⁴³

The enforcement agencies' job is not only to stop firms from engaging in anticompetitive conduct that harms consumers but also to provide guidance to health care providers so that they can avoid engaging in conduct that violates antitrust laws. So to help health care

providers determine what kind of conduct will trigger federal antitrust enforcement, the FTC and DOJ have issued Statements of Antitrust Enforcement Policy in Health Care.⁴⁴ These provide guidance on activities that fall in "safety zones," describing conduct that the agencies will not challenge under the antitrust laws, absent extraordinary circumstances. The policy statements also describe activities that are per se violations of the antitrust laws, i.e., violations that need no investigation of their precise effects on market competition because the parties' intentions are blatantly anticompetitive. The FTC and DOJ also issue advisory opinions on proposed conduct or arrangements upon request, intended to help providers determine whether activity they wish to pursue will trigger antitrust enforcement by either of the agencies.

State Enforcement Agencies

State attorneys general can enforce not only their own state's antitrust laws but also federal antitrust laws to the extent they cover harm caused to the state's consumers.⁴⁵ In California, a health care transaction may be reviewed by the CA-AG's Antitrust Law Section, which investigates potential violations of state and federal law and can litigate in both state and federal courts. If a health care merger in California involves a nonprofit public benefit corporation that operates or controls a "health facility" as defined in Health and Safety Code §1250, the parties seeking to merge must provide written notice to the CA-AG and obtain consent prior to any sale or transfer of ownership or control of a material amount of the corporation's assets. The CA-AG's Charitable Trusts Section also reviews such transactions for their impact on charitable assets and the accessibility and availability of health care services in the service area. In considering whether to consent to any such transfer, the CA-AG must also consider whether the transaction may tend to create a monopoly or substantially lessen competition. Private parties can also seek to enforce federal antitrust laws in state or federal court.

Recent Evolution of Health Care Antitrust Enforcement

Rapid and substantial hospital consolidation occurred during the mid-1980s and throughout the 1990s, in part to counterbalance the increasing presence of managed care, which pressured hospitals to reduce costs and excess capacity. The FTC opposed a number of these mergers as anticompetitive but lost most of these challenges in

court. An FTC commissioner attributed the losses in part to “the courts’ acceptance of faulty economic analysis of geographic markets (through improper reliance on the Elzinga-Hogarty [E-H] test) and competitive effects (through improper use of critical loss analysis).”⁴⁶

In early 2000, the FTC announced that it would analyze with new vigor the effects of recently consummated and proposed hospital transactions, and challenge those that had resulted in anticompetitive price increases. The review of consummated transactions resulted in four published retrospectives and showed that the methodology relied on by courts was flawed and failed to identify anticompetitive mergers. The retrospective analyses demonstrated that price changes of the merged entity were higher compared to those of control entities over the same time frame. They showed that the mergers tended to have anticompetitive effects and provided strong evidence that the agencies had been right to challenge those hospital deals.⁴⁷ The FTC reassessed its approach and began emphasizing how a merger can leave the direct payer for hospital services, most often the insurer, with few provider alternatives to include in its network. With fewer alternatives, the bargaining leverage of the combined hospital increases, which leads to higher prices.⁴⁸

Subsequently, the FTC successfully challenged Evanston Northwestern Healthcare’s acquisition of Highland Park Hospital (2007), the first in a series of such successful challenges.⁴⁹ Most recently, and despite the 2010 passage of the ACA encouraging some kinds of integration, the FTC has successfully challenged hospital mergers in Toledo, Ohio (*In the Matter of ProMedica Health System Inc.*), and Rockford, Illinois (*FTC v. OSF Healthcare System*).⁵⁰ It also succeeded with its first fully litigated challenge to a hospital acquisition of competing physician practices (*FTC v. St. Luke’s Health System*).⁵¹

This string of successes by the FTC can be attributed in part to the new Horizontal Merger Guidelines (“2010 Guidelines”) issued on August 19, 2010, jointly by the FTC and the DOJ, and the findings from the FTC’s retrospective analyses. These 2010 Guidelines, replacing the Horizontal Merger Guidelines issued by the two agencies in 1992 and slightly revised in 1997, offered a more nuanced application of market definition, market concentration, merger specificity, and efficiencies provisions. Specifically, with regard to the limitations of the E-H approach to defining geographic markets, the FTC’s

analyses of previous cases was helpful in that it placed less emphasis on E-H and led to the development of a better economic and legal enforcement approach using bargaining and “willingness-to-pay” modeling. Under this new analytic framework, the modeling focuses on whether a merger among providers that are close substitutes increases the merged provider’s leverage with health plans because of inadequate alternatives, thus gaining the merged provider the ability to obtain supra-competitive pricing.

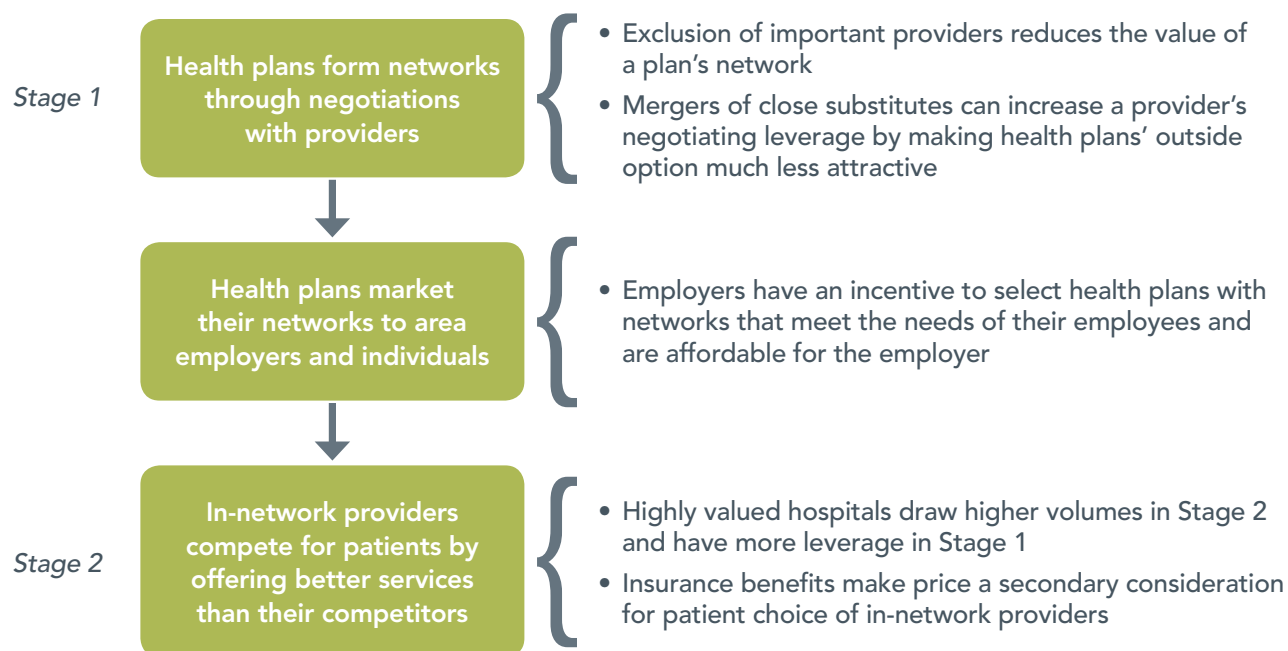
The importance of how the geographic and product markets are defined is highlighted by a 2013 decision by the United States District Court for the Northern District of California rejecting an antitrust challenge to a consolidation sought by Sutter, a large Northern California health care system.⁵² The court rejected the enforcement agencies’ definition of the applicable product market (all contracted access to all health care services through health plans) and geographic market (an “amorphous region” of 22 counties “that is not tethered to any factual allegations about Sutter’s market power”), holding that they were defined too broadly under the guidelines and therefore failed to identify properly the specific services that competed with each other or the geographic area where the competition took place.⁵³

Familiarity with the new merger guidelines is critical to providers who are concerned about possible intervention by regulatory agencies. One key change in the 2010 Guidelines from previous guidelines is greater receptiveness to a variety of methods to analyze evidence in determining whether a merger may substantially lessen competition. Also, the methods of analysis are now more consistent with the FTC’s two-stage view of competition between health care facilities. (See Figure 3, page 13.)

The more flexible approach set out in the 2010 Guidelines differs from the earlier guidelines in several ways:

- ▶ The “market definition” is not an end in itself or a necessary starting point for a merger analysis, in contrast to the five-step analytic process described in the earlier guidelines that relies on first defining a relevant geographic and product market with respect to each of the products of the merging firms.⁵⁴
- ▶ The thresholds for measurement of market concentration have been updated. A measure known as the Herfindahl-Hirschman Index (HHI),

Figure 3. FTC Two-Stage View of Competition Between Health Care Facilities



Source: Competition Economics.

calculated by summing the squares of each merging firm's market share, is used to quantify market concentration; the threshold at which the enforcement agencies see the potential for harm has been raised from the levels set out in the earlier guidelines.

- There is greater emphasis on "coordinated effects." A red flag is raised if the enforcement agencies believe the merger will increase the market's vulnerability to coordinated conduct. (See sidebar.)
- There is more attention paid to whether a merger increases the risk of either explicit collusion among competitors or "parallel conduct," which involves less overt or formal agreements on pricing or terms of sale, but still has the effect of reducing competition and consumer choice.

Adverse Competitive Effects: Coordinated and Unilateral

Coordinated Effects. A merger can enhance the market power of the merged entity and its remaining rival, post-merger entities by increasing the risk of coordinated, accommodating, or interdependent behavior among them. Adverse competitive effects arising in this manner are referred to as coordinated effects.⁵⁵ For example, as a result of a merger from three competing entities to only two, those two entities might increase the price for the services they both offer through an implicit agreement or parallel accommodating behavior, which would become easier to monitor and manage than when there were three independent entities.

Unilateral Effects. A merger can enhance the new entity's market power simply by eliminating competition between the merging parties. This effect can arise even if the merger causes no changes in the way other firms behave. Adverse competitive effects arising in this manner are referred to as unilateral effects.⁵⁶ The simplest, most obvious unilateral effect arises when a merger results in a monopoly, which eliminates all competition in the relevant market, such as when all hospitals in a market consolidate into one hospital system.

Impact and Implications of the St. Luke's Case

The tension between consumer protection through the principles of antitrust and the promotion of more efficient health care through the integration of health care providers — and the newer methods by which courts may resolve these tensions — was spotlighted by the 2014 case of *St. Alphonsus Medical Center – Nampa v. St. Luke's Health System*.⁵⁷ This case is particularly significant because it involved an FTC challenge to a hospital's acquisition of a physician practice group, a type of consolidation transaction that jumped 139% nationally in just one year (2010 to 2011) immediately following passage of the ACA.⁵⁸

On January 24, 2014, the United States District Court for Idaho held that St. Luke's Health System's (St. Luke's) acquisition of Saltzer Medical Group (Saltzer), violated Section 7 of the Clayton Act and ordered St. Luke's to fully divest itself of Saltzer's physicians and assets. The case is significant for two reasons: (1) it was the first victory for the FTC involving the acquisition of a provider group by a hospital system, and (2) the ruling demonstrated that despite its policies strongly encouraging pro-consumer integration of health care delivery in a number of ways, the ACA does not guarantee that all health care service consolidations will pass legal muster. Despite the ACA's encouragement of health care integration, the court found that, in this case, there were less anticompetitive ways to achieve this goal other than a full-fledged acquisition.

During a four-week trial in the fall of 2013, two health care systems competing with St. Luke's — St. Alphonsus Health System and the Treasure Valley Hospital, a surgical center — joined the FTC and the Idaho Attorney General in challenging the St. Luke's/Saltzer merger. St. Alphonsus and Treasure Valley argued that St. Luke's would steer patients away from other hospitals if it were allowed to keep Saltzer, with the resulting loss of business forcing them to cut services and jobs and reduce the quality of choice for consumers. The FTC and the Idaho Attorney General asserted that the St. Luke's/Saltzer deal broke antitrust laws by giving St. Luke's control of nearly 80% of the primary care market in the city of Nampa. (Although the case involved a hospital's acquisition of a physician group, ultimately the case was viewed by the

court as a horizontal merger of physician groups.) The agencies argued that this dominance would allow St. Luke's, unfettered by competition, to increase primary care prices, thereby driving up insurance premiums and patient costs.

Analysis of the Relevant Product and Geographic Markets

Two important steps in any antitrust case (other than a prosecution in which the conduct is considered a *per se* violation of law) are defining the product market and defining the geographic market. Both sides in the St. Luke's case agreed that the product market was adult primary care physician (PCP) services, including physician services provided to commercially insured patients age 18 and over by physicians practicing internal medicine, family practice, and general practice. They differed, however, as to what was the appropriate geographic market for purposes of analysis, and it was on this basis that the court's decision ultimately rested.

As part of defining the product and geographic markets, economists use a "hypothetical monopolist" test. This test evaluates whether all the sellers in the proposed market would be able to impose a small but significant, non-transitory increase in price (SSNIP), generally 5% to 10%, and still make a profit.⁵⁹ If not, that means the scope of the market is bigger, because consumers would not be able to turn to other alternatives. While St. Luke's/Saltzer relied on patient flow analysis to argue for a large geographic market area — which would have resulted in lower market shares — they did not prevail. Instead, the court defined the geographic market more narrowly as the city of Nampa, accepting the plaintiffs' view that the St. Luke's/Saltzer approach ignored industry structure and economic research demonstrating that patient flows alone are an inappropriate basis for evaluating a SSNIP. Based on evidence from a broad range of market participants, the plaintiffs showed that patients prefer local access to the PCPs within the city of Nampa, and that health plans believed that including Nampa PCPs in-network was very important, so the proper geographic market for analysis of the case was the city of Nampa itself, and the court agreed.

Market Shares, Concentration, and Competitive Effects

Once the product and geographic markets had been defined in the case, the plaintiffs demonstrated that the increase in concentration from the St. Luke's/Saltzer merger was presumptively anticompetitive under the FTC-DOJ 2010 Horizontal Merger Guidelines. St. Luke's and Saltzer together accounted for almost 80% of PCP services in Nampa. The merger increased the HHI market concentration measure from 4,612 to 6,219. This increase more than met the criteria (post-merger HHI above 2,500 and HHI increase more than 200 points) for "presumed likely to enhance market power."⁶⁰

Diversion analysis, a tool for measuring the extent to which firms or products are close substitutes for each other, also supported the claim that the acquisition would substantially lessen competition. The diversion analysis performed in the case showed that St. Luke's and Saltzer's PCPs are each other's closest substitutes, such that the acquisition substantially enhanced St. Luke's/Saltzer's bargaining leverage to increase reimbursements.

Analysis of Possible Mitigation: Entry, Expansion, and Efficiencies

When a health care consolidation is challenged under antitrust law, the integrating entities may defend by showing that the apparent impact of reduced competition will be mitigated in certain ways. These include demonstrating that opportunities exist for:

- ▶ **Market entry.** Other providers are likely to enter the market and provide new competition.
- ▶ **Market expansion.** Existing providers are likely to expand their practices and provide increased competition.
- ▶ **Increased efficiencies.** The consolidation might result in greater efficiency by the consolidated entities that would not have occurred if the providers continued to operate independently, and that it will reduce costs sufficiently to result in price decreases that outweigh any price increases that would result from the reduction in competition.

In the St. Luke's/Saltzer case, however, none of these mitigating effects was demonstrated to the satisfaction of the

court. The prospect of market entry by other providers was shown to be unlikely. Also, St. Luke's experts claimed that previous St. Luke's PCP acquisitions had lowered overall spending for health care services rendered to patients under its care. However, based on a comparison of health care spending for patients in two groups, the "treatment group" (patients under the care of PCPs acquired by St. Luke's) and a "control group" (patients under the care of comparable non-acquired PCPs), there was no evidence of systematic reductions in health care spending.⁶¹

Summary: What the St. Luke's Case Says About Integration and Antitrust

The St. Luke's case represents the first time a federal court has found a hospital's purchase of a physician practice to be unlawful, though it should be noted that, technically, the case was tried as a transaction involving two physician groups rather than as a merger between a hospital and a physician group. The case sent a message that while the ACA promotes integration, it does not sanction merger activity that reduces competition in violation of antitrust law. The case is also a reminder that a court may step in not only to block a pending transaction but also to undo a consummated one.

The court in St. Luke's found that the acquisition would have anticompetitive effects which violated Section 7 of the federal Clayton Act, as well as the state's Idaho Competition Act. The court agreed that St. Luke's acquisition and other efforts toward greater integration could improve the delivery of health care but found that there were other ways to achieve the same effect that did not pose such a risk of increased costs and therefore would not violate antitrust laws. The acquisition enabled the new, combined entity to negotiate higher reimbursement rates from health insurance plans, which would likely be passed on to the consumer, and also to raise rates for ancillary services (such as x-rays). Thus, the court required St. Luke's to fully divest itself of Saltzer's physicians and assets and to take any further action needed to unwind the acquisition. The district court's decision was upheld in February 2015 by a federal appeals court, which affirmed that St. Luke's violated state and federal antitrust laws when it acquired the medical group.

Implications of the St. Luke's Decision for California Health Care Markets

In response to many of the payment and delivery reforms included in the ACA, as well as those spurred by state action in Medicaid and other programs, California health care providers and insurers are scurrying to consolidate in order to remain viable. The extent of integration ranges from complete consolidation through mergers, to joint ventures, to simple clinical integration with no financial integration at all. Integration between providers and insurers that lowers costs, increases productivity, and/or improves quality can potentially benefit consumers. However, as was demonstrated in the St. Luke's decision, these broadly positive effects may not be enough to overcome likely anticompetitive effects, particularly if the integration leads to significant consolidation of market power, creating a power imbalance among providers and payers in the market. In the case of the consolidation of Saltzer and St. Luke's, the combined entity had 80% of the PCPs in the city of Nampa, and therefore a very dominant market position "that ran a risk of higher reimbursement rates . . . that will be passed on to the consumer."⁶²

FTC officials recently indicated that the agency challenges fewer than 1% of health care transactions. However, health care providers in that 1% can attest to the considerable expense of time and money associated with such challenges, especially if it reaches litigation.⁶³ And while transactions in major California urban areas are unlikely to result in the degree of concentration seen in the St. Luke's case, the ruling could be highly relevant in many smaller urban, suburban, and rural areas of the state where there are fewer health care entities in each market. Additionally, that case also serves as reminder that smaller deals, well-below the Hart-Scott-Rodino jurisdictional thresholds, can face intense scrutiny and legal challenges.

So, as health care organizations in California scramble to strategically position themselves in a new health care marketplace, consolidations are one option for addressing the challenge of thin margins, the need for investment in medical technology, and a better competitive position generally. But while the FTC and DOJ understand and

support the goals of the ACA to improve health care delivery through integration, the St. Luke's decision, plus the 2010 revision of the Horizontal Merger Guidelines and other recent agency actions, demonstrates that the agencies will still enforce the antitrust laws to protect competition. Therefore, options for achieving integrated health care delivery without the degree of merger or consolidation that raises antitrust concerns should be pursued if available.⁶⁴

Avoiding Health Care Antitrust Challenges by Enforcement Agencies

Financial Versus Clinical Integration

Success in the post-ACA health care market, including population health management, requires both financial and clinical integration. But the two types of integration are not the same thing, and clinical integration does not necessarily require full financial integration.

Financial integration among providers involves shared financial data, shared financial risk and reward, mutual dependency on financial outcomes, and aligned financial incentives. However, the St. Luke's case sent the message that full financial integration in the form of mergers or acquisitions is not always necessary to achieve the benefits of clinical integration, and may not be an acceptable route under antitrust laws. (In that regard, it should be noted that there is nothing about California's medical foundation model, used to avoid the state's prohibition on direct employment of physicians by hospitals, that would provide a safe harbor from antitrust enforcement.) Clinical integration among providers, which can but does not necessarily include financial integration, involves shared clinical data and shared patient relationships, mutual dependency on clinical outcomes, and aligned clinical incentives.⁶⁵

Transactions among providers that increase financial leverage without sufficient clinical integration often raise a red flag with regulators. For example, in a California case from July 2003, the FTC challenged a PPO product from Brown & Toland Physicians, a medical group based in San Francisco. The FTC alleged that the PPO product was not sufficiently clinically integrated to justify joint contract negotiations on behalf of network physicians, and that Brown & Toland's conduct had the

purpose and effect of raising prices for physician services in San Francisco.⁶⁶ In January 2004, the FTC and Brown & Toland settled this dispute under terms of a consent agreement by which Brown & Toland was to take steps to improve its clinical integration.⁶⁷

Steps to Reduce the Likelihood of Antitrust Challenges

Consolidating health care entities that wish to avoid antitrust challenges from regulatory agencies need first to understand the 2010 Horizontal Merger Guidelines.⁶⁸ Prior to entering into formal agreements with other health care organizations, these entities should consider the following questions spurred by those guidelines, and by the St. Luke's case:

- ▶ Can the parties demonstrate bona fide purposes for the integration, as opposed to simply a mechanism to enhance leverage with payers through joint negotiation? For example, in several advisory opinions the FTC has concluded that arrangements to improve quality and control costs through clinical integration, as opposed to primarily financial integration, are unlikely to violate antitrust law.⁶⁹ Also, the FTC will consider whether agreements among participants regarding the terms on which they will deal with health care insurers are reasonably necessary to achieve the benefits of the collaboration. If so, then the collaboration is not likely to be considered per se illegal and instead will be evaluated under a "rule of reason" standard, which considers whether the likely effect of the collaboration will be to help or harm competitors and consumers.⁷⁰
- ▶ To what extent is common ownership, or quasi-employment of physicians, necessary for the coordinated entities to create scale and align financial and quality incentives, or would looser clinical affiliations be sufficient to achieve the same objective of better care coordination?
- ▶ To what extent are efficiencies being claimed available only through the specific post-integration structure, or could the parties achieve the same results through a clinical arrangement rather than financial integration?
- ▶ To what extent will the combined entity raise rates for ancillary services (such as x-rays, charged at a higher hospital-billing rate), which will be passed on to patients? Price increases to consumers

without significant compensating effects are likely to be viewed as anticompetitive behavior.

- ▶ To what extent could the combined entity's anticompetitive bargaining advantage be used in ways (in addition to price increases) that could cause substantial injury to consumers? Examples of such harm might be reduced output and diminished innovation resulting from decreased competitive constraints or incentives.
- ▶ Will the combined entity have a dominant market position that will enable it to negotiate higher reimbursement rates from health insurance plans, which will be passed on to the consumer?
- ▶ Will proclaimed savings and efficiencies from the merger be passed on to the consumer?
- ▶ Is the organization relying on the foundation model to align incentives between hospitals and physicians, without formally owning and operating the physician clinics?⁷¹ Indirect employment through a foundation will most likely not diminish regulatory agencies' concerns about the impact of physician-hospital organization; the agencies will treat this type of arrangement as if it were employment.

As providers consider these questions, California is likely to see two trends that address the tensions between the incentives of the ACA and the antitrust issues raised by the St. Luke's case and the Horizontal Merger Guidelines:

- ▶ **Creation of more integrated systems like Kaiser, better positioned to address population health.** In California and around the country, hospital systems are acquiring health insurers or otherwise integrating insurance into their system.⁷² In May 2014, St. Louis-based Ascension Health, the country's largest nonprofit hospital system, was "in talks to acquire an unnamed insurance company that operates in 18 states."⁷³ Sutter Health, a major hospital system in California, applied for a Knox-Keene license that would allow them to have a health insurance product, and by January 2013 they had launched Sutter Health Plus, their own insurance coverage. Also, Memorial Care Health System, a six-hospital network based in Fountain Valley, California, launched an insurance arm in 2013. Hospitals aligning or consolidating with, or creating, insurance businesses are likely to try to achieve a better design of incentives for

higher-quality care (to reduce their own insurance costs), consolidation of similar functions like human resources or tech support to cut costs, and improvement of margins on new Medicare payment models in the ACA. By combining the functions of health care services and health care insurance, these integrated systems can put competitors at a disadvantage. If this advantage ultimately decreases competition, it could allow the organization to raise premiums. Watchful of threats to competition and the effects on consumers and patients, antitrust regulators, like health care providers, are working to keep up with these transitioning market dynamics.

- **Greater focus on strategic alliances rather than mergers per se.** Historically, mergers have been the preferred way to achieve size, scale, and bargaining power with health care payers. However, with hospital administrators citing a chilling effect from the FTC's scrutiny and high-profile rulings against the industry, traditional approaches to consolidation are now less appealing.⁷⁴ Consequently, hospitals are seeking out partnerships that are not mergers per se and instead pursuing a growing trend of affiliations, alliances, joint ventures, and other "non-merger mergers" that involve coming together to share knowledge, assets, or branding rather than ownership.⁷⁵ For example, Dignity Health System has stated that it is looking for other ways to build relationships, and in the summer of 2014 agreed to a joint venture in Arizona with Ascension Health and Tenet.⁷⁶ Their joint venture will allow Dignity, Ascension, and Tenet to realize synergies while the companies remain separate and intact. Despite this partnership structure, however, a critical question will remain as to the extent the parties involved will have increased bargaining leverage with other payers or providers.

Conclusion

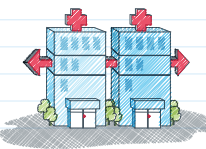







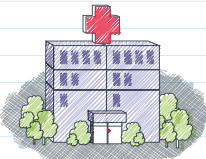


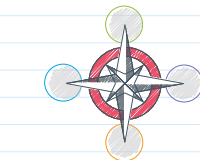


Consolidation in health care is now a widespread, powerful trend that is likely to continue for the foreseeable future throughout California and the rest of the nation. Providers are confronted with shrinking operating margins in core service lines, with pressures to control risk and costs, and with strong incentives to achieve better scale to fund growth and remain competitive. Consolidation to acquire new capabilities is also becoming more prominent to help providers monitor and improve continuity in care.

The creation of large, consolidated health care systems, however, raises concerns among regulators about monopolies and decreased competition. The types and levels of integration now occurring are becoming increasingly complex, making enforcement challenges concomitantly complex. Similarly, it is becoming increasingly difficult for providers to determine how to integrate organizations without drawing negative regulatory attention. Evaluations of competitive effects by regulatory agencies cannot be based on a simple, standard approach or be dispositive based on a single measure. Instead, each transaction must be evaluated independently, based on a number of factors, including the level of clinical and financial integration as measured against the FTC and DOJ's 2010 Merger Guidelines. Ultimately, because of the complex and distinctive nature of some transactions, both health care providers and regulatory agencies will be moving forward on a path that is not always clearly paved, in their parallel efforts to determine whether a transaction is "likely, on balance, to be pro-competitive or competitively neutral," and therefore will benefit — or at least not harm — the community it serves.

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Appendix: "Field Guide to Hospital Partnership and Affiliation Models"

<h2>CLINICAL Affiliation</h2> 	<p>Agreement for organizations to collaborate on an initiative or to provide a specific service together; may involve local, regional, or national partners</p> <p>Examples: Evergreen Healthcare with Virginia Mason, Mayo Clinic Care Network, Cleveland Clinic Affiliate Program</p> <p>Cost: Varies depending on clinical area of focus; may require investment in staff or IT infrastructure</p> <p>Benefits:</p> <ol style="list-style-type: none">1. Allows for co-branding of clinical services2. Supports mutually beneficial exchange of referrals3. Enables shared investment in expensive resources including staff and equipment <p>Drawbacks:</p> <ol style="list-style-type: none">1. If forged with local competitor, creates significant risk of competition for volumes2. Partnership is limited to specific focus of agreement	<p><1 YEAR </p>	
<h2>REGIONAL Collaborative</h2> 	<p>Flexible umbrella structure for partnering on specific initiatives and building the foundation for potential future integration; often encompasses many independent organizations in a common geographic area</p> <p>Examples: Allspire Health Partners, Stratus Healthcare, BJC Collaborative, Noble Health Alliance, Health Innovations Ohio</p> <p>Cost: Varies depending on partnership goals; best practice sharing networks require little more than an investment in time, whereas shared IT or operational functions require capital investment</p> <p>Benefits:</p> <ol style="list-style-type: none">1. Offers low-risk, low-investment model2. Opens communication with other providers, enabling exploration of additional partnership opportunities3. Supports large number of partners to expand best practice sharing, economies of intellect <p>Drawbacks:</p> <ol style="list-style-type: none">1. Lack of formal legal or financial integration limits ability to hold partners accountable2. Loose nature of affiliation enables partners to easily dissolve partnership	<p><1 YEAR </p>	
<h2>ACCOUNTABLE CARE Organization</h2> 	<p>Independent entity formed for entering into risk-based contracts; owned by constituent organizations, creates shared accountability among participating providers</p> <p>Examples: Quality Health Solutions, Arizona Care Network, Accountable Care Alliance</p> <p>Cost: Significant start-up investment and ongoing operating cost to succeed as population health manager</p> <p>Benefits:</p> <ol style="list-style-type: none">1. Enables joint contracting with private payers by sharing risk2. Supports participation in public payer ACO programs3. Facilitates development of shared quality incentives4. Allows for shared investment in population health infrastructure <p>Drawbacks:</p> <ol style="list-style-type: none">1. Requires costly and time-consuming integration of IT, staff, and clinical processes2. No guarantee of success under risk-based contracts	<p>1–2 YEARS </p>	
<h2>CLINICALLY INTEGRATED Hospital Network</h2> 	<p>Collection of hospitals that enter into joint payer contracts to improve care coordination and clinical outcomes; modeled after physician clinical integration networks</p> <p>Examples: Long Island Health Network, Vanderbilt Health Affiliated Network</p> <p>Cost: Significant administrative and capital costs to meet baseline thresholds for IT and physician integration, although costs vary with degree of clinical integration desired</p> <p>Benefits:</p> <ol style="list-style-type: none">1. Enables joint contracting with private payers2. Facilitates some degree of clinical integration3. Establishes performance-based incentives <p>Drawbacks:</p> <ol style="list-style-type: none">1. Has potential for significant regulatory scrutiny2. Limited legal precedence or guidance is available	<p>>2 YEARS </p>	
<h2>MERGER or ACQUISITION</h2> 	<p>Formal purchase of one organization's assets by another, or the combination of two organizations' assets into a single entity</p> <p>Examples: Baylor Scott and White, Community Health Systems/Health Management Associates, Trinity Health/Catholic Healthcare East, Tenet/Vanguard</p> <p>Cost: Significant legal costs to bring deal to fruition; significant administrative costs to effectively integrate organizations after deal closes</p> <p>Benefits:</p> <ol style="list-style-type: none">1. Enables joint contracting with private payers2. Facilitates balance sheet consolidation, debt refinancing3. Supports consolidation of governance structures4. Centralizes authority to make difficult decisions around consolidation and rationalization <p>Drawbacks:</p> <ol style="list-style-type: none">1. Elevates risk of lost time and resources if deal doesn't close2. Requires difficult and time-consuming integration of processes and culture3. Limits ability to use network membership as performance incentive	<p>1–2 YEARS </p>	
<h2>STRATEGIC FRAMEWORK for Partnership Decisions</h2>			
<p>①</p> 	<p>②</p> 	<p>③</p> 	<p>④</p> 
What strategic aims do we want to advance through partnership?	What are the specific elements of integration that must be in place for your partnership to achieve those aims?	What other organizations are the most attractive partners given your goals and the required elements of integration?	Which legal structure offers the most appropriate environment for pursuing meaningful integration?



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46. Julie Brill, "Competition in Health Care Markets," keynote address for the 2014 Hal White Antitrust Conference, June 9, 2014; *FTC v. Hospital Board of Directors of Lee County*, 1994-1 Trade Cas. (CCH) ¶ 70,209 (M.D. Fla.), *aff'd*, 38 F.3d 1184 (11th Cir. 1994); *In re Adventist Health System/West*, 117 F.T.C. 224 (1994); *FTC v. Freeman Hospital*, 911 F. Supp. 1213 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997); *FTC v. Tenet Healthcare Corp.*, 17 F. Supp. 2d 937 (E.D. Mo. 1998), *rev'd*, 186 F.3d 1045 (8th Cir. 1999).
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48. See, e.g., Opinion of the Commission, *In re ProMedica Health Sys., Inc.*, Docket No. 9346 (June 25, 2012) at 6, 12, 35-39, 47-49, www.ftc.gov.
49. Opinion of the Commission, *In re Evanston Northwestern Healthcare Corp.*, Docket No. 9315 (August 6, 2007), www.ftc.gov.
50. *ProMedica Health System, Inc. v. FTC*, 749 F.3d 559 (6th Cir. 2014) (upholding an FTC decision condemning a hospital acquisition and ordering a full divestiture of the acquired assets) and *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069 (D. Ill. 2012) (holding that OSF Healthcare's proposed acquisition of Rockford Health System would substantially reduce competition among hospitals and primary care physicians and rejecting the parties' efficiency claims).
51. *St. Alphonsus Medical Center – Nampa Inc. v. St. Luke's Health System Ltd.*, Findings of Fact and Conclusions of Law, No. 12-0560, Docket No. 464 (January 24, 2014), appeal Docket No. 14-35173 (9th Cir., filed March 7, 2014).
52. The plaintiffs were two Sutter customers who filed a class action lawsuit on behalf of a putative class consisting of any person in Northern California who had been enrolled since September 2008 in a licensed health care service plan that had a contractual relationship with Sutter.
53. *Sidibe v. Sutter Health*, No. C 12-04854 LB (N.D. Cal. June 3, 2013).
54. Bradley C. Weber, "DOJ and FTC Issue New Horizontal Merger Guidelines," *ABA Health eSource* 7, no. 1 (September 2010), www.americanbar.org and Merger Policy Statement, FERC Stats. & Regs. ¶ 31,044 at 30,118, 30,130. The five steps are (1) assess whether the merger would significantly increase concentration and result in a concentrated market, properly defined and measured; (2) assess whether the merger, in light of market concentration and other factors that characterize the market, raises concern about potential adverse competitive effects; (3) assess whether market entry would be timely, likely, and sufficient either to deter or counteract the competitive effects of concern; (4) assess whether the merger would result in increases in efficiency that cannot reasonably be achieved through the parties by other means; and (5) assess whether either party to the merger would fail without the merger, causing its assets to exit the market. *Id.* at 30,111.
55. *Horizontal Merger Guidelines*, US Department of Justice and the Federal Trade Commission, August 19, 2010, www.ftc.gov.
56. US Department of Justice and FTC, *Horizontal Merger Guidelines*.
57. *St. Alphonsus Medical Center – Nampa Inc. et al. v. St. Luke's Health System*, No. 1:12-cv-00560-BLW (D. Idaho March 31, 2014).
58. *Physician-Hospital Employment: This Time It's Different*, Deloitte, 2013, www2.deloitte.com.
59. Trial Tr. at 1311-14 (testimony of Dr. Dranove).
60. Presumption may be rebutted by persuasive evidence showing that the merger is unlikely to enhance market power, but in this case no such evidence was presented.
61. "Demonstratives for the Testimony of Professor David Dranove," Idaho Office of the Attorney General, October 2, 2013.

62. *St. Alphonsus Medical Center – Nampa Inc. v. St. Luke’s Health System*, No. 14-35173, 2015 U.S. App. Lexis 2098 (9th Cir. February 10, 2015). The district court decision may be found at *St. Alphonsus Medical Center - Nampa Inc. v. St. Luke’s Health System*, No. 1:12-cv-00560-BLW, 2014 US Dist. LEXIS 9264 (D. Idaho January 24, 2014).
63. Deborah L. Feinstein, “Antitrust Enforcement in Health Care: Proscription, not Prescription,” Fifth National Accountable Care Organization Summit, June 19, 2014, www.ftc.gov.
64. Judy Packer-Tursman, “Two Hospital Antitrust Cases You Should be Watching,” *HealthcareDIVE*, June 20, 2014, www.healthcaredive.com.
65. The Federal Trade Commission and Department of Justice define clinical integration as “the network implementing an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.” (Source: DOJ and FTC, *Statements of Antitrust Enforcement Policy in Health Care*, Statement 8.)
66. “Brown & Toland to Resume PPO Contract Negotiations,” *PR Newswire*, accessed March 27, 2015, www.prnewswire.com.
67. The proposed consent agreement bars Brown & Toland from (1) negotiating with any payer on behalf of any physician; (2) dealing or refusing to deal with any payer based on price or other terms; and (3) jointly determining price or other terms upon which any physician deals with payers. Brown & Toland may engage in this conduct if such conduct is reasonably necessary to the formation of a “qualified risk-sharing joint arrangement” or a “qualified clinically-integrated joint arrangement,” as defined by the order. The consent agreement also orders Brown & Toland to notify the FTC at least 60 days before entering into any arrangement with physicians or contacting any payer, except for those arrangements under which Brown & Toland will be paid a capitated amount, and contains standard recordkeeping provisions to assist the FTC in monitoring the respondent’s compliance. (Source: “San Francisco’s Brown & Toland Medical Group Settles FTC Price Fixing Charges,” Federal Trade Commission, www.ftc.gov.)
68. US Department of Justice and FTC, *Horizontal Merger Guidelines*.
69. Markus H. Meier, “Letter to McAfee & Taft, RE: Norman PHO Advisory Opinion,” Federal Trade Commission, February 13, 2013, www.ftc.gov; Markus H. Meier, “Letter to Ober, Kaler, Grimes & Shriver, RE: TriState Health Partners Inc. Advisory Opinion,” Federal Trade Commission, April 13, 2009, www.ftc.gov; Markus H. Meier, “Ober, Kaler, Grimes & Shriver, RE: Greater Rochester Independent Practice Association Inc. Advisory Opinion,” Federal Trade Commission, September 17, 2007, www.ftc.gov. In evaluating health care collaborations that claim likely efficiencies from clinical integration, FTC staff have focused on the programs’ structural capabilities, systems, and processes for achieving such efficiencies, and the motivations and incentives for the participants to embrace the programs’ goals.
70. Feinstein, “Antitrust Enforcement in Health Care.”
71. California law bans most hospitals from employing physicians directly, requiring them instead to create affiliated arrangements with physician groups who contract with doctors.
72. Austin Frakt, “When Hospital Systems Buy Health Insurers,” *New York Times*, May 25, 2014, www.nytimes.com.
73. Melanie Evans, “Ascension Considers Major Insurance Play,” *Modern Healthcare*, May 22, 2014, www.modernhealthcare.com.
74. Dan Diamond, “Hospital Mergers Are Out. ‘Strategic Alliances’ Are In. Is Obamacare Responsible?” *California Healthline*, July 30, 2014, www.californiahealthline.org.
75. Dan Diamond, “Hospital Mergers Are Out.”
76. *Ibid.*