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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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[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.