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Redefining Care and Competition Models in Health Care

Kenneth W. Field[1]

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

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

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

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

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

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

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

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

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

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

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

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

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

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