A STRONGER SECOND COMPETITOR? ANALYZING THE COMPETITIVE EFFECTS OF THE *BETH ISRAEL LAHEY HEALTH* TRANSACTION

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I. BACKGROUND

Could a merger between rival firms create a stronger second competitor to the market leader in a way that strengthens competition and benefits consumers? The answer is theoretically ambiguous, and little if any empirical economic research squarely addresses this question. Recently, however, the Massachusetts Health Policy Commission ("HPC") analyzed this very issue in its evaluation of a proposed merger of several hospital systems in the Boston area. Specifically, the HPC evaluated whether the new system, Beth Israel Lahey Health ("BILH"), would be able to compete more effectively with Partners HealthCare ("Partners"), the largest and most expensive healthcare system in the region, and thereby reduce overall healthcare costs.

The transaction arose in July 2017, when Beth Israel Deaconess Medical Center ("BIDMC") and some of its affiliates (together, "Beth Israel Deaconess Care Organization" or "BIDCO"), Lahey Health System ("Lahey"), Mount Auburn Hospital, and their respective physician groups, agreed to merge. Under Massachusetts law, the HPC, an independent state agency established by the Commonwealth's landmark healthcare cost containment law (Chapter 224 of the Acts of 2012),[2] may conduct a comprehensive analysis of any transaction anticipated to have a significant impact on healthcare costs or market functioning and may issue a public cost and market impact review report ("CMIR Report").[3] A transaction cannot close until the Commission issues its Final CMIR Report. The HPC cannot directly block a transaction, but if it concludes that a transaction may have harmful effects, the HPC may refer the transaction to the Attorney General's Office or other state agencies.

The HPC issued its Final CMIR Report in September 2018.[4] It identified significant competitive overlap between the parties such that the merger would enhance their bargaining leverage with insurers. It estimated that higher post-merger prices could increase spending for inpatient, outpatient, and adult primary care services by $128 to $171 million per year and increase spending on specialty services by $30 to $60 million per year.[5]

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2 Mass.gov, "About the Health Policy Commission (HPC)," https://www.mass.gov/about-the-health-policy-commission-hpc.

3 See Mass. Gen. Laws ch. 6D, § 13 (requiring healthcare providers to notify the HPC before making material changes to their operations or governance). See also Mass. Health Policy Comm'n, 958 CMR 7.00: Notices of Material Change and Cost and Market Impact Reviews (Jan. 2, 2015), http://www.mass.gov/anf/docs/hpc/regs-and-notices/consolidated-regulations-circ.pdf.

4 Massachusetts Health Policy Commission, "Massachusetts Health Policy Commission Review of the Proposed Merger of Lahey Health System; CareGroup and its Component Parts, Beth Israel Deaconess Medical Center, New England Baptist Hospital, and Mount Auburn Hospital; Seacoast Regional Health Systems; and Each of their Corporate Subsidiaries into Beth Israel Lahey Health; and The Acquisition of the Beth Israel Deaconess Care Organization by Beth Israel Lahey Health; and The Contracting Affiliation Between Beth Israel Lahey Health and Mount Auburn Cambridge Independent Practice Association," (HPC-CMIR-2017-2), pursuant to M.G.L. ch. 6D, § 13, Final Report, Sept. 27, 2018, https://www.mass.gov/files/documents/2018/09/27/Final%20CMIR%20Report%20-%20Beth%20Israel%20Lahey%20Health.pdf [Final CMIR Report].

5 Final CMIR Report, 3.

The HPC also evaluated whether the merger would create efficiencies or other benefits for the community that could offset the likely competitive harm. Of particular interest, it looked at whether BILH could reduce healthcare costs by attracting volume away from the more expensive Partners system.[6] Patients shifting from Partners to BILH would generate immediate savings because BILH was projected to maintain lower per unit prices than Partners after the merger. Moreover, a more attractive and effective competitor to Partners could, potentially, also reduce Partners' bargaining leverage with insurers, leading to additional savings from lower prices (or lower future price increases) for Partners' services. The HPC also considered whether the combined entity could more effectively anchor narrow-network health plans, which have been shown to have lower healthcare spending.[7] Ultimately, the HPC concluded that the potential spending reductions arising from the merger would likely be insufficient to offset projected price increases.[8]

Based on these findings, the HPC referred the transaction for further review to the Massachusetts Attorney General, who ultimately approved the transaction with conditions.[9] Under the terms of the settlement, BILH must (i) limit price increases below a cap based on the healthcare cost growth benchmark for seven years; (ii) invest $71.6 million to support healthcare services for low-income and underserved populations in Massachusetts; (iii) participate in MassHealth, the state's combined Medicaid and Children's Health Insurance Program; (iv) engage in joint business planning with affiliated safety-net hospitals, including Lawrence General, Cambridge Health Alliance, and Signature Brockton Hospital, for eight years; and (v) retain a third party to ensure BILH's compliance for ten years.[10] Shortly after the Attorney General's approval, the Federal Trade Commission ("FTC") closed its investigation.[11]

In this article, we review the HPC's analysis of competitive issues raised by the BILH transaction, with a focus on the potentially pro-competitive effects of creating a stronger second competitor to the market leader.

A. The Parties and the Transaction

The parties signed the agreement to create BILH in July 2017 and closed the transaction on March 1, 2019.[12] The combined system now contracts on behalf of 13 hospitals in the greater Boston area, ranging from academic medical centers to a specialty hospital to community hospitals, as well as over 4,000 physicians.[13] The transaction gave BILH about a 24 percent share of inpatient discharges statewide, a 25 percent share of outpatient services statewide, and an 18 percent share of adult primary care services statewide.

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6 The HPC also evaluated the parties' plans for several initiatives to improve quality and access to care.

7 See Dafny, Leemore S., Igal Hendel, Victoria Marone & Christopher Ody, "Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth," *Health Affairs* 36 (2017): 1606–14; Dafny, Leemore, Igal Hendel & Nathan Wilson, "Narrow Networks on the Health Insurance Exchanges: What Do They Look Like and How Do They Affect Pricing? A Case Study of Texas," *American Economic Review* 105 (2015): 110–14. See also Ho, Kate & Robin Lee, "Equilibrium Insurer-Provider Networks: Bargaining and Exclusion in Health Care Markets," *American Economic Review*, 109 (2019): 473–522; Polsky, Daniel, Zuleyha Cidav & Ashley Swanson, "Marketplace Plans with Narrow Physician Networks Feature Lower Monthly Premiums Than Plans with Larger Networks," *Health Affairs* 35 (2016): 1842–48.

8 Final CMIR Report, 4.

9 The HPC also recommended that the Department of Public Health ("DPH") reconsider its conditions for approval of the parties' Determination of Need application, and the DPH revised its conditions in response.

10 Assurance of Discontinuance Pursuant to M.G.L. Chapters 93A, § 5 and 93, § 9, *Commonwealth of Massachusetts v. Beth Israel Lahey Health, Inc.* (Suffolk Cty. Super. Ct. Nov. 28, 2018); Mass.gov, "AG Healey Reaches Settlement with Beth Israel, Lahey Health over Proposed Merger," news release, Nov. 29, 2018, https://www.mass.gov/news/ag-healey-reaches-settlement-with-beth-israel-lahey-health-over-proposed-merger.

11 Federal Trade Commission, "Statement of the Federal Trade Commission Concerning the Proposed Affiliation of CareGroup, Inc., Lahey Health Systems, Inc.; Seacoast Regional Health System, Inc.; BIDCO Hospital LLC: and BIDCO Physicians LLC," Nov. 29, 2018, https://www.ftc.gov/system/files/documents/closing_letters/nid/1710118_bidmc_commission_closing_statement.pdf.

12 Beth Israel Lahey Health, "Beth Israel Lahey Health Begins Journey to Transform Health Care," https://www.bilh.org/in-the-news/2019/2/28/beth-israel-lahey-health-begins-journey-to-transform-health-care.

13 Final CMIR Report, 26. Beth Israel Deaconess Health System was the second largest system in Massachusetts, with its flagship academic medical center in downtown Boston (BIDMC) and three community hospitals around Boston. Lahey Health was a four-hospital system in northern Boston suburbs. Mount Auburn was a fairly large independent hospital in Cambridge. BIDCO contracting affiliates Anna Jaques Hospital and New England Baptist Hospital also became corporate members of the merged entity; BIDCO members Cambridge Health Alliance and Lawrence General Hospital will continue to contract jointly with BILH without affiliating corporately. Final CMIR Report, 1.

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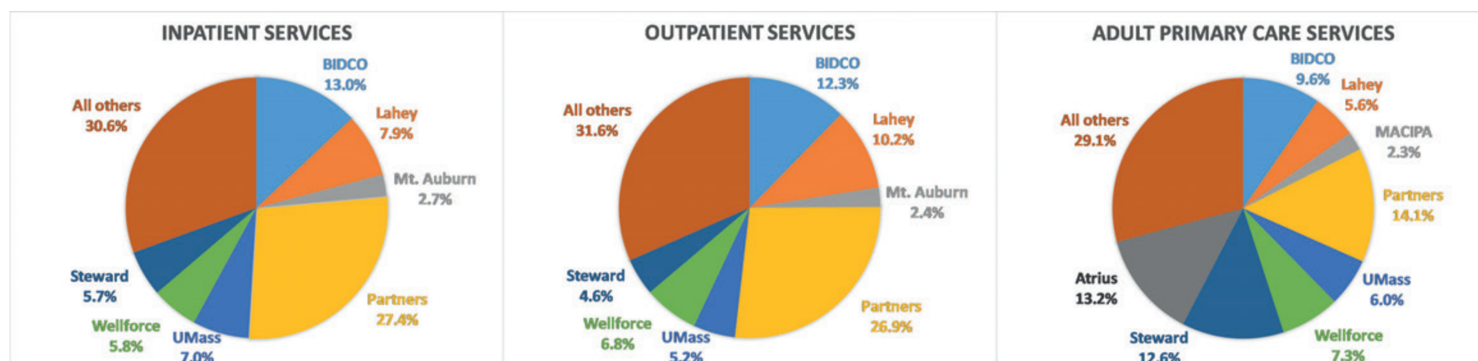
Partners HealthCare, the largest system in Massachusetts and the parent company of Massachusetts General and Brigham and Women's hospitals, currently contracts on behalf of 13 hospitals and more than 5,000 physicians in Massachusetts.[14] Statewide, Partners has about a 27 percent share of inpatient discharges, a 27 percent share of outpatient services, and a 14 percent share of adult primary care services. Accordingly, the BILH transaction created a hospital system that is comparable in size and geographic expanse to Partners. The third, fourth, and fifth largest hospital systems — UMass Memorial Health Care, Wellforce, and Steward Health — have between a 5 percent and 7 percent share of inpatient discharges statewide. See Figure 1.

Figure 1. Statewide shares of inpatient, outpatient, and adult primary care services



Source: Final CMIR Report, 45, 47.

B. Competitive Rationale for the Merger

Among the stated rationales for the merger, the parties aspire to "create a large, lower-cost health network that can compete with Partners HealthCare."[15] Because the new system would be lower priced than Partners, post-merger growth in its patient volume could reduce healthcare spending. This potential is real, because it has been well-documented that Partners is, by a substantial margin, the most expensive healthcare system in Massachusetts — in 2016, its commercial inpatient services prices were 25 percent to 40 percent above the state average, depending on the payer.[16] However, growth in volume at the new BILH entity would not unambiguously reduce overall healthcare spending because, based on the HPC's analysis, the BIDCO-owned and Lahey hospitals are not generally priced below Boston area hospitals other than Partners.[17]

14 Final CMIR Report, 26–27.

15 McCluskey, Priyanka D., "Beth Israel and Lahey Health Sign Final Agreement to Merge," *Boston Globe*, July 13, 2017, https://www.bostonglobe.com/business/2017/07/13/beth-israel-deaconess-and-lahey-health-sign-final-agreement-merge/lZWtE3YWeQZyRvaWGYXxAO/story.html.

16 Final CMIR Report, 32–33. Partners outpatient services prices were 5 percent to 35 percent above the state average.

17 Final CMIR Report, 33–34 ("The BID-owned system is consistently the second-highest priced system for inpatient services, and Lahey is generally comparably priced to Steward Health Care System (Steward) and Wellforce. … BIDCO, Lahey, and MACIPA [Mount Auburn Cambridge Independent Practice Association] generally have low to moderate physician prices compared to other eastern Massachusetts physician groups, and they are consistently lower-priced than Partners and Atrius.").

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II. HPC'S ANALYSES OF POTENTIAL BENEFITS AND POTENTIAL HARMS

A. Bargaining Leverage and Price Effects

To analyze the likely competitive effects of the BILH transaction, the HPC relied on well-established tools of hospital merger enforcement. Since the early 2000s, economists have analyzed hospital competition using a two-stage model that matches the industry-specific circumstances that determine hospital prices.[18] Courts have accepted the two-stage model of competition in multiple recent provider merger challenges won by the FTC.[19]

In the first stage, insurers negotiate with hospitals over the terms, including price, for inclusion of the hospitals in the insurers' provider networks. In the second stage, patients choose the hospital at which to receive care when the need arises. Patients will primarily choose among in-network hospitals, because doing so generally entails substantially lower out-of-pocket costs. A hospital's bargaining leverage in negotiations with insurers in the first stage is derived from the incremental profits to the insurer, whether from higher enrollment or higher premiums, from including the hospital in its network.[20] The value that enrollees derive from inclusion of a hospital in a plan's network is referred to as the willingness-to-pay ("WTP") for that hospital. That is, the WTP for a hospital is defined as the difference between the value of a network that includes that hospital and one that does not.[21]

The inclusion of a hospital that is valued highly by a significant number of patients and for which there is no close substitute will generally increase the attractiveness of a health plan's network and increase plan enrollment. As a result, such a hospital will have a high WTP and be able to command high prices from insurers. In contrast, inclusion of a hospital for which a close substitute hospital is already part of the network or is available to be added will contribute less to the overall attractiveness of the health plan; such a hospital will have lower WTP and will not be able to negotiate as high a price. For this reason, a merger of substitute hospitals for which other close substitutes are unavailable will increase both their WTP and their ability to negotiate higher prices. Economic research has shown that hospitals and systems with higher WTP values can charge higher prices and earn higher profits.[22]

The HPC employed WTP analysis to measure the BILH transaction's likely impact on the new system's ability to negotiate higher prices with commercial payers. First, the HPC used a model of patient hospital choice to estimate the WTP for hospitals in Massachusetts. Second, it established the relationship between WTP and prices in commercial networks for those hospitals. Finally, it used the choice model to predict the change in the parties' WTP and the implied price increase.[23] The HPC found that the estimated change in WTP implied predicted price increases of between 5.0 percent and 7.8 percent for inpatient services, which mapped to an annual commercial spending increase of between $37.9 and

18 Vistnes, Gregory, "Hospitals, Mergers, and Two-Stage Competition," *Antitrust Law Journal* 67, no. 3 (2000): 671–92.

19 See Opinion, *Saint Alphonsus Med. Ctr.–Nampa Inc. v. St. Luke's Health Sys., Ltd.*, No. 14-35173 (9th Cir. Feb. 10, 2015), at n.10 ("This 'two-stage model' of health care competition is 'the accepted model.'" Citing John J. Miles, 1 Health Care & Antitrust L. § 1:5 (2014)). *Complaint, In re Evanston Northwestern Healthcare Corp.*, No. 9315 (2004). See also *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1266-78 (N.D. Ill. 1989), aff'd, 898 F.2d 1278 (7th Cir. 1990); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559 (6th Cir. 2014); *St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775 (9th Cir. 2015); *FTC et al. v. Advocate Health Care et al.*, No. 15 C 11473 (7th Cir. Oct. 31, 2016); and *FTC et al. v. Penn State Hershey Medical Center et al.*, No. 1:15-cv-2363 (3d Cir. June 2016). For a summary of these cases and a discussion of implications, see Capps, Cory, Laura Kmitch, Zenon Zabinski & Slava Zayats, "The Continuing Saga of Hospital Merger Enforcement," *Antitrust Law Journal*, forthcoming.

20 See Gowrisankaran, Gautam, Aviv Nevo & Robert Town, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *American Economic Review* 105, no. 1 (2015): 172–203; Capps, Cory, David Dranove & Mark Satterthwaite, "Competition and Market Power in Option Demand Markets," *RAND Journal of Economics* (2003): 737–63; Town, Robert & Gregory Vistnes, "Hospital Competition in HMO Networks," *Journal of Health Economics* 20, no. 5 (2001): 733–53.

21 For example, if a network that includes a given hospital is worth $10 million to a health plan's customers and one that does not is worth $8 million, then the WTP for that hospital will equal the difference, $2 million.

22 Capps, Dranove & Satterthwaite (2003) and Town & Vistnes (2001). Related research by Professor Katherine Ho of Columbia University has established that having a network of hospitals with higher WTP increases the demand for a health plan. Ho, Katherine, "The Welfare Effects of Restricted Hospital Choice in the US Medical Care Market," *Journal of Applied Econometrics* 21, no. 7 (2006): 1039–79; Gaynor, Martin, Kate Ho & Robert J. Town, "The Industrial Organization of Health-Care Markets," *Journal of Economic Literature* 53, no. 2 (2015): 235–84.

23 Final CMIR Report, 50.

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$59.2 million compared to pre-merger spending for those services.[24]

The HPC also considered retrospective analyses of prior acquisitions by the parties. Their past transactions, which entailed lower competitive overlap and lesser competitive concern, showed no evidence of significant price increases post-merger. As stated by the HPC, "[a]s Lahey and BIDCO have grown by affiliating with or acquiring new community hospitals, their prices have not generally risen relative to competitors, and their spending has grown at generally the same rate as the rest of the market based on current available data."[25] In the BILH transaction, the HPC concluded that the greater competitive overlap between the merging parties implied a higher risk of price increases than in previous transactions.[26]

B. Care Retention and Redirection

The price increase predicted by the WTP model is an all-else-equal measure of the extent of competition eliminated by a merger. Specifically, the standard WTP analysis does not incorporate other factors that might reduce inpatient spending, such as care retention and redirection, more viable narrow-network products, or dynamic effects of intensified competition between Partners and BILH. Accordingly, the HPC further evaluated whether the price increases predicted under the baseline WTP analysis could be offset if BILH were to become a more effective competitor to the higher-priced Partners.

The most direct mechanism by which healthcare spending could fall would be for BILH to shift volume away from Partners.[27] BILH could attract volume from Partners by increasing retention of existing BILH primary care patients, increasing the attractiveness of the system for patients through enhanced branding, or recruiting new physicians to the system. The HPC considered potential cost savings from each of these mechanisms. But several factors could attenuate or eliminate such savings. First, BILH could draw volume from lower-priced hospitals as well as from Partners, in which case the relative magnitude of each shift would determine the effect on overall spending. Second, if BILH were to increase its prices, then the per patient savings from attracting patients from Partners would shrink while the per patient spending increase from attracting patients from lower-priced hospitals would grow.[28] The HPC also evaluated these potential offsets to savings.

Retention of Existing BILH Patients. The HPC analyzed non-BILH hospital utilization by the parties' existing patients. It estimated that, assuming BILH's projections of post-merger patient retention could be achieved, increased retention of existing primary care patients would reduce spending by $2.5 million to $4.6 million annually for inpatient and outpatient services, after accounting for predicted post-merger price changes.[29]

Brand Enhancement. The HPC used the same hospital choice model that underlies the WTP analysis to predict the hospitals from which BILH, with an enhanced brand, would draw additional patients. It found that 56 percent of new commercial inpatient volume would likely come from Partners, 13.5 percent from Wellforce, 9.7 percent from Steward, and the remainder from other hospitals.[30] Again, relying on the parties' projected post-merger volume increase, the HPC estimated that enhanced branding could lead to $1.1 million to $2.5 million in net post-merger savings after incorporating likely post-merger price increases.[31]

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24 Final CMIR Report, 51. The HPC also estimated spending increases of $78.9 million to $100.0 million for outpatient facility services and $11.5 million for adult primary care services. Final CMIR Report, 52. The parties contended that HPC's price prediction did not take into account the Massachusetts regulatory environment, including the healthcare cost growth benchmark for healthcare providers (Chapter 224 of the Acts of 2012). In response, the HPC stated that the price prediction is based on price data from after the implementation of the benchmark, and that the benchmark is not intended to function as a price cap for individual providers. Final CMIR Report, Exhibit B at 12.

25 Final CMIR Report, 3.

26 Final CMIR Report, note 123.

27 BILH could also achieve additional cost savings by shifting patient volume within BILH away from BIDMC and Lahey Medical Center to less expensive BILH hospitals. The HPC estimated that this could generate about $2 million to $3 million in annual savings. Final CMIR Report, 61.

28 Final CMIR Report, 57–59.

29 Final CMIR Report, 58–59.

30 Final CMIR Report, 59. The WTP analysis relied on a choice model that predicts patients' choices of hospital based on hospital and patient characteristics. The model included a "hospital fixed effect" specific to each hospital that captures unobserved hospital characteristics, such as brand, that are valued by patients. To study the effect of enhanced brand, the HPC increased the fixed effect of the parties' hospitals by an amount sufficient to generate a specified amount of additional volume (e.g. 10 percent). Predictions derived from the model with the increased BILH fixed effects identify the hospitals from which additional patients would likely come. Final CMIR Report, note 204.

31 Final CMIR Report, 59–60.

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Physician Recruitment. To evaluate the effect of BILH recruiting new primary care patients through physician recruitment or brand enhancement, the HPC compared the total medical expenses ("TME") for the parties' physician groups with that of other groups in the parties' service areas. It found that, on average, the parties' patients had $32 per member per month lower TME than patients of other groups. To achieve cost savings sufficient to offset the projected price increases, the HPC estimated the parties would need to attract 333,000 to 443,000 new patients. This is approximately the total patient population of the largest three commercial payers in the area, which is an implausibly high number.[32]

Discussion. Overall, the HPC concluded that any plausible shifts in volume from Partners to BILH would be insufficient to offset likely post-merger price increases by the parties.[33] One factor that limits savings from volume shifts is that savings accrue only on marginal (i.e., redirected) patients, whereas a post-merger price increase would apply to all of the system's patients. As a result, for shifts in volume to achieve meaningful net savings, the total number of patients who change providers post-merger must be large. In addition, increased attractiveness and utilization of BILH would likely make it more difficult for health plans to exclude the combined system from their networks, which would further increase the system's bargaining leverage and potential post-merger price increases (over and above the effect of internalized substitution as measured by the WTP analysis).

An open question, however, is the effect an enhanced BILH would have on the bargaining leverage of *other* systems, particularly that of Partners. At present, the economic literature provides little direct guidance. At one end of the spectrum, BILH might become a second "must-have" system in the area behind Partners, solidifying its bargaining position without significantly chipping away at Partners' market power. At the other end, if BILH were to become a true substitute for Partners, the merger could diminish or remove Partners' must-have status.[34] The parties, of course, argued that the latter is more likely.[35]

To measure the potential effects of an enhanced BILH on bargaining leverage and prices, the HPC considered how a 10 percent increase in BILH's volume (consistent with the parties' expectations) would change WTP for all Boston-area hospital systems. It found that the decrease in WTP for Partners would generate about a 0.7 to 1.1 percent decrease in Partners' prices and savings of $8.8 to $13.8 million. The decrease in WTP for the other systems would lead to price decreases implying predicted savings of $3.1 to $4.9 million. However, the enhanced brand of BILH would allow it to negotiate higher prices, increasing inpatient spending by $14.9 to $23.3 million. Thus, the HPC concluded that an enhanced BILH brand would only generate overall savings if BILH agreed to cap post-merger price increases.[36]

A relevant question from an antitrust perspective is whether these effects are merger specific. The answer will depend on the merger under consideration. In general, there may be certain investments with returns to scale that would be profitable for a larger system to undertake, but not for a smaller system. For example, marketing expenditures to grow a system's reputation are likely to benefit every hospital in the system. A larger system, then, may benefit more from a marketing campaign with a fixed budget. Even when such investments can be identified, a full antitrust analysis would also consider whether an alternative affiliation short of a merger could facilitate the same outcome.

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32 Final CMIR Report, 60–61.

33 Final CMIR Report, 62.

34 Shaked & Sutton provide a theoretical discussion of how quality differentiation between firms can weaken price competition between them and, conversely, how reduced quality differentiation can intensify competition. A more attractive BILH could reduce differentiation and thereby increase the price competition faced by Partners. Shaked, Ayner & John Sutton, "Relaxing Price Competition through Product Differentiation," *Review of Economic Studies* 49, no. 1 (1982): 3–13.

35 From its review of past hospital mergers in other markets, the HPC did identify one instance in which a merger of smaller competitors may have enhanced competition with the market leader. OSF HealthCare's Saint Francis Medical Center ("SFMC") had long been the market leader in Peoria, Illinois, and was included in nearly all commercial insurance networks, while its rival, Methodist Medical Center ("MMC"), was included in fewer networks. After MMC acquired two smaller hospitals in the area and affiliated with a larger regional system, UnityPoint Health, BCBS of Illinois terminated its contract with SFMC and replaced it with MMC. Ultimately, SFMC was added back to the network, presumably at a price lower than what had led to the termination. It is possible that the strengthening of MMC enabled to become a more effective substitute for SFMC. Final CMIR Report, 65 at n. 226.

36 Final CMIR Report, 67.

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C. Anchor for New Insurance Products

The parties also argued that the geographic reach of the new system would allow it to anchor new tiered- or narrow-network insurance products. In general, economic research has shown that narrow-network plans commonly have lower premiums, which can benefit consumers.[37] These plans may achieve lower costs by excluding higher-priced hospitals from the network or by placing them on a lower tier, steering patients to less expensive providers. Hospitals may also be willing to accept lower prices from a narrow-network plan if inclusion generates sufficient additional volume.

A free rider problem could limit the effectiveness of the latter mechanism, however. A hospital in a narrow-network plan will have an incentive to lower its prices if doing so results in lower plan premiums that attract new enrollees to the plan and thus additional volume for the hospital. However, including multiple competing hospital systems in a narrow network dilutes this incentive because each system individually bears the cost of decreasing its prices, but all systems collectively share the additional patient volume that stems from increased enrollment. A merger between these hospitals could help internalize the volume benefits of cutting prices, making price decreases more likely.

The HPC investigated whether the creation of BILH could enhance competition through more effective narrow-network products. It observed that the three largest commercial payers in the Boston area already offer plans that include BIDCO and Lahey and exclude Partners, but that these products tend to have low enrollment.[38] For a new narrow-network product to draw significant volume away from higher-priced providers, it would need to offer lower premiums than existing narrow-network products. Post-merger, the combined BILH system theoretically would have a greater incentive to lower its prices for narrow-network products. If such price decreases materialized and were effective, they could also lead rival hospitals and health plans to respond by lowering their own prices and premiums. However, when asked, the parties stated that they did not intend to lower prices post-merger.[39] Accordingly, the HPC concluded that price decreases were unlikely to be realized.

III. CONCLUSION

The HPC identified mechanisms by which the formation of BILH could lead to higher prices and increased healthcare spending, as well as mechanisms by which BILH could reduce healthcare spending. It used economic analysis to quantify the mechanisms, spending-increasing and spending-decreasing alike, that were amenable to quantification. The HPC generally found that the likely net effect was to increase spending. However, while it recognized the potential benefits of creating a stronger competitor to the market leader, Partners, the HPC was not able to fully quantify the spending decreases that might result were that to occur. As noted, this is in large part because the economic literature does not provide significant guidance into the circumstances under which eliminating existing competitors while simultaneously creating a closer second competitor to a market leader will increase competition and lower spending, much less by how much. Based on the final outcome, the Massachusetts Attorney General appears to have concluded that this potential benefit, in conjunction with BILH's price growth cap and other commitments, was sufficient for the Commonwealth to allow the merger to close.

This naturally leads to the question of the implications for other healthcare transactions, particularly those in which conduct remedies are on offer. While it is difficult to be certain, the BILH outcome appears largely specific to the institutions and market circumstances in Massachusetts. As one example, the weight placed on creating a stronger competitor to the market leader in this instance is unlikely to imply that mergers *generally* will go unchallenged or be solvable via conduct remedies if they do not involve the market leader. Moreover, Massachusetts' agencies have a long track record of collecting claims and other data and using those data to monitor and report on provider pricing. Other states may be less able to monitor and track prices, which could make price restrictions less effective and less attractive.

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37 See *supra* note 7.

38 Final CMIR Report, note 221.

39 Final CMIR Report, notes 223, 224.

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Indeed, the FTC's recent history shows that its enforcement decisions can go either way. Just three years ago, the FTC strongly (but unsuccessfully) opposed an effort by another state to allow a hospital merger to proceed under a conduct remedy.[40] Here, the FTC issued a statement upon closing its investigation of the BILH transaction, stating, "The assessment of whether to take enforcement action was a close call. However, based on Commission staff's work and in light of the settlement obtained by the Massachusetts AG, we have decided to close this investigation."[41] Thus, the FTC found that the facts, economic analysis, and remedies sufficiently outweighed the risk of harm, but not by a large margin.

40 Letter from Alexis J. Gilman, Assistant Director, Bureau of Competition, Federal Trade Commission, to Cynthia H. Dellinger, Assistant General Counsel, West Virginia Health Care Authority, and Douglas L. Davis, Assistant Attorney General, West Virginia, *RE Cabell Huntington Hospital Inc.'s Application for Approval of Cooperative Agreement* (Apr. 18, 2016), https://www.ftc.gov/system/files/documents/public_statements/945863/160418virginiahealthcare.pdf.

41 See *supra* note 11.

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