



**AAI's Series on Competition in the Delivery
and Payment of Healthcare Services**

**PART I
CONSOLIDATION IN PROVIDER AND INSURER MARKETS:
ENFORCEMENT ISSUES AND PRIORITIES**

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I. Introduction

The U.S. healthcare sector is undergoing rapid change. Providers and payers are adopting new organizational forms as payment methods and delivery models transform. Some of the changes underway have been spurred by the Affordable Care Act (ACA). Others are the result of market forces and sectoral changes that were long underway before the ACA was passed. Still others are in anticipation of a new policy direction from Republican policymakers. And virtually all changes in some way relate to the private sector's efforts to adapt to new revenue models and technologies.

Many of these forces have created strong financial incentives for assorted healthcare entities to join forces, some opportunistically to aggregate market power, and some to bring greater value to an inefficient delivery system. Though there is little empirical doubt that competitive markets generate enormous benefits for patients and consumers, reducing the cost of healthcare while improving its quality, the need for swift and predictably pro-competitive policies may never be more pressing than it is today.

Unfortunately, the current policy environment has inherited healthcare markets that for many years suffered from inadequate antitrust attention. Among policymakers' most pressing challenges is to confront the market harms stemming from unchallenged transactions that now bestow many market participants with monopoly power. Attentive antitrust enforcement—with a particular focus on merger review—is therefore critical to assure that the pro-competitive benefits of financial and clinical integration are not thwarted by excessive concentration, collusion, or abuse of dominant positions. Pervasive market concentration stemming from inadequate enforcement in prior years

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leaves current policymakers little room for error and has raised the stakes for today's enforcement challenges.

The current challenges confronting the healthcare markets involve both a recurrence of the familiar horizontal mergers among providers and insurers and also a complex set of new vertical arrangements. Because the policy community cannot afford to continue playing catch-up, realizing the competitive harms of certain industrial realignments only after they win regulatory or judicial approval, antitrust law must be aggressive and decisive. The most recent wave of transactions pose special threats to competition in many geographic markets, in part because the competitive harms are less familiar and because the rate of integration is outpacing what traditional agency resources can police.

The foregoing problem arises in part from the rush to consolidation induced by hospitals and physicians wanting to be assured they will be in a strong bargaining position.¹ But formation of large and dominant integrated systems creates the potent risk that many local delivery markets will be deprived of effective inter-system rivalry.² Absent meaningful rivalry, horizontally and vertically integrated entities—including large health systems and Accountable Care Organizations (ACOs)—will not face incentives to innovate, conserve costs, or pass on savings to consumers.

Vigorous antitrust enforcement is even more urgent in light of current market conditions. For example, U.S. healthcare spending now amounts to over 18% of GDP and dwarfs healthcare spending in all the other OECD nations. Recent research confirms that this is predominantly because Americans pay higher prices than foreign counterparts for comparable services and products.³ Much of this pricing power has been linked to the inability and reticence of antitrust policymakers—federal agencies, state officials, and the courts—to prevent industry consolidation in the late 1980s through the mid-00s. We should bear in mind that nation's economy is paying for past policy failures, and the more unsustainable healthcare spending becomes, the more the nation can ill-afford an ambivalent competition agenda.

Part I of this White Paper series *Competition in the Delivery and Payment of Healthcare Services* identifies and analyzes the major concerns and priorities surrounding consolidation in the markets for delivery and payment of healthcare services. It is followed in Part II by an assessment of the antitrust remedies, broader alternative regulatory responses, and advocacy efforts that are needed to address systemic competition problems in healthcare. The first section of Part I addresses consolidation and market power in provider markets. This includes horizontal and vertical mergers involving hospitals, physician practices, ACOs. The second section considers consolidation in the health insurer sector, including horizontal insurer mergers and vertical mergers involving insurers and other entities, such as pharmacy benefit managers (PBMs). The final section concludes with policy recommendations.

² See Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811, 844 (2011) (“As hospitals buy up or otherwise affiliate with physician practices, as physician practices merge, and as hospitals merge with rivals, there may be little room for formation of competing ACOs in many markets.”).

³ Papanicolas I, Woskie LR & Jha AK, *Health Care Spending in the United States and Other High-Income Countries*, 319 JAMA 1024 (Mar. 13, 2018).

II. Consolidation and Market Power in Provider Markets

A. The Competitive Landscape of Provider Markets

Hospitals with a dominant position in their markets (so-called “must have” hospitals) are a major (perhaps *the* major) driver of cost in healthcare.⁴ Economic studies demonstrate that the bargaining leverage these hospitals possess enables them to obtain reimbursement at levels not explained by quality, demographics, patient mix, or other factors.⁵ Weak antitrust enforcement and erroneous judicial decisions bear much of the responsibility for the current state of affairs. Beginning in the mid-1990s, the Federal Trade Commission (FTC), U.S. Department of Justice (DOJ), and one state Attorney General (AG) accumulated seven consecutive losses in federal court cases seeking to enjoin hospital mergers. The results are the product of a variety of factors: plain judicial error, poor case selection, failure to focus on the differentiated nature of hospital markets, and perhaps a growing antipathy toward the effects of managed care and an accompanying sympathy for nonprofit providers.⁶

Mergers involving physician practices have also increased dramatically in recent years, with hospital acquisitions of physician practices growing most rapidly.⁷ Only recently have consolidations and acquisitions of physician practices garnered more than the little attention given in the past. Because of the size of the transactions involved, mergers and acquisitions of physician practices do not reach the reporting thresholds of the Hart-Scott-Rodino law and agencies have been reluctant to challenge a consummated merger and ask a court to “unscramble the egg.” In one pending case, the State of Washington sought divestiture of physician practices by a hospital that resulted in a monopoly of orthopedic physician services.⁸ The relief sought in most cases, however, has been to police the conduct of the merged practice rather than seek divestiture, a practice that does not replicate the advantages of market competition and may entrench provider dominance.

B. Horizontal Linkages Among Hospitals

In recent years, the enforcement tide has started to turn with respect to hospital mergers. Following a series of “retrospective reviews” of consummated hospital mergers, the FTC was able to

⁴ See Off. of Mass. Att’y Gen. Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 61/2(b)* (Mar. 16, 2010), available at <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf>; Claudia H. Williams, et al., *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* ROBERT WOOD JOHNSON FOUND. (2006) [hereinafter *Robert Wood Johnson Hospital Consolidation*], available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1; Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update*, ROBERT WOOD JOHNSON FOUND. 1 (2012) (reviewing economic literature and concluding that provider mergers in concentrated markets generally is linked to price increases); Martin Gaynor et al., *Making Health Care Markets Work: Competition Policy for Health Care*, 317 JAMA 1313 (2017).

⁵ *Id.*; see also Avik Roy, *Hospital Monopolies the Biggest Driver of Health Costs that Nobody Talks About*, FORBES (Aug. 22, 2011), <http://www.forbes.com/sites/theapothecary/2011/08/22/hospital-monopolies-the-biggest-driver-of-health-costs-that-nobody-talks-about>; see also Robert Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggest Policy Remedies May Be Needed*, 31 HEALTH AFF. 973, 973 (2012).

⁶ See Thomas L. Greaney, *Chicago’s Procrustean Bed: Applying Antitrust in Health Care*, 71 ANTITRUST L.J. 857 (2004); Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121 (2007).

⁷ U.S. Gov’t Accountability Office, GAO-16-189, *Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform* 9-10 (2015) (physicians practicing in vertically integrated settings increasing from approximately 96,000 to 182,000 between 2007 and 2014).

⁸ *State of Washington v. Franciscan Health System, et al.*, No. 3:17-cv-05690 (W.D. Wash. Aug. 31, 2017).

demonstrate that concentrative mergers did meaningful harm to consumers, and a post-consummation challenge to a hospital merger found that the merger violated the Clayton Act.⁹ The FTC has since won several important challenges to hospital mergers in federal court,¹⁰ and questionable combinations have been abandoned when agency scrutiny was focused on them.¹¹ These decisions are particularly noteworthy because they apply sound economic analysis to clarify, and in some cases correct, past judicial mistakes.

For example, relying on the testimony of reliable third parties, particularly payers and economists applying sophisticated analyses under the Merger Guidelines hypothetical monopolist test, courts have found that competition among hospitals for primary and secondary acute care services is local.¹² Notably these cases have rejected the approach of early hospital merger cases—discredited by sound economic analyses—that resulted in overly broad geographic market definitions and excused mergers to near monopoly.¹³ In addition, courts have rejected simplistic justifications (the “ACA made me do it” defense) and related claims that the ACA’s encouragement of cost-effective integration of provider services somehow amounts to a limitation on the antitrust laws.¹⁴ Likewise, arguments that the presence of large insurance companies with purchasing power should mitigate concerns about mergers to monopoly have been rejected.¹⁵

Last, and perhaps most important, courts have adopted economic learning on how hospitals compete. This analysis finds that hospital care is purchased in “two stages.” In the first, which is highly price-sensitive, insurers and hospitals negotiate to determine whether the hospitals will be in the insurers’ networks and how much the insurers will pay them. In the second stage, hospitals compete to attract patients, based primarily on non-price factors like convenience and reputation for quality.¹⁶ Since insured patients are generally insensitive to retail hospital prices while insurers

⁹ *In re Evanston Northwestern Healthcare Corporation*, Complaint Summary, FTC No. 9315 (Apr. 28, 2008), available at <http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf>.

¹⁰ *FTC v. Advocate Health Care Network*, 841 F.3d 460 (7th Cir. 2016); *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327 (3d Cir. 2016); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559 (6th Cir. 2014).

¹¹ An emboldened FTC might have also encouraged other state policymakers to openly question and voice skepticism of proposed industry consolidations. A proposed “marriage” between North Carolina’s UNC and Atrium hospital systems, for example, was abandoned after it triggered scrutiny and criticism from the state’s AG and Treasurer. *See* Deon Roberts & John Murawski, *Questions About Control Kill Merger Deal Between Atrium Health and UNC Health Care*, CHARLOTTE OBSERVER (March 3, 2018), <http://www.charlotteobserver.com/news/business/article203125129.html>.

¹² *Id.*; *see also Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd. (St. Luke's)*, 778 F.3d 775, 793 (9th Cir. 2015) (applying same analysis and finding highly localized market for primary care physician services).

¹³ *See e.g., Penn State Hershey Med. Ctr.*, 838 F.3d at 340-41 (explaining the “silent majority fallacy” which induced some courts to assume that the willingness of some individuals to travel large distance for hospital care implied that markets were equally large); *see also* Cory S. Capps, *From Rockford to Joplin and Back Again: The Impact of Economics on Hospital Merger Enforcement*, 59 ANTITRUST BULL. 443 (2014).

¹⁴ *See Penn State Hershey Med. Ctr.*, 838 F.3d at 353 (stating that it is not the court’s job to consider “the soundness of any legislative policy that may have compelled the Hospitals to undertake this merger”); *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1095 (N.D. Ill. 2012) (“defendants’ claim that the merger is essential to meet the challenges of healthcare reform is inherently difficult to evaluate” and in any event contradicted by evidence that it will remain profitable under healthcare reform).

¹⁵ *See FTC et al. v. Sanford Health, et al.*, No. 1:17-cv-00133 (D.N.D. Dec. 15, 2017); *see generally* Thomas L. Greaney, *New Health Care Symposium: Dubious Health Care Merger Justifications—The Sumo Wrestler And ‘Government Made Me Do It’ Defenses*, HEALTH AFF. BLOG (Feb. 24, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160224.053297/full>; Richard Scheffler et al. Health Affairs; Richard Scheffler et al., *Insurer Market Power Lowers Prices in Numerous Concentrated Provider Markets*, 36 HEALTH AFF. 1539 (2017).

¹⁶ Greg Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L.J. 671 (2000); Aviv Nevo, Deputy Assistant Att’y Gen., Antitrust Div., U.S. Dep’t of Justice, *Mergers that Increase Bargaining Leverage, Remarks as Prepared for the Stanford*

respond to both prices and patient preferences, this analytical approach puts the proper focus of antitrust concern on competition for network inclusion.¹⁷

Another emerging issue of concern involves combinations of hospitals serving separate geographic markets, so-called “cross-market mergers.” Recent economic analysis suggests that these mergers can have anticompetitive effects in the bargaining between the merged entity and its common customers, i.e. employers and insurers, in different geographic markets. The mechanisms have not yet been clearly established as to how such cross-market mergers create additional market power, but mounting anecdotal and casual evidence suggests that cross-market mergers are adversely affecting price competition in several healthcare markets.

One pathway in which mergers of multi-market hospital systems harm consumers might be through the contracting process with larger employers. Some industry observers suggest that common customers seek to contract with a bundle of providers and therefore consider tradeoffs between providers that are in different geographic and product markets, as opposed to tradeoffs between direct competitors. Cross-market mergers can enhance a health system’s market power by tying acquired providers to a system’s strongest “must-have” providers. Moreover, increasing the number of important providers in a system increases the number and significance of network “holes” the merged health system can threaten if the health plan does not accept the health system’s higher prices, particularly when bargaining on an all-or-nothing basis.¹⁸

In addition, health plans have recently expressed serious concerns that large hospital systems serving multiple, adjoining or nearby geographic markets have prevented plans from negotiating favorable rates.¹⁹ Recent economic studies find that large, geographically dispersed hospital systems have increasingly leveraged their market power by bargaining on an all-or-nothing basis and have raised prices beyond what would be expected due to local market advantages.²⁰

For example, research by Leemore Dafny, a former deputy director for healthcare and antitrust in the FTC Bureau of Economics, showed that out-of-market systems acquiring independent hospitals led to hospitals increasing prices by 7-10% between 1996 and 2012.²¹ Larger price effects are observed when the merging hospitals are within close proximity of each other (while remaining in separate markets) and when the merging hospitals contract with common insurers. The authors

Institute for Economic Policy Research and Cornerstone Research Conference on Antitrust in Highly Innovative Industries (Jan. 22, 2014), <https://www.justice.gov/atr/file/517781/download>.

¹⁷ *Advocate Health Care Network*, 841 F.3d at 475 (“[I]nsurers are the most relevant buyers.”).

¹⁸ Gregory Vistnes & Yanis Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79 ANTITRUST L.J. 253, 255 (2013) (“[E]ven though a health plan may be able to continue marketing its plan to employers when they have one or two important ‘holes’ in their provider network, at some point a plan may have so many holes in its network that employers will be unwilling to offer that plan to their employees.”).

¹⁹ Robert Berenson et al., *supra* note 5.

²⁰ Glenn A. Melnick & Katya Fonkych, *Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-Hospital Systems*, 53 INQUIRY 1, 5 (2016).

²¹ Leemore S. Dafny, Kate Ho & Robin S. Lee, *The Price Effects of Cross-Market Hospital Mergers* (Nat’l Bureau of Econ. Research, Working Paper No. 22106, 2016), <http://www.nber.org/papers/w22106> (revised June 2018); *see also* Jaime S. King & Erin Fuse Brown, *The Anticompetitive Potential of Cross-Market Mergers in Healthcare*, 11 ST. LOUIS U. J. HEALTH L. & POL’Y 43 (2018) (discussing the potential for analyzing the effects of a merger on a health plan’s entire provider network and the need for limiting principles to identify cross-market mergers with the greatest risk to competition); Matthew S. Lewis & Kevin E. Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, 48 RAND J. ECON. 579 (2017) (finding out-of-market mergers leading to price increases of 17%).

conclude that “combinations across broader areas should be carefully evaluated by antitrust authorities, particularly if customers (such as employers) value insurance products containing both merging parties, if there is significant commuting between the areas where the merging parties are located, and/or if the same insurers are dominant.”²² At the very least, enforcers should be sensitive to findings that traditional techniques to define geographic markets would fail to identify anticompetitive consequences from such cross-market mergers.²³

Research on cross-market mergers has appropriately accelerated in recent years, as the incidence of cross-market mergers has risen exponentially. Academics will need to focus research efforts to determine—and be able to testify convincingly on—the consequences of such mergers before they evade adequate scrutiny. Similarly, the FTC must be attentive to this new wave of regional mergers and will likely need to employ alternative strategies to assess and block cross-market mergers that are expected to inflict anticompetitive harm.²⁴

C. Horizontal Linkages Among Physicians

The FTC’s first challenge to a physician merger commenced in 2012 and involved the acquisitions by the largest hospital system in the Reno, Nevada area of two cardiology groups. The merger would have resulted in the system employing 88% of the active cardiologists in the market. The FTC entered into a consent order that did not enjoin the merger but rather required the system to release physicians from covenants so as not to compete.²⁵ Subsequently, in *Saint Alphonsus Medical Center-Nampa & FTC v. St. Luke’s Health System [St. Luke’s]*,²⁶ the FTC prevailed in a challenge against the acquisition of Saltzer, a physician group, with the hospital system, St. Luke’s.

Saltzer is the largest and most prestigious group of primary care physicians (PCPs) in Nampa, Idaho; a city located about 20 miles west of Boise, the state capital and largest city in Idaho. With this acquisition, St. Luke’s added sixteen PCPs to the seven it had previously acquired, giving it approximately 80% of the PCPs practicing in the Nampa market. Examining the merger as a horizontal combination in the market for adult primary care physician services in a highly localized geographic market of Nampa, the U.S. Court of Appeals for the Ninth Circuit affirmed a district court’s decision that St. Luke’s acquisition violated Section 7.

These successful challenges to hospital acquisitions of physician practices can send an important signal that consolidation of physician practices, like hospital consolidation, can undermine market efficiency by strengthening providers’ bargaining power. Moreover, the *St. Luke’s* case established important precedents that should guide future inquiries. For example, the district court considered a variety of facts that were likely to influence whether entry would prove “timely, likely, and sufficient in its magnitude, character, and scope to deter or counteract the competitive effects” of the

²² *Id.* See also Mitchell D. Raup & Herbert F. Allen, *Can Mergers Between Healthcare Providers in Different Markets Raise Antitrust Concerns?* “Yes,” *Say Top Enforcers at FTC and DOJ*, POSINELLI (March 2015) (summary of Professor Dafny’s talk at 2015 FTC & DOJ workshop), <http://sftp.polsinelli.com/publications/at/upd0315-1at.htm>.

²³ Lewis, *supra* note 21 (summarizing research and concluding “hospitals in different, nearby, markets can constrain one another’s pricing because contracting occurs at broader geographic units.”).

²⁴ See King & Fuse Brown, *supra* note 21 (discussing litigation issues in potential challenges to cross-market mergers).

²⁵ *In the Matter of Renown Health*, FTC No. C-4366 (Dec. 4, 2012), available at www.ftc.gov/enforcement/cases-proceedings/1110101/renown-health-matter.

²⁶ *St. Luke’s*, 778 F.3d at 791.

proposed transaction.²⁷ The court relied on factors such as the disinclination of young doctors to live in the relevant market, past difficulties in recruiting physicians, and the time involved in earning a reputation to compete with established practices.²⁸

Another important issue raised in *St. Luke's* was the dimension of the geographic market for adult primary care services. The district court rejected arguments that the willingness of a significant number of Nampa residents to receive care in neighboring Boise was sufficient to extend the boundaries of the market. A final issue, and probably the most vigorously contested question in the *St. Luke's* case, concerned the assessment and weighing of efficiencies flowing from integration made possible by the merger.

For example, the merging parties claimed that the transaction would create vertical linkages that would align care and integrate delivery of services, which in turn would facilitate cost-saving, efficiency-enhancing reforms. While acknowledging potential benefits from integration,²⁹ the district court, citing the Merger Guidelines, found the claimed efficiencies not “likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects.”³⁰

More recently, a federal district court enjoined a proposed acquisition by the leading hospital in Bismark-Mandan, North Dakota area of a multispecialty group practice.³¹ The court found the acquisition would substantially lessen competition in four distinct physician service lines, primary care services, pediatric services, obstetrics and gynecology services, and general surgery services. The court adopted the two-stage competition framework discussed above and relied on testimony of the three primary commercial insurance payers to conclude the market for these services was local and would result in post-merger market shares ranging from 86% to 100% in the four physician services.

Notably, the court rejected the “power buyer” defense that was predicated on the fact that the dominant payer in North Dakota had a statewide share of 55-65% of the commercial health insurance market. It concluded that payers including the dominant insurer lacked a meaningful alternative for physician services and that the sole competing hospital would not be able to recruit physicians or expand capacity to counter the market power of the defendant system in physician services. In addition, the court closely examined claims that new entry would obviate competitive concerns. It found that practical barriers to recruiting a sufficient number of physicians and the lag time inherent in establishing viable practices made it unlikely that entry would be timely or sufficient to restore competition to pre-merger levels.

These cases serve as reminders that FTC and state AGs need to be especially vigilant in monitoring physician acquisitions regardless of the size of the market. Recent research indicates that almost all

²⁷ *Id.* (citing Dep’t of Justice & FTC 2010 Merger Guidelines §9) (district court’s holding on entry issues was not contested on appeal).

²⁸ *Id.* (expert testimony detailed the delays inherent in “ramping up” a new practice).

²⁹ *St. Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys.*, 2014 U.S. Dist. LEXIS 182869, at *62 (D. Idaho, Jan. 24, 2014) (hinting at a potential conflict between the antitrust laws and the innovations encouraged by health reform: “In a world that was not governed by the Clayton Act, the best result might be to approve the Acquisition and monitor its outcome to see if the predicted price increases actually occurred. In other words, the Acquisition could serve as a controlled experiment.”).

³⁰ *Id.* at *57. (quoting Dep’t of Justice & Fed. Trade Comm’n Merger Guidelines §10).

³¹ *Fed. Trade Comm’n et al. v. Sanford Health, et al.*, No. 1:17-cv-00133 (D.N.D. Dec. 15 2017).

physician mergers are not reportable under Hart-Scott-Rodino thresholds, and hence may escape notice of enforcers before concentration.³² Moreover, much of the increase in concentration has occurred through small acquisitions that may not exceed Merger Guidelines standards. Enforcers therefore should in some cases consider challenging horizontal acquisitions that while causing only modest increases in market share, nevertheless are evidence of an observable trend toward increased concentration.³³

Enforcers should also build upon the precedents in horizontal cases to investigate and challenge anticompetitive hospital acquisitions of physician practices that are purely vertical. Although private plaintiffs fully litigated the vertical aspects of the acquisition in the *St. Luke's* case, the court chose to rely solely on horizontal issues presented by the FTC, perhaps illustrating that horizontal theories offer more reliable strategies to stop anticompetitive acquisitions.

D. Vertical Linkages of Hospitals and Physicians

Vertical linkages between hospitals with market power and physician practices present critical implications for competition. As discussed above, many acquisitions of physician practices by hospital systems also present important horizontal concerns because of the acquiring hospital's ownership of other physician practices. Antitrust enforcers have tended to challenge these acquisitions on horizontal grounds rather than on more difficult vertical theories. Nevertheless, antitrust precedent has long recognized several kinds of anticompetitive effects that can flow from vertical mergers—foreclosure; raising rivals' costs; increased anticompetitive coordination; and regulatory evasion.³⁴ The *St. Luke's* case illustrates that both enforcers and courts shy away from relying on vertical theories to block anticompetitive acquisitions when horizontal theories are available. Nonetheless, the antitrust community will eventually have to confront the legality of dominant hospitals acquiring physician practices. Nationwide, the pace of physician practices joining hospitals and health systems continues to accelerate, causing the share of physicians employed by hospitals to rise from 25% to 42% from 2012-2016.³⁵

The core concern with hospital acquisitions of physician practices is that they may foreclose rival hospitals and potential entrants in the hospital services market, preventing such competitors from obtaining a sufficient base of patients and depriving access to physicians to admit, treat, or refer to their facilities. The economic harm visited on consumers may flow from either (1) elimination of rival hospitals from competing in a hospital service market so as to increase the market power of the integrated hospital in a service market or (2) foreclosure of the non-vertically consolidated hospitals resulting, causing higher average costs, higher prices, and less formidable competitive challenges to vertically integrated hospitals with market power.³⁶

³² Cory Capps et al., *Physician Practice Consolidation Driven by Small Acquisitions, So Antitrust Agencies Have Few Tools to Intervene*, 36 HEALTH AFF. 1556 (2017).

³³ *Brown Shoe Co. v. U.S.*, 370 U.S. 294 (1962).

³⁴ See generally Phillip E. Areeda & Herbert Hovenkamp, ANTITRUST LAW ¶¶ 756-57 (3d ed. 2008); see also Steven C. Salop & Daniel P. Culley, *Potential Competitive Effects of Vertical Mergers: A How-To Guide for Practitioners*, GEO. UNIV. L. CTR. 28-30 (2014), <http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=2404&context=facpub>.

³⁵ Avalere Health & Physicians Advocacy Institute, *Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2016*, PHYSICIANS ADVOCACY INST. (2018).

³⁶ See Declaration of Debra Haas-Wilson ¶ 93, *St. Luke's*, 2014 WL 407446 (No. 1:12-CV-00560- BLW), 2012 WL 9515607 [hereinafter *Debra Haas-Wilson Declaration*].

One particularly costly consequence of such foreclosure is that it enshrines hospital-based care as the prevailing model and denies referrals to lower-cost alternatives, such as ambulatory clinics, outpatient facilities, or specialized providers. These vertical linkages not only foreclose competition but also sustain the market dominance of the costliest centers for healthcare services. Close scrutiny of vertical mergers is therefore warranted for many of the same reasons discussed earlier with respect to hospital mergers. Formation of large and dominant integrated systems creates the risk that many local delivery markets will be deprived of effective inter-system rivalry.³⁷

A number of recent studies indicate that hospital acquisition of physician practices is associated with higher prices for physician services.³⁸ These higher costs spill over to government programs as well. MedPAC has found that Medicare prices increase because the higher prices attributable to the market power of hospitals that acquire physician practices.³⁹ Moreover, preserving physician independence in concentrated markets can have salutary effects, such as increasing incentives to form stand-alone facilities, such as specialty hospitals and ambulatory surgical facilities that will compete with dominant acute care hospitals. Given the many alternative methods of achieving the benefits of clinical and economic integration,⁴⁰ the risks associated with turning a blind eye to vertical mergers is apparent, and the urgency of developing robust theories and aggressive enforcement actions against vertical linkages is growing.⁴¹

E. Accountable Care Organizations

Some policymakers and industry leaders have offered ACOs as an organizational solution to a healthcare delivery system plagued by duplicative services, avoidable errors, and other impediments to efficiency and quality. Since ACOs generally involve some form of organizational integration of providers, the concerns discussed above with respect to physician and hospital consolidation apply to their formation and operation. ACOs, in theory, could offer an attractive solution to problems stemming from the complexity and fragmentation of the healthcare delivery system.⁴² Together with good information systems and compensation arrangements, vertical integration of complementary healthcare entities can achieve important efficiencies by reducing medical errors, eliminating

³⁷ See Thomas L. Greaney & Douglas Ross, *Navigating Through the Fog of Vertical Merger Law: A Guide to Counseling Hospital-Physician Consolidation Under the Clayton Act*, 91 U. WASH. L. REV. 199 (2016).

³⁸ Laurence C. Baker, M. Kate Bundorf & Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, 33 HEALTH AFF. 756 (2014); James C. Robinson & Kelly Miller, *Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California*, 312 JAMA 1663 (2014) (finding hospital-owned physician organizations had 10-20% higher total expenditures/patient than physician-owned organizations); Cory Capps, David Dranove & Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending* 1 (Inst. for Policy Research, Northwestern Univ., Working Paper No. WP-15-02, 2015) (finding that vertical integration was associated with a 13.7% increase in physician prices).

³⁹ Medicare Payment Advisory Comm'n (MedPAC), Report to the Congress: Medicare and the Health Care Delivery System 299 (June 2017).

⁴⁰ See *Debra Hass-Wilson Declaration*, *supra* note 36; see also Brief of Amici Curiae Economic Professors in support of Plaintiffs/Appellees Urging Affirmance, *St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775 (9th Cir. 2015) (No. 14-35173) ("There is little evidence that best practices cannot be adopted by physicians who are affiliated rather than owned. ACOs and other risk-bearing provider collaborations can and do take a number of different organizational forms.").

⁴¹ See Thomas L. Greaney, *The New Wave of Healthcare Mergers Does the "Vertical=Good" Maxim Apply?*, J. L. MED. & ETHICS (forthcoming 2018).

⁴² Einer Elhauge, *Why We Should Care About Health Care Fragmentation and How to Fix it*, in THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 1 (E. Elhauge ed., 2010).

duplicative services and facilities, and coordinating elements needed to deliver high-quality, patient-centered care.⁴³

Skeptics have long noted that “available evidence suggests that the cost savings [from ACOs] will be very small to nonexistent” and warn that any purported reductions in expenditures “will simply be shifted to payors in the commercial sector.”⁴⁴ In fact, early assessments of the Pioneer ACOs and the Center for Medicare & Medicaid Information (CMMI), Medicare Shared Savings Program (MSSP), indicate that ACOs thus far have generated minimal efficiencies, with savings that are apparently less than the bonus payments designed to induce those savings.⁴⁵ Others have warned, more generally, that efforts to replicate early successes in integrated delivery systems—which serve as models for reformers’ aspirations—have often failed, partly because many physicians are reluctant to forgo the lucrative possibilities of unconstrained fee-for-service practice. Additionally, physicians who do integrate with hospital systems predictably resist adhering to efficiency-enhancing management.

In contrast to the varying views on their potential benefits, there is widespread agreement that ACOs could engineer and leverage greater monopoly power in an already-concentrated healthcare market.⁴⁶ While it does not appear that the considerable consolidation that has occurred in recent years is associated with ACO development, there is evidence of defensive consolidation in response to new payment models.⁴⁷ For example, the Medicare Access and CHIP Reauthorization Act provides strong incentives for physicians to join “Alternative Payment Models” such as two-sided risk ACOs. Concerns have been raised that large hospital systems have engaged in “ACO squatting,” i.e. forming large networks that enables them to refuse to accept new payment methods in negotiating with commercial insurers.⁴⁸

⁴³ Alain C. Enthoven & Laura A. Tollen, *Competition in Health Care: It Takes Systems to Pursue Quality and Efficiency*, 427 HEALTH AFF. (2005), <http://content.healthaffairs.org/content/early/2005/09/07/hlthaff.w5.420.short>.

⁴⁴ See e.g., Jeff Goldsmith, *Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers*, 30 HEALTH AFF. 32, 35 (2011); J. Thomas Rosch, *Accountable Care Organizations: What Exactly Are We Getting?*, Remarks Before the ABA Section of Antitrust Law Forum (Nov. 17, 2011), available at <https://www.ftc.gov/public-statements/2011/11/accountable-care-organizations-what-exactly-are-we-getting>; Ezekial Emanuel & Topher Spiro, *The Coming Shock in Health-Care Cost Increases*, WALL ST. J. (Jul. 7, 2015), <http://www.wsj.com/articles/SB11301772451238044816904581084584272004382>.

⁴⁵ J. Michael McWilliams et al., *Performance in Year 1 of Pioneer Accountable Care Organizations*, 373 NEW ENG. J. MED. 777 (2015); David J. Nyweide et al., *Association of Pioneer Accountable Care Organizations vs traditional Medicare Fee for Service with Spending, Utilization, and Patient Experience*, 313 JAMA 2152 (2015); J. Michael McWilliams et al., *Early Performance of Accountable Care Organizations in Medicare*, 374 N. ENG. J. MED. 2357 (2016).

⁴⁶ Barak D. Richman & Kevin A. Schulman, *A Cautious Path Forward on Accountable Care Organizations*, 305 JAMA 602 (2011); Doug Hastings et al., *Accountable Care Organizations and Market Power Issues*, AM. HEALTH INS. PLANS (2010), https://www.lcc.leg.mn/inactive/lchca/payment_reform/ACO-White_paper.pdf; Robert A. Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699, 699 (2010) (nothing ACOs’ “potential not only to produce higher quality at lower cost but also to exacerbate the trend toward greater provider market power”); Jeff Goldsmith, *Analyzing Shifts in Economic Risks to Providers in Proposed Payment and Delivery System Reforms*, 29 HEALTH AFF. 1299, 1304 (2010) (“Whether the savings from better care coordination for Medicare patients will be offset by much higher costs to private insurers of a seemingly inevitable . . . wave of provider consolidation remains to be seen.”).

⁴⁷ Hannah T. Neprash et al., *Little Evidence Exists to Support the Expectation that Providers Would Consolidate to Enter New Payment Models*, 36 HEALTH AFF. 346 (2017).

⁴⁸ Gaynor & Town et al., *supra* note 4 at 18.

Of particular concern are ACOs that are sponsored or organized by hospitals, in which hospitals serve as an epicenter to coordinate and which any efficient delivery system would use sparingly. Because hospital investments can be designed to leverage control of ACOs to encourage referrals, rather than harness their potential efficiencies to avoid costly hospitalizations, hospital-led ACOs might facilitate the worst fears from vertical integration, described in Section II.A.2.⁴⁹ For this reason, the *St. Luke's* court's ruling was significant in affirming that the antitrust laws will apply in full force to ACOs and other consolidations that are allegedly encouraged by statutes or federal agencies.

Yet empirical evidence on some ACOs might suggest that certain forms of integration can generate hoped-for efficiencies and quality improvements. One promising finding of the CMMI MSSP program was that independent primary care ACO groups created more cost savings than did hospital-integrated groups. The authors suggested that such physicians “have stronger incentives to lower inpatient and hospital outpatient spending than groups integrated with hospitals because their shared-savings bonuses are not offset by forgone profits from reductions in hospital care.”⁵⁰

These findings are parallel to growing evidence that small, physician owned practices have lower costs and better quality than large hospital owned practices and may be able to compete successfully if allowed to develop.⁵¹ Because of the difficulties such ACOs face in raising capital and overcoming other barriers to entry, proactive regulation may be advisable, as discussed in Part II of this series. We therefore encourage the FTC and DOJ to closely review shared information from the Centers for Medicare & Medicaid Services (CMS)⁵² regarding performance (quality and cost) of MSSP and Pioneer ACOs and evaluate implications regarding the resulting effects of concentration and efficiency in commercial markets. We additionally encourage the antitrust agencies to undertake case studies on competitive performance in commercial markets in which MSSP or Pioneer ACOs exceed safety zone thresholds.

The foregoing would be useful steps in monitoring how ACOs shape competition in private healthcare markets and ensuring that MSSP and other policies do not lead to adverse consequences for private payers and consumers of healthcare. Although compelling evidence suggests that the nation's delivery system suffers from costly fragmentation and inefficient organization, there is good reason to fear that most ACOs have exacerbated the problems of consolidation more than they have generate benefits from coordination.⁵³

⁴⁹ Kevin A. Schulman & Barak D. Richman, *Reassessing ACOs and Health Care Reform*, 316 JAMA 707, 708 (2016) (“Health care delivery needs to move away from the costly infrastructure of hospitals and toward more sustainable platforms.”).

⁵⁰ McWilliams et al., *supra* note 45.

⁵¹ Martin Gaynor et al., *supra* note 4 at 18 (“[P]rimary care-centric independent ACOs can compete favorably under new value-based models...[and] likely do more to foster competition than ACOs led by hospitals or by multi-specialty groups.”).

⁵² *Medicare Shared Savings Program: Accountable Care Organizations*, 76 Fed. Reg. 67,802, 67,806-961 (Nov. 2, 2011) (in promulgating its Final Rule on ACOs, CMS promised to share information with the Federal Antitrust Agencies and work with them regarding risks of anticompetitive spillovers into commercial markets).

⁵³ Cf. Barak Richman, *How to Make Health Care Accountable When We Don't Know What Works*, HARV. BUS. REV. (2014) (“We should admit that we don't know what works and, instead, test a variety of potential solutions that could address fragmentation.”).

III. Health Insurer Mergers

A. The Competitive Landscape of Health Insurance Markets

Until recently, consolidation in the health insurance sector has faced only a handful of antitrust challenges, and those have been settled by divestitures of a relatively small portion of the overall combination of plans.⁵⁴ As a result, according to an American Medical Association (AMA) study, over 90% of regional insurance markets are highly concentrated using Merger Guidelines thresholds and 43% of Metropolitan Statistical Areas had at least one insurer with at least a 50% share of the market.⁵⁵ Consolidation has not led to benefits for consumers; instead, for example, employer premiums increased 69% from 2004 to 2014 while real median household income *declined* by over five percent since 2004.⁵⁶ Economic studies confirm that plan competition makes a difference: mergers of health insurers resulted in significant premium increases where the combination increased market share.⁵⁷ Similarly, the analysis of competition in healthcare marketplaces (“exchanges”) suggests that markets with fewer insurers experience higher prices and entry by one large carrier would have reduced premiums in key plan offerings by 11.1%.⁵⁸

It is important to remember that the insurance industry is undergoing rapid evolution, as payers are experimenting with a variety of innovative measures to control cost and improve quality of care. In virtually every region of the country, plans are beginning to develop innovations such as “value-based payment,” “pay for performance,” and other alternative methods of provider reimbursement.⁵⁹ In addition, payers are undertaking a wide variety of new organizational relationships with providers, such as ACOs and tiered networks. As is true in every sector of the economy, competition is critical to preserving incentives to continue innovation: given the pace of change and relative early stage of these developments, preserving competition in payment and delivery models is especially important.

⁵⁴ See e.g., Complaint, *United States v. Humana, Inc.*, No. 1:12-cv-00464 (D.D.C. Mar. 27, 2012), <http://justice.gov/atr/cases/f281600/281618.pdf> (divestitures of Medicare Advantage plans in five states and in 45 counties); see also Press Release, U.S. Dep’t of Justice, *Amerigroup Corp.’s Divestiture of Its Virginia Operations Addresses Department of Justice’s Concerns with Wellpoint Inc.’s Proposed Acquisition of Amerigroup* (Nov. 28, 2012), available at <http://www.justice.gov/opa/pr/amerigroup-corp-s-divestiture-its-virginia-operations-addresses-department-justice-s-concerns> (requiring Amerigroup divest its Medicaid managed care plans in Northern Virginia).

⁵⁵ Andis Robeznieks, *Health Insurance Markets Are Highly Concentrated, New Report Reveals*, AM. MED. ASS’N WIRE (Oct. 23, 2017), <https://wire.ama-assn.org/ama-news/health-insurance-markets-are-highly-concentrated-new-report-reveals>.

⁵⁶ 2014 *Employer Health Benefits Survey*, KAISER FAM. FOUND. (Sept. 10, 2014), <http://kff.org/report-section/ehbs-2014-summary-of-findings>; *Real Median Household Income in the United States*, ECON. RES. FED. RES. BANK OF ST. LOUIS, <https://research.stlouisfed.org/fred2/series/MEHOINUSA672N> (last updated Sep. 13, 2017).

⁵⁷ Leemore Dafny et al., *Paying a Premium on Your Premium? Consolidation in the Health Insurance Industry*, 102 AM. ECON. REV. 1161 (2012); see also Douglas Wholey et al., *The Effect of Market Structure on HMO Premiums*, 14 J. OF HEALTH ECON. 81 (1995); James Robinson, *Consolidation and the Transformation of Competition in Health Insurance*, 23 HEALTH AFF. 11 (2004).

⁵⁸ Leemore Dafny et al., *More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces*, 1 AM J. HEALTH ECON. 53, 73-79 (2015).

⁵⁹ See Douglas Conrad, *Implementing Value-Based Payment Reform: Learning from the Field of Practice*, HEALTH AFF. BLOG (Apr. 14, 2015), <http://healthaffairs.org/blog/2015/04/14/implementing-value-based-payment-reform-learning-from-the-field-of-practice>.

B. Horizontal Mergers of Insurers

While some may argue that payer consolidation benefits consumers by enabling insurers to counter the market power of dominant providers, such effects cannot be presumed to occur. As a matter of economics, there is no basis to assume that offsetting market power will result in lower prices for consumers. According to the simplest theory, two monopolies—the double marginalization problem—inflict more economic harm on consumers than one monopoly, and strategic interactions between dominant insurers and providers can lead to an assortment of other anticompetitive outcomes. The health sector has ample experience with dominant insurers reaching understandings or explicit agreements with large health systems in which the two sides reciprocally agreed to protect the other’s economic interest.⁶⁰ And even if cost reductions are realized, dominant insurers lack incentives to pass them on to consumers.

The law governing health insurance mergers was clarified considerably by two successful cases brought by the DOJ at the end of 2016. These cases involved proposed mergers involving four of the nation’s five largest national commercial insurers. Aetna, the nation’s third largest insurer, proposed to acquire Humana, the fourth largest, for \$54 billion. Anthem, the second largest insurer, also sought to acquire Cigna, the fifth largest, for \$37 billion. The well-reasoned opinions in these cases establish noteworthy precedents regarding market definition and efficiency justifications that should guide future evaluations of health insurance mergers.⁶¹

Following a six-week bench trial in the Anthem-Cigna case, the district court permanently enjoined the merger on the basis of its likely substantial anticompetitive effect in two relevant markets: the market for the sale of health insurance to “national accounts” in certain states and the market for the sale of health insurance to large group employers in Richmond, Virginia.⁶² The court defined a “national account” as an employer purchasing health insurance for more than 5,000 employees across more than one state. It also found that the relevant geographic market for national accounts was the fourteen Anthem states, because that is where Anthem and Cigna currently compete most prominently, given the geographical restrictions imposed on Anthem under its Blue Cross license. It went on to find a presumption of anticompetitive effect based on the combined company’s market share, an increase in the HHI by 537 to 3000 and the fact that the merger reduced the number of competitors in the national account market from four to three.

After finding that Anthem had produced sufficient evidence to rebut the government’s *prima facie* case by demonstrating that United Healthcare, not Cigna, was Anthem’s primary competitor, and that national accounts tend to be sophisticated, well-informed customers, the court weighed the merger’s overall effect and concluded that the defendants’ efficiency justifications were wanting. The Ninth Circuit disagreed with the district court that claimed cost savings were not merger specific.

⁶⁰ See e.g., Raup & Allen, *supra* note 22; *West Penn Allegheny Health Sys. v. UPMC*, 627 F.3d 85 (3d Cir. 2010) (the Court found that University of Pittsburgh Medical Center who had a 55% share of Allegheny County market for hospital services had engaged in anticompetitive conduct when it aligned itself with the insurer Highmark who had between 60% and 80% market share since 2000, to protect one another from competition); see also *supra* Section II. A; Clark C. Havighurst & Bark D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 878 (2011) (“*Challenging Anticompetitive Terms in Insurer-Provider Contracts.*”)

⁶¹ The American Antitrust Institute closely analyzed these mergers and urged the Justice Department to take action. See Letter from Thomas L. Greaney, Professor of Law/Co-Dir., Ctr. for Health L. Studs. & Diana Moss, President, Am. Antitrust Inst., to William J. Baer, Assistant Att’y General, U.S. Dep’t of Justice, Antitrust Division (Jan. 11, 2016).

⁶² *United States v. Anthem, Inc.*, 2017 U.S. Dist. LEXIS 20707 (D.D.C., Feb. 8, 2017).

However, the court rejected the claim that efficiencies premised on alleged lower costs resulting from Anthem's ability to reduce reimbursement to physicians on the basis that it was not verifiable. It also concluded that the merger's effect on competition for large employers in Richmond Virginia was likely to substantially lessen competition based on the resulting increase in concentration (between 64% and 78%) and the absence of effective alternatives or likely entrants.

Perhaps most telling was a remark made by DOJ expert witness David Dranove, when he was asked to assess the merger's impact on innovation. Dranove's expressed concern that, once Cigna became part of the larger Anthem, it would stop innovating. (The DOJ's lead attorney, Jon Jacobs, emphasized this theme during summation, stating, "This merger will eliminate Cigna's incentive to innovate.") But Dranove made a broader observation about the industry, not just about Cigna and Anthem, when he decried the lack of industry-wide innovation among health insurers. He concluded, "My evaluation left me quite sober.... I was very concerned about the path this industry has been going on."⁶³ Dranove's lament focuses enforcers' attention on the critical need for dynamism in payment and insurance models, and it begs for an antitrust framework that assesses proposed mergers bearing in mind the industry's woeful record of innovation.⁶⁴

Simultaneous with the Anthem-Cigna merger, the DOJ, District of Columbia, and eight state AGs successfully challenged the merger of Aetna and Humana.⁶⁵ The court found the parties competed head to head in distinct markets, albeit different from the ones analyzed in the Anthem-Cigna merger. The district court found the merger would be likely substantially to lessen competition in the sale of Medicare Advantage (MA) plans in 364 counties and in the sale of commercial insurance on public exchange markets. After closely examining the switching behavior of beneficiaries between MA products and traditional Medicare, extensive econometric evidence applying the hypothetical monopolist test, differences between the coverage offered by each, and pricing strategies employed by MA firms, the court concluded that the sale of MA plans is a relevant antitrust product market.

Notably, the court was not persuaded that the government's extensive regulatory authority over MA plans provided an adequate assurance that the merger would harm consumer. Further, it closely analyzed the likelihood that a proposed purchaser of some of defendants' plans could step in and maintain the competitive status quo. Recognizing the uncertainties involved in taking over the business and the prospective buyers shortcomings, the court declined to find—as some courts have in the past—that the spinoff would obviate competitive concerns. Finally, in an interesting twist, the court rejected Aetna's claim that any harm to exchange markets was mooted by its decision to withdraw from those markets. The court found that Aetna withdrew from the individual public exchanges in three states to evade judicial scrutiny of the proposed merger and that absent this strategy future competition was likely.⁶⁶

⁶³ Jimmy Hoover, *Economist Says Anthem-Cigna Deal Will Stifle Innovation*, LAW360 (Nov. 28, 2016, 8:41 PM), <https://www.law360.com/health/articles/866453/economist-says-anthem-cigna-deal-will-stifleinnovation>.

⁶⁴ Barak D. Richman & Kevin A. Schulman, *A Novel Look at Antitrust Analysis in Health Insurance Markets*, COMPETITION POL'Y INT'L ANTITRUST CHRONICLE (July 2017).

⁶⁵ *United States v. Aetna, Inc.*, 240 F. Supp. 3d 1 (D.D.C. 2017).

⁶⁶ See Abbe R. Gluck & Thomas L. Greaney, *Court Blocks Aetna-Humana Deal: The Mega-Mergers Meet the Trump Administration Next*, HEALTH AFF. BLOG (Jan. 30, 2017),

<https://www.healthaffairs.org/doi/10.1377/hblog20170130.058511/full> (noting the court refused to "view competition as an on-off switch where a merging party can simply switch it off entirely by withdrawing from a market (potentially temporarily)").

Together the decisions in these cases set a high bar for future horizontal mergers among commercial insurers. Enforcers and courts will need to closely examine the impact of consolidations in the numerous and distinct product lines in which health insurance is sold. Moreover, claims that ease of entry, government regulation, promised efficiencies, and proposed divestiture remedies obviate competitive concerns should require strong evidentiary support.

C. Vertical Mergers Involving Insurers

A new wave of vertical mergers has recently witnessed insurers uniting with providers and others in the healthcare supply chain. For example, insurers have begun to integrate vertically with pharmacies and pharmacy benefit managers,⁶⁷ hospitals,⁶⁸ surgicenters,⁶⁹ and, as discussed above, physician groups.⁷⁰ Several of the mergers currently under review would combine formidable competitors in their respective sectors. For example, Cigna, one of the largest health insurers in the country has proposed to acquire Express Scripts, the nation's largest pharmacy benefit manager. CVS, the largest US drugstore chain and one the second largest pharmacy benefit manager, has announced an agreement to acquire Aetna, the third biggest health insurer. Moreover, the largest health insurer, UnitedHealth, which operates the third largest PBM and owns 250 urgent care centers and 200 surgical centers, is planning to acquire DaVita Medical group which operates over 300 clinics and urgent care centers and employs over 2,000 healthcare providers.⁷¹

While each of these mergers may offer some degree of integrative benefits, it is important not to ignore the potential harms and to appreciate the sheer scale involved in the transactions. Moreover, as a growing body of scholarship suggests, a reliance on Chicago School paradigms that shortchange competitive risks has resulted in lax vertical merger enforcement.⁷² A more balanced approach would identify conditions under which mergers can increase the ability or incentive for a merged firm to behave in ways that harms competition at a horizontal level. By combining inputs with distribution, for example, a vertical merger can enhance incentives for the merged firm to exclude its

⁶⁷ Katie Thomas, Reed Abelson & Chad Bray, *Cigna to Buy Express Scripts in \$52 Billion Health Care Deal*, N.Y. TIMES (March 8, 2018), <https://www.nytimes.com/2018/03/08/business/dealbook/cigna-express-scripts.html>; Michael J. de la Merced & Reed Abelson, *CVS to Buy Aetna for \$69 Billion in a Deal That May Reshape the Health Industry*, N.Y. TIMES (Dec. 3, 2017), <https://www.nytimes.com/2017/12/03/business/dealbook/cvs-is-said-to-agree-to-buy-aetna-reshaping-health-care-industry.html>.

⁶⁸ See Molly Gamble, *The Quiet Takeover: Insurers Buying Physicians and Hospitals*, BECKERS HOSP. REV. (2011), <https://www.beckershospitalreview.com/hospital-management-administration/the-quiet-takeover-insurers-buying-physicians-and-hospitals.html>; Reed Abelson, *As Health Care Changes, Insurers, Hospitals and Drugstores Team Up*, N.Y. TIMES (Nov. 26, 2017), <https://www.nytimes.com/2017/11/26/health/health-care-hospitals-insurers.html>.

⁶⁹ Reed Abelson, *UnitedHealth Group to Buy Outpatient Surgery Chain for \$2.3 Billion*, N.Y. TIMES (Jan. 9, 2017), <https://www.nytimes.com/2017/01/09/business/unitedhealth-surgical-care-affiliates.html>.

⁷⁰ Reed Abelson, *UnitedHealth Buys Large Doctors Group as Lines Blur in Health Care*, N.Y. TIMES (Dec. 6, 2017), <https://www.nytimes.com/2017/12/06/health/unitedhealth-doctors-insurance.html>.

⁷¹ Anna Wilde Mathews, *UnitedHealth to Buy Large Doctor Group for \$4.9 Billion*, WALL ST. J. (Dec. 6, 2017), <https://www.wsj.com/articles/unitedhealth-to-buy-major-doctor-group-for-4-9-billion-from-davita-1512560700>.

⁷² Steven C. Salop, *Invigorating Vertical Merger Enforcement*, 127 YALE L.J. 1962, 1963 (2018) (“Chicago School economics and laissez-faire ideology have intentionally targeted vertical merger enforcement. This assault has been largely successful. Enforcement has been infrequent, and remedies have been limited.”); Michael H. Riordan & Steven C. Salop, *Evaluating Vertical Mergers: A Post-Chicago Approach*, 63 ANTITRUST L.J. 513 (1995); see also Herbert Hovenkamp, *Robert Bork and Vertical Integration: Leverage, Foreclosure and Efficiency*, 79 ANTITRUST L.J. 983, 983 (2014) (describing and critiquing Bork’s “beguilingly simple” account of the effects of vertical mergers).

downstream or upstream rivals, either by raising their costs or cutting off their access to critical resources.⁷³

The proposed mergers of CVS and Aetna and Express Scripts and Cigna illustrate the kinds of potential harms from vertical mergers combining payment and the provision of healthcare items and services. As detailed in the AAI letter regarding CVS/Aetna⁷⁴ and other commentary,⁷⁵ the combination of the largest retail pharmacy chain (CVS) and one of the two largest PBMs (CVS-Caremark) with the third largest health insurer (Aetna) in the U.S might enhance the ability and incentive to exclude rivals and facilitate coordination. For example, CVS-Aetna will likely enjoy enhanced bargaining leverage vis-a-vis rival insurers in offering PBM services. The combined entity would likely have strong incentives to disadvantage health insurers in the formularies it develops for them or the pharmacy networks it supplies. Likewise, the merger enhances the risk of “customer foreclosure” by cutting off rivals’ access to Aetna, thus impairing competition in the retail pharmacy and PBM markets.

Further, the merger enhances risks of horizontal coordination. For example, CVS has contracted with the second largest health insurer, Anthem, to provide PBM services, which puts CVS in the position to obtain information on both Aetna and Anthem subscribers.⁷⁶ And, with the possible merger of Express-Scripts and Cigna along with United HealthCare’s ownership of a PBM subsidiary, three of nation’s largest health insurers will control over 80% of the nation’s PBM market. The risks of coordination among the three giant middlemen controlling drug and health services management are apparent.

At the same time, some insurer-led vertical mergers have the potential to offer plausible efficiencies that other mergers do not. Integrating health insurance and pharmaceutical benefits might mean that pharmaceutical benefits will no longer be considered in isolation from medical and hospital benefits. When benefits are separate, pharmaceutical products are considered a cost, even if use of these products could offset substantial costs elsewhere in the healthcare system. Examinations of Medicare Advantage plans reveal that plans that added Part D pharmaceutical benefits increased pharmaceutical spending while decreasing medical and overall spending. Thus, integration could align spending incentives so insurers with control over medical and pharmaceutical expenditures can use drugs to substitute for costlier medical services.⁷⁷ Moreover, since drug rebates are a major

⁷³ Steven C. Salop & David T. Scheffman, *Raising Rivals’ Costs: Recent Advances in the Theory of Industrial Structure*, 73 AM. ECON. REV. 267 (1983); Thomas G. Krattenmaker & Steven C. Salop, *Anticompetitive Exclusion: Raising Rivals’ Costs to Achieve Power over Price*, 96 YALE L.J. 209 (1986).

⁷⁴ Letter from Diana L. Moss, President, Am. Antitrust Inst. to Makan Delrahim, Assistant Att’y Gen., U.S. Dep’t of Justice, Antitrust Division (March, 2017).

⁷⁵ *Statement of the American Medical Association to the Subcommittee On Regulatory Reform, Commercial and Antitrust Law, Re: Competition in the Pharmaceutical Supply Chain: The Proposed Merger of CVS Health and Aetna* (Feb. 27, 2018); *Statement of George Slover, Senior Policy Council, Consumers Union, Before the Subcommittee on Regulatory Reform, Commercial and Antitrust Law House Committee on the Judiciary on Competition In the Pharmaceutical Supply Chain: The Proposed Merger Of CVS Health and Aetna* (Feb. 27, 2018), <https://judiciary.house.gov/wp-content/uploads/2018/02/Slover-Testimony.pdf>.

⁷⁶ While the merging parties may agree to adopt “firewalls” to limit the internal exchange of competitively sensitive information, there is ample cause for concern that the merging parties can adapt workarounds to the efficacy of regulatory prohibitions. See Makan Delrahim, Asst. Att’y Gen., Dep’t of Justice, Antitrust Div., Keynote Address at American Bar Association’s Antitrust Fall Forum (Nov. 16, 2017), <https://www.justice.gov/opa/speech/assistant-attorney-general-makan-delrahim-delivers-keynote-address-american-bar>.

⁷⁷ Amanda Starc & Robert J. Town, *Externalities and Benefit Design in Health Insurance* (Nat’l Bureau of Econ. Research, Working Paper No. 21783, 2105).

source of profits for stand-alone PBMs, integration could mean that decisions related to formulary tiers would be based on holistic assessments of the costs and benefits of particular drugs, rather than on profits from rebates.

In short, insurer-PBM integrations could signal a major change in the way pharmaceuticals are purchased and used, and these mergers might enable insurers to rationalize the structure of health benefits altogether.⁷⁸ Several key issues remain: are these potential benefits merger-specific, that is are there barriers to insurers entering the PBM market themselves, and do the benefits mitigate competitive harms the merger may impose? Antitrust policymakers ought, as they certainly currently are, scrutinize these mega-mergers carefully, balancing certain fears of market foreclosure with possible attractive realignments of healthcare spending. In addition, policymakers and academics alike ought swiftly to synthesize any lessons from these industrial reorganizations to inform other areas of health policy, including payment reform, insurance regulation, and Food and Drug Administration policy.

IV. Antitrust Remedies and Regulatory Alternatives

A. Conduct Versus Structural Relief

One important issue that has arisen in challenges to provider consolidation has concerned the question of remedy. Although many challenges by state AGs to hospital and physician mergers have resulted in settlements or abandonment of the acquisition,⁷⁹ some state AGs have been satisfied with so-called “conduct remedies” that allow the merger to go forward but require the merged entity to abide by certain restrictions. For example, state decrees have entailed restrictions on raising prices to commercial insurers;⁸⁰ promises that the merged entity will negotiate in “good faith”; and provisions that require the merging parties to employ “separate and independent” negotiating teams when contracting with payers.⁸¹ Several important cases rejecting proposed conduct remedies explain the

⁷⁸ See Kevin Schulman & Barak Richman, *The Evolving Pharmaceutical Benefits Market*, JAMA (April 6, 2018), <https://jamanetwork.com/journals/jama/fullarticle/2678286>.

⁷⁹ See e.g., *Commonwealth of Pennsylvania v. Urology of Central Pennsylvania, Inc., Urology Associates of Central Pennsylvania, P.C., Mid-Penn Urology, Inc. and Harrisburg Uro-Care Group* (M.D. Pa. Case No. 11-01625) (Merger of five urology practices resulting in a group constituting over half the urologists in the relevant market); *State of Maine v. MaineHealth, Maine Medical Center, Maine Cardiology Associates, P.A. and Cardiovascular consultants of Maine, P.A.* (Maine Sup. Ct. 2011) (Acquisition of the largest major cardiology practices in the Portland, Maine area by a local Hospital); see also David A. Ettinger, *Current Antitrust Issues Relating to Physician Mergers, Acquisitions and Combinations*, AM. HEALTH LAWYERS ASS'N (2012), https://www.healthlawyers.org/events/programs/materials/documents/phy12/papers/b_ettinger.pdf (describing acquisition of two cardiology practices constituting 60% of cardiologists in the relevant market by Providence Health Care in Spokane, Washington; acquisition abandoned after FTC commenced investigation).

⁸⁰ *Statement of Bureau of Competition Director Richard Feinstein on the Abandonment by Providence Health & Services of its Plan to Acquire Spokane Cardiology and Heart Clinics Northwest in Spokane, Washington*, FED. TRADE COMM'N (Apr. 8, 2011), https://www.ftc.gov/sites/default/files/documents/closing_letters/providence-health-services/spokane-cardiology-and-hearts-clinic-northwest/110321providencestatement.pdf (hospital abandoned the acquisition of the two clinics after the FTC began the investigation); see also Kristiana Garcia & Toby Singer, *Pennsylvania Attorney General Challenge to Physician Group Consolidation: Lessons for the Future*, AM. HEALTH LAWYERS ASS'N (2011), https://www.healthlawyers.org/Members/PracticeGroups/Documents/EmailAlerts/PA_AG_Challenge_Physician_Group_Consolidation_ES.pdf (Pennsylvania AG's consent decree against Urology of Central Pennsylvania is an example of a conduct remedy that may appease state enforcers and highlights the problems with creating decrees after transactions have been consummated).

⁸¹ See *Commonwealth v. Partners Healthcare Sys.*, 2015 Mass. Super. LEXIS 4, at *4-5 (Mass. Super. Ct. Jan. 29, 2015) (the FTC itself employed a conduct decree in one case); *In re Evanston Northwestern Healthcare Corp.*, FTC No. 9315, 2007 WL

difficulties with the foregoing approach.

In the *Partners Health Care Sys.* case, the Superior Court of Massachusetts rejected a proposed settlement by the state AG that entailed restrictions on pricing, bidding for managed care contracts, and future acquisitions.⁸² The court also found the proposed settlement was not in the public interest, as it would “cement Partners’[s] already strong position in the healthcare market and give it the ability, because of this market muscle, to exact higher prices from insurers for the services its providers render,” and it rejected the price caps and conduct-based remedies as being insufficient to offset the anticompetitive effects of the mergers.⁸³ Notably the court questioned its own capacity to undertake monitoring and administration of price and bargaining between the hospital system and payers.⁸⁴

Likewise in the *St. Luke’s* case discussed in Part I, the district court declined to impose a remedy requiring separate bargaining groups to negotiate with insurers, as had another district court deciding a challenge to a hospital merger.⁸⁵ In both cases the courts recognized the difficulties inherent in policing provider-payer bargaining and the perils of judicial “entanglement with the competitive process.”⁸⁶ The skepticism of the Massachusetts court is well warranted. Extensive economic evidence reviewed by the court⁸⁷ casts grave doubt on the likelihood that courts can craft regulatory decrees that can constrain market power, let alone replicate the consumer benefits of market competition. A careful examination of the issue by John Kwoka and Diana Moss well summarizes the economic impact of such remedies.⁸⁸ Kwoka further notes that:

Conduct remedies do not preserve the same number of independent entities; rather, they allow industry consolidation. Conduct remedies do not preserve incentives for independent conduct; rather, they seek to thwart the natural incentives of the merged entity to behave as a single firm. Conduct remedies are not self-enforcing; rather, they require costly monitoring in an effort to secure compliance. And for all these reasons, as my research shows, conduct remedies are generally ineffective at preventing harm to consumers and competition.⁸⁹

2286195, at *7 (Aug. 6, 2007) [hereinafter *Evanston Northwestern Healthcare Commission Decision*], (noting that they do not endorse such remedies as a general policy).

⁸² *Partners Healthcare Sys.*, 2015 Mass. Super. LEXIS 4 (among other things Partners agreed to price caps, including both a general cap on raising providers’ rates on commercial business a “total medical expense” cap on business for which Partners bore “commercial risk.” It also agreed to non-price restrictions such as enabling insurers would to purchase à la carte access to the Partners network, and prohibiting Partners from negotiating on behalf of physicians with insurers to garner higher reimbursement rates).

⁸³ *Id.* at *2-3.

⁸⁴ *Id.* at *29-30.

⁸⁵ *In re ProMedica Health System, Inc.*, FTC No. 9346, 2012 WL1155392, at *48–50 (March 28, 2012), adopted as modified, 2012 WL 2450574 (June 25, 2012).

⁸⁶ *St. Luke’s*, 778 F.3d at 793 (quoting U.S. Dep’t of Justice, *Antitrust Division Policy Guide to Merger Remedies* § II n.12 (2011)).

⁸⁷ See e.g., Commonwealth of Mass. Health Pol’y Comm’n, *Review of Partners HealthCare System’s Proposed Acquisition of Hallmark Health Corporation*, HPC-CMIR-2013-4 (Sep. 3, 2014); John E. Kwoka & Diana L. Moss, *Behavioral Merger Remedies: Evaluation and Implication for Antitrust Enforcement*, 57 ANTITRUST BULL. 979, (2012); see also Regina H. Herzlinger et al., *Market-Based Solutions to Antitrust Threats—The Rejection of the Partners Settlement*, 372 NEW ENG. J. MED. 1287 (2015).

⁸⁸ Kwoka & Moss, *supra* note 87.

⁸⁹ John E. Kwoka & Neal F. Finnegan, *Declaration of John E. Kwoka, JR., Neal F. Finnegan Distinguished Professor of Economics, Northeastern University*, AM. ANTITRUST INST., 3 (Sep. 8, 2014), <http://www.antitrustinstitute.org/sites/default/files/Kwoka%20Final.pdf>.

We similarly discourage the acceptance of conduct remedies in merger cases, and recommend that the FTC actively oppose any conduct remedies crafted by state enforcers to resolve local actions. Instead, as discussed in Part II, the Agencies should seek out proactive approaches to deal with the problem of extant hospital market power.

In addition, enforcers should reconsider employing conduct remedies to redress problematic vertical mergers.⁹⁰ Settlements imposing behavioral restrictions to limit competitive harm requires a degree of foresight and administrative skill that is generally beyond the capacity of courts and enforcers.⁹¹ Instead, enforcers should give attention to enunciating enforcement principles and developing presumptions and burden-shifting rules in litigation that, consistent with economic principles, are attentive to the risks of foreclosure, raising rivals costs and facilitating coordination.⁹²

B. Certificate of Public Advantage Laws

A number of states have sought to regulate dominant hospitals by enacting so-called Certificate of Public Advantage (COPA) laws. These laws allow state authorities to grant state-action immunity to merging healthcare entities, conditioned on continued state oversight of the consolidated entity's promises to limit price increases, maintain critical access facilities, report on quality, and invest in community- and population-health activities. Under the two-prong test for state action immunity, a merger can be immunized from federal antitrust scrutiny if it is undertaken pursuant to a "clearly articulated and affirmatively expressed state policy" and "actively supervised" by the state. Notably, the latter requirement compels states approving mergers and conferring such immunity to follow a thoroughgoing regulatory scheme that addresses the costs and benefits of the merger to consumers.

COPAs satisfying these requirements empower state regulatory agencies to immunize mergers from federal antitrust challenge while retaining supervision over the merged entity's conduct for a period of time. For example, the FTC was forced to abandon a challenge to a hospital merger to near monopoly in West Virginia after that state adopted COPA law and ultimately approved the merger.⁹³ The FTC also participated in COPA proceedings in two states over the merger of the Wellmont Health System and Mountain States spanning eastern Tennessee and southwest Virginia, arguing that the proposed merger would lessen competition in markets in both states. Both state authorities, finding that the benefits to the community under continued state oversight outweighed any potential harm from lost competition, employed COPAs to approve the merger and foreclose further FTC scrutiny.⁹⁴

⁹⁰ See *supra* notes 87, 89 and accompanying text.

⁹¹ See Delrahim, *supra* note 76; see also *United States v. Comcast Corp.*, 808 F. Supp. 2d 145 (D. D.C. 2011); Ted Johnson, *Senator Asks DOJ to Take Another Look at Comcast-NBC Universal Merger*, VARIETY (Dec. 13, 2017), www.heritage.org/technology/commentary/time-repeal-the-ftcs-common-carrier-jurisdictional-exemption-among-other.

⁹² See Salop, *supra* note 72.

⁹³ See Press Release, Fed. Trade Comm'n, *FTC Dismisses Complaint Challenging Merger of Cabell Huntington Hospital and St. Mary's Medical Center* (Jul. 6, 2016), <https://www.ftc.gov/news-events/press-releases/2016/07/ftc-dismisses-complaint-challenging-merger-cabell-huntington>.

⁹⁴ See Alex Kacik, Mountain States, *Wellmont Skirt Federal Regulation and Score Merger Approval*, Mod. Healthcare (Nov. 3, 2017).

COPA laws are problematic on a variety of grounds.⁹⁵ The list of factors to be considered are frequently numerous, conflicting, and not subject to empirical analysis or measurement.⁹⁶ Beyond the sheer volume of information necessary to address such complex policy considerations, weighing them against competitive harm is an intractable task. The statutory formulae requires that regulators evaluate and weigh incommensurables without guidance as to priorities or standards of proof. Even if standards can be accurately measured and weighed, political and practical problems abound.

Similar problems often arise when states permit “affiliations” and other horizontal joint venture agreements that allow coordinated behavior among competing hospitals. In some cases, these arrangements might be treated as a merger to the extent that they involve a combination of control and unite economic interests of the two parties. Where the affiliation is less complete, the combination may entail illegal price fixing or market allocations or may easily morph into such agreements over time. In any event, however they are labeled, affiliations that aggregate market power through horizontal combinations should be closely monitored, and state efforts to facilitate such affiliations through procedures that offer antitrust immunity should be resisted strongly.

It is important to add the political risks that are inherent in the COPA experiment. The nation’s unhappy experience with certificate of need laws provides a cautionary tale of open-ended regulatory authority that can be misdirected to serve private, rather than public interests. Moreover, administrative processes are subject to the long-recognized dangers associated with government regulation: “capture” of the process by the regulated entities; administrative inefficiency and regulatory lag; insufficient incentives for innovation; and slow response to changing market conditions. In short, there is little reason to have confidence that COPA proceedings can ascertain when consolidations will generate benefits that outweigh costs to competition, and given the weighty evidence that provider consolidations impose significant economic harm, they frequently amount to evasions of needed FTC scrutiny.

V. Policy Recommendations

Part I of this series takes a close look at the myriad competitive issues raised by ongoing consolidation in provider and insurers markets. These are multidimensional issues that raise substantive concerns for enforcers and courts. They also suggest a useful agenda for furthering academic and policy research that supports more vigorous enforcement. Some of the major takeaways from the analysis include:

- **Absent meaningful rivalry, rivals in provider and payment markets will not face incentives to innovate, conserve costs, or pass on savings to consumers. Vigorous antitrust enforcement, with a particular focus on merger review, is critical to assure that the pro-competitive benefits of financial and clinical integration are not thwarted by excessive concentration, collusion, or abuse of dominant positions.**
- **Enforcers should aggressively pursue harmful provider mergers. The FTC has recently successfully demonstrated that concentrative hospital mergers did meaningful harm to**

⁹⁵ See Thomas L. Greaney, *Coping with Concentration*, 36 HEALTH AFF. 1564 (2017).

⁹⁶ See e.g., W. Va. Code §16-29B-28(c) (requiring that the board consider evidence that a consolidation will improve quality of care, ensure the affordability of care, increase patient access to providers, enable consolidating parties to achieve cost savings, and improve the health status of the community).

consumers and judicial opinion on hospital mergers in recent years has been marked by a number of important changes, ranging from finding for more local geographic markets, to rejecting arguments that the ACA limits the antitrust laws or that large insurance companies with purchasing power should mitigate concerns about mergers to monopoly.

- Research on cross-market mergers has accelerated as their incidence has risen. The FTC should be attentive to this new wave of regional mergers and will need to employ alternative strategies to assess and block anticompetitive transactions. Further research is also needed to ensure such mergers do not evade scrutiny.
- The FTC and state AGs should be vigilant in monitoring acquisitions of physician practices. Horizontal mergers among physician practices raise familiar concerns that have heightened effects in already-concentrated markets. Less familiar but perhaps even more pernicious are vertical acquisitions of physician practices by dominant hospitals. Enforcers should consider challenging acquisitions that, while causing only modest increases in market share, contribute to a trend toward increasing concentration. Moreover, the many alternative methods of achieving the benefits of clinical and economic integration highlight the urgency of developing robust theories and aggressive enforcement actions against vertical linkages.
- There is good reason to fear that most ACOs have exacerbated the problems of consolidation more than they have generated benefits from coordination. The FTC and DOJ should work with CMS to review information and undertake case studies on competitive performance in commercial markets to evaluate implications regarding the resulting effects of concentration and efficiency in commercial markets.
- Successful challenges of commercial insurer mergers by the DOJ set a high bar for future horizontal mergers. Enforcers and courts should closely examine the impact of such mergers in distinct health insurance product markets, paying particular attention to the need for innovation in insurance markets, and require strong evidentiary support for claims that easy entry, government regulation, and proposed divestitures obviate competitive concerns.
- As vertical mergers proposals involving healthcare entities such as insurers and PBMs tick upward, enforcers should clearly enunciate enforcement principles and develop presumptions and burden-shifting rules in litigation that are attentive to the risks of foreclosure, raising rivals costs and facilitating coordination. Moreover, enforcers should avoid employing ineffective conduct remedies to redress problematic vertical mergers.
- Consent decrees containing structural remedies that constrain market power in some cases can replicate the consumer benefits of competition. However, behavioral remedies that require course to dictate and supervise competitive conduct should be discouraged in merger cases and the FTC actively should oppose any conduct remedies crafted by state enforcers. Rather, the agencies should seek proactive approaches to deal with extant hospital market power.

- **COPA proceedings are unlikely to ascertain when consolidations will generate benefits that outweigh costs to competition and administrative controls have proven to be a poor substitute for marketplace competition. Given the weighty evidence that provider consolidations impose significant economic harm, COPAs frequently amount to evasions of needed FTC scrutiny. COPAs present the danger of counteracting needed, long-awaited federal antitrust scrutiny in a political environment in which providers can lobby state and local policymakers for antitrust immunity.**