Chapter 4. Something Old, Something New: Accounting for Accountable Care in Antitrust Analysis

Robert W. McCann

Drinker Biddle & Reath LLP

If you want something new, you have to stop doing something old.

—Peter F. Drucker

Table of contents

Introduction

From the perspective of antitrust compliance and enforcement, the movement toward accountable care changes everything. Or perhaps it changes nothing. Both views have found advocates since the Affordable Care Act (ACA) became law in 2010.

On the one hand, the assumption of risk by providers, the alignment of economic incentives, and the statistical measurement and modeling of health status all argue for a larger scale of provider operations, including scale gained through merger and acquisition. Moreover, an increasing assumption of population health risk by providers may chal-

lenge some fundamental assumptions about price competition in provider markets. On the other hand, there is a great unevenness in the adoption of risk arrangements and population health management strategies across the country and understandable reluctance on the part of antitrust regulators to assume that provider collaboration and consolidation is the sine qua non for translating the theories of health reform into new models of health care delivery.

In the widely reported *St. Luke's* case, the FTC successfully challenged the acquisition of a large medical group by a hospital-based health system. That acquisition was defended in part based on the defendants' views about the efficiencies required to compete in a post-ACA marketplace. Those arguments were rejected by the court, a result that the FTC described as an "important victory."[1]

The antitrust-health reform debate is not likely to end soon. There are interesting questions that lie underneath—a few of which will be discussed in this chapter. But perhaps the most important question is what traditional antitrust enforcement views mean for innovation in health care delivery and whether those views will promote or impede the drive to make health care delivery more efficient and more effective.[2]

What Is the Debate About?

From the outset, the FTC has taken the position that the ACA is not an excuse for providers to aggregate market power notwithstanding that the Act's fundamental concept—Accountable Care Organizations (ACOs)—is built on a foundation of increased provider collaboration. Shortly after the ACA was enacted, the Director of the FTC's Bureau of Competition made a strong statement to that effect in con-

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[1]Press Release, Fed. Trade Comm'n, Statement of FTC Chairwoman Edith Ramirez on the U.S. District Court in the District of Idaho Ruling in the Matter of the Federal Trade Commission and the State of Idaho v. St. Luke's Health System Ltd. and Saltzer Medical Group, P.A. (Jan. 24, 2014), *available at* http://www.ftc.gov/news-events/press-releases/2014/01/statement-ftc-chairwoman-edith-ramirez-us-district-court-district.

[2]*See* Hoffman, A. and E. Emanuel, Reengineering US Health Care JAMA (Feb. 20, 2013) at 661 (arguing that reform to improve quality and reduce costs requires innovation and a multimodality approach).

nection with the closing of an investigation into a health system's acquisition of two specialty physician practices:[3]

> The Bureau of Competition recognizes that physicians across the country are exploring a variety of new business arrangements as part of an effort to achieve cost containment and quality objectives. Some of the new business arrangements include consolidating with other same-specialty or multi-specialty physician groups, entering into employment arrangements with hospitals, and forming other affiliations. Such arrangements have the potential to generate cost savings and quality benefits for patients. However, in some cases, such arrangements can create highly concentrated markets that may harm consumers through higher prices or lower quality of care. As is reflected by this investigation and its resolution, the Commission will aggressively enforce the antitrust laws to ensure that consolidation among health care providers will not increase health care costs in local communities across the United States.

The FTC has continued the message that collaboration is good—but only up to a point. This view has typically been couched in statements concerning the "compatibility" of the ACA and the antitrust laws, without any true acknowledgment that a fully realized accountable care marketplace may look nothing like the hospital and health care competition models on which the FTC historically has relied.

> Antitrust enforcers recognized that provider collaboration represents an innovative way to seek to lower healthcare costs and improve the quality of care. We, of course, do not want to stand in the way of those goals. At the same time, we want to ensure that the financial savings and improved patient outcomes that could result from these collaborative efforts are not lost because of increased provider concentration and coordination.[4]

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[3]Press Release, Fed. Trade Comm'n, 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 (Mar. 21, 2011), *available at* http://www.ftc.gov/sites/default/files/documents/closing__letters/providence-health-services/spokane-cardiology-and-hearts-clinic-northwest/110321providencestatement.pdf.

[4]Edith Ramirez, Chairwoman, Fed. Trade Comm'n, Keynote Address at 11th Annual Loyola Antitrust Colloquium, *Antitrust, Accountable Care Organizations, and the Promise of Health Care Reform*, at 2 (April 29, 2011), *available at* http://www.ftc.gov/sites/default/files/documents/publi

> The FTC's work and the ACA share the common goals of promoting high-quality and cost-effective health care.[5]
>
> [It is] critical to recognize that the integration of care provided to patients is fully compatible with core antitrust principles. . . . [and] there is *no tension* between rigorous antitrust enforcement and bona fide efforts to coordinate care, so long as those efforts do not result in the accumulation of market power.[6]

In point of fact, the tensions between antitrust enforcement and clinical collaboration models are real and are only beginning to come into empirical focus.

Accountable Care and the *St. Luke's* Decision

To date, *FTC v. St. Luke's Health System* is the only litigated federal antitrust enforcement action in which enhancement of accountable care activities was offered as a material argument in defense of the challenged combination.[7] Although the court expressed sympathy for the parties' objectives, it ultimately was persuaded that traditional merger analysis would not countenance the accountable care effi-

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c__statements/antitrust-accountable-careorganizations-and-promise-health-care-reform/110429loyolaspeech.pdf.

[5]Julie Brill, Commissioner, Fed. Trade Comm'n, Keynote Address at the Hal White Antitrust Conference, *Competition in Health Care Markets*, at 6 (June 9, 2014), *available at* http://www.ftc.gov/system/files/documents/public__statements/314861/140609halwhite.pdf.

[6]Deborah L. Feinstein, Director Bureau of Competition, Fed. Trade Comm'n, Fifth National Accountable Care Organization Summit, *Antitrust Enforcement in Health Care: Proscription, not Prescription*, at 2 (June 19, 2014), *available at* http://www.ftc.gov/system/files/documents/public__statements/409481/140619__aco__speech.pdf (emphasis added).

[7]Findings of Fact & Conclusions of Law at ¶ 51, Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Jan. 24, 2014), appeal dktd., No. 14-35173 (9th Cir. filed Mar. 7, 2014). Although efficiency arguments of an accountable care-related nature also were made by the defendants in the FTC's *ProMedica* and *OSF Health System* matters, they appear to have been advanced on a limited and tangential basis in those cases and in any event received little attention from the respective courts. *See* Findings of Fact and Conclusions of Law at ¶¶ 274–283, F.T.C. v. ProMedica Health System, Inc., 2011-1 Trade Cas. (CCH) ¶ 77395, 2011 WL 1219281, at *41-*42 (N.D. Ohio 2011) (primarily discussing implications for electronic health records systems); F.T.C. v. OSF Healthcare System, 852 F. Supp. 2d 1069, 1092 (N.D. Ill. 2012) (discussing clinical practice standardization).

ciency arguments. The decision illustrates the difficult path for accountable care efficiency arguments under current enforcement policies.

The Complaint. In 2013, the FTC and the Idaho Attorney General filed a complaint for an injunction to block St. Luke's Health System's (St. Luke's) acquisition of the Saltzer Medical Group (Saltzer) in Nampa, Idaho, alleging that the acquisition would substantially lessen competition for health care services in Nampa and Caldwell, Idaho.[8] In its complaint, the FTC alleged that the combination would give St. Luke's close to a 60% share of the market for primary care physician (PCP) services in the Nampa area; that Saltzer is the leading group of independent multispecialty physicians in Nampa, followed by St. Luke's, and then St. Alphonsus Health System ("St. Alphonsus"); that this combination of the two largest providers of PCP services in the Nampa area would create a highly concentrated market and was, therefore, presumptively unlawful under the DOJ/FTC Horizontal Merger Guidelines.[9]

The FTC's principal contention was a traditional horizontal merger effects allegation—that the acquisition would increase St. Luke's negotiating leverage with commercial health plans, resulting in higher prices for St. Luke's' PCP services.[10] The FTC asserted that prior to the Saltzer transaction, health plans had been able to counteract St. Luke's' leverage because there were sufficient physician alternatives, namely Saltzer and St. Alphonsus, and those alterna-

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[8]Press Release, Fed. Trade Comm'n, FTC and Idaho Attorney General Challenge St. Luke's Health System's Acquisition of Saltzer Medical Group as Anticompetitive (Mar. 12, 2013), *available at* http://www.ftc.gov/news-events/press-releases/2013/03/ftc-and-idaho-attorney-general-challenge-st-lukes-health-systems.

[9]Complaint at ¶¶ 3, 7, 12–13, 16, St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Mar. 26, 2013); U.S.Dep't of Justice & Fed. Trade Comm'n,*Horizontal Merger Guidelines* (2010), http://www.justice.gov/atr/public/guidelines/hmg-2010.pdf (hereinafter "*Merger Guidelines*" or "*Guidelines*").

[10]Complaint at ¶¶ 3–4, St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Mar. 26, 2013).

tives constrained St. Luke's pricing decisions.[11] With the elimination of Saltzer as a credible alternative to St. Luke's, however, health plans allegedly would be compelled to accept St. Luke's' price demands because they would be unable to offer a commercially viable network to employers in the Nampa area that did not include St. Luke's-Saltzer.[12] The FTC asked the court to permanently enjoin St. Luke's' acquisition of Saltzer and order that St. Luke's divest all of the assets it acquired in order to restore competition in the Nampa area.[13]

St. Luke's' Efficiency Claims. St. Luke's disputed the contention that the acquisition would lead to a loss of competition or would result in supracompetitive price increases, challenging among other things the FTC's delineation of Nampa, Idaho, as a relevant geographic market.[14] St. Luke's further argued that the combination would generate substantial efficiencies and procompetitive effects because it would enable integrated, value-based patient care consistent with the objectives of federal health reform legislation.[15] This would include shared use of St. Luke's' information technology, including electronic medical records, aligned incentives to enable a transition to value-based compensation, and provision of outcome-based care to the local population. St.

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[11]Complaint at ¶¶ 3–4, St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Mar. 26, 2013). Before the FTC and the Idaho Attorney General filed their complaint, St. Alphonsus brought suit against St. Luke's under section 7 of the Clayton Act to enjoin the acquisition. *See* Amended Complaint, St. Alphonsus Medical Center-Nampa v. St. Luke's Health Sys., Ltd., No. 1:12-cv-00560 (D. Idaho Jan. 15, 2013). That complaint alleged different theories of competitive harm than those put forth by the FTC. *See id.* St. Alphonsus' case was subsequently consolidated with the FTC's for discovery and trial. *See* Order of Consolidation, St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Mar. 19, 2013).

[12]*See* Complaint at ¶ 3, St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Mar. 26, 2013).

[13]*See* Complaint at ¶¶ 5, 25, St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Mar. 26, 2013).

[14]*See* Defendants' Corrected Proposed Findings of Fact and Conclusions of Law at ¶¶ 83–84, 188–190, St. Luke's Health System, Ltd., No. 13-cv-116 (D. Idaho Jan. 7, 2014).

[15]*See* Defendants' Corrected Proposed Findings of Fact and Conclusions of Law at ¶¶ 149, 155, 199–200, St. Luke's Health System, Ltd., No. 13-cv-116 (D. Idaho Jan. 7, 2014).

Luke's contended that these benefits could not be achieved through a less-integrated affiliation:[16]

> The transaction's benefits are merger-specific because the transaction will enhance the ability of the combined St. Luke's/Saltzer to offer coordinated, patient-centered care; to support physicians in the practice of evidence-based medicine in an environment that rewards teamwork and value of care rather than volume of care; to accept risk and accountability for patients' outcomes; and to manage population health.

St. Luke's asserted that full integration was necessary because St. Luke's and Saltzer could not achieve these benefits "as effectively or as quickly by any looser affiliation or other means."[17]

The Court's Decision. Following a four-week trial, the court ruled that St. Luke's' acquisition of Saltzer violated section 7 of the Clayton Act and the Idaho Competition Act.[18] The court permanently enjoined the acquisition and ordered St. Luke's to fully divest itself of Saltzer's physicians and assets.

The court observed that although many view the U.S. health care system as offering quality care (as is the view in Idaho), health care costs are ever-increasing at a rate that outpaces inflation. The court noted that there is a "rough consensus" that the way to address this cost-quality dilemma is to move away from our current fee-for-service reimbursement model, which rewards high volumes, not quality procedures, to a system that focuses on maintaining a patient's health and rewards successful patient outcomes, innovation, and use of less-expensive means of achieving quality care. In the court's words, "such a system would

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[16]Defendants' Corrected Proposed Findings of Fact and Conclusions of Law at ¶ 199, St. Luke's Health System, Ltd., No. 13-cv-116 (D. Idaho Jan. 7, 2014).

[17]*See* Defendants' Corrected Proposed Findings of Fact and Conclusions of Law at ¶ 199, St. Luke's Health System, Ltd., No. 13-cv-116 (D. Idaho Jan. 7, 2014).

[18]Findings of Fact & Conclusions of Law at ¶ 51, Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Jan. 24, 2014), appeal dktd., No. 14-35173 (9th Cir. filed Mar. 7, 2014).

move the focus of healthcare back to the patient, where it belongs."[19]

The court acknowledged that there has been a "broad if not slow movement" to such a system, and St. Luke's has been one of the few hospitals that saw it coming and got out in front of it. The court noted that St. Luke's began assembling physician groups who worked together to practice integrated medicine and compensated physicians based on patient outcomes—an effort for which the court said St. Luke's should be "applauded." St. Luke's' acquisition of Saltzer, the court explained, was consistent with St. Luke's' intention to improve patient outcomes, and the court believed that the Saltzer acquisition likely would achieve that objective.[20]

Nonetheless, the court read the evidence to be as alleged in the FTC's complaint and concluded that, by virtue of giving St. Luke's control of nearly 80% of the PCPs in Nampa, the Saltzer acquisition would enable St. Luke's to extract higher reimbursement rates that would be passed on to employers and consumers in higher premiums. Finding that less restrictive means were available to achieve the benefits of integrated medicine, the court concluded that the acquisition violated the antitrust laws and should be unwound.[21]

The court rejected St. Luke's' efficiency arguments because it found that the proffered efficiencies were not merger-specific, i.e., that St. Luke's could use less restrictive means than acquiring the Saltzer physicians to achieve the same procompetitive benefits of integrated medicine.[22] Relying in part on testimony from the Idaho Blue Cross plan, the court found that integrated care delivery does not require physi-

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[19]*See* Findings of Fact & Conclusions of Law at ¶ 2, Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Jan. 24, 2014), appeal dktd., No. 14-35173 (9th Cir. filed Mar. 7, 2014).

[20]*See* Findings of Fact & Conclusions of Law at ¶¶ 2–3, Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Jan. 24, 2014), appeal dktd., No. 14-35173 (9th Cir. filed Mar. 7, 2014).

[21]*See* Findings of Fact & Conclusions of Law at ¶¶ 3–4, Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Jan. 24, 2014), appeal dktd., No. 14-35173 (9th Cir. filed Mar. 7, 2014).

[22]*See* Findings of Fact & Conclusions of Law at ¶¶ 33–34, Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Jan. 24, 2014), appeal dktd., No. 14-35173 (9th Cir. filed Mar. 7, 2014).

cians to be employed and that there is no empirical evidence to suggest that an employment model is essential. The court observed that "[t]here are a number of organizational structures that will create a team of unified and committed physicians other than [one] . . . that employs physicians and [creates] a substantial concentration of market power."[23]

In the court's view, so long as the physicians are committed to improving the quality of health care and lowering costs, it is irrelevant whether they are employed or independent.[24] It concluded that because "a committed team can be assembled without employing physicians, a committed team is not a merger-specific efficiency" resulting from the acquisition.[25] The court similarly concluded that the proffered efficiencies associated with St. Luke's' use of electronic medical records could be created without employing the Saltzer physicians.[26]

The defendants have challenged this conclusion on appeal:[27]

> This analysis is woefully incomplete. In short, the court's analysis rested almost exclusively on aspirational generalities about physicians—*i.e.*, that both independent and employed physicians have their patients' best interests at heart, and that both are capable of working in a "committed team." . . . Significantly, the court made no effort to determine, on the evidence presented in this case, whether *the Saltzer physicians* could have achieved integrated care by some less restrictive means than the affiliation with St. Luke's. And the court did not address its own findings that the Saltzer physicians—

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[23]Findings of Fact & Conclusions of Law at ¶ 47, Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Jan. 24, 2014), appeal dktd., No. 14-35173 (9th Cir. filed Mar. 7, 2014).

[24]*See* Findings of Fact & Conclusions of Law at ¶ 33, Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Jan. 24, 2014), appeal dktd., No. 14-35173 (9th Cir. filed Mar. 7, 2014).

[25]Findings of Fact & Conclusions of Law at ¶ 34, Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Jan. 24, 2014), appeal dktd., No. 14-35173 (9th Cir. filed Mar. 7, 2014).

[26]*See* Findings of Fact & Conclusions of Law at ¶ 47, Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd., No. 13-cv-116 (D. Idaho Jan. 24, 2014), appeal dktd., No. 14-35173 (9th Cir. filed Mar. 7, 2014).

[27]Brief of Appellants, Saint Alphonsus Medical Center–Nampa Inc., et al. v. St. Luke's Health System, Ltd., No. 14-35173 (9th Cir. June 12, 2014) at 48–49.

despite years of efforts to move toward integrated, value-based care as an independent group—had been unable to do so.

The *St. Luke's* decision has erected a seemingly difficult barrier to the assertion of an efficiency defense built on the implementation of accountable care strategies. It is interesting to note here, however, that the FTC chose to bring this case solely as a horizontal merger challenge whereas St. Luke's' efficiency arguments pertained more directly to the vertical aspects of the combination. This is an important strategic choice for the FTC given that most provider combinations have at last some horizontal elements, and under the Merger Guidelines, horizontal market shares drive the analysis in the first instance.

Accountable Care and Merger Analysis

In exploring the intersection between health care delivery reform and the antitrust laws, it seems clear that not everyone ascribes the same meaning to health reform. This is not a surprise because the path from fee-for-service medicine to population health management—broadly described as the movement toward "accountable care"—follows no fixed course. A wide range of factors could influence the pace and direction of change in any particular market, including:

- The socio-economic characteristics of the local market, and the extent to which health care spending is putting pressure on that market.
- Market experience with insurance products other than broad-network, open-access PPOs.
- The extent of the entrepreneurial culture among physicians and other providers in the market or, conversely, their experience with cooperative delivery ventures.[28]
- The extent of commercial insurance competition in the market. If the market is dominated by a single commercial carrier, that carrier may have little incentive to push providers and consumers into new delivery

[28] *See* Gawande, A., "The Cost Conundrum," *The New Yorker* (June 1, 2009) at 36.

models, and may have little incentive to share risk and profits with providers.[29]

- A significant academic medical presence in the market, which is generally associated with both higher costs and historical consumer preferences for health plan access to academic medical centers and their faculty specialists.

Accountable care is generally described in terms of pursuing the "Triple Aim," a term coined to express the mutuality of the objectives of improving the patient experience, improving health outcomes, and reducing the total cost of care.[30] The Triple Aim embodies the premise that improving clinical processes and improving the coordination and management of care will lead simultaneously to better patient outcomes and lower expenditures. That, of course, describes a type of efficiency—producing the same or a better product at a lower total cost.

Clinical Integration. For most provider organizations, the accountable care journey has two stages. The first stage is characterized by the creation of the structures and processes of clinical integration. Although this task is more easily described than performed, the major foundational work of clinical integration typically entails:[31]

- Development and implementation of clinical protocols, and the related development and implementation of internal clinical performance measurement and reporting systems;
- Investment in information systems and related resources to support the clinical performance model,

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[29]In this regard, it is no surprise that Blue Cross of Idaho opposed the St Luke's-Saltzer acquisition.

[30]The Triple Aim is a framework for health system performance optimization articulated by the Institute for Healthcare Improvement. *See* http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx.

[31]*See generally* Grauman, D., et al., "Developing a CIN for Strategic Value," Healthcare Financial Management (July 2014); Butts, D. and M. Strilesky, "The 7 Components of a Clinical Integration Network," *Becker's Hospital Review* (Oct. 19, 2012), *available at* http://www.beckershospitalreview.com/hospital-physician-relationships/the-7-components-of-a-clinical-integration-network.html; Shields, M., et al., "A Model for Integrating Independent Physicians Into Accountable Care Organizations," 30 *Health Affairs* 161 (2011).

including efforts either to align provider investment in electronic health records systems or to enable collection of common data elements from diverse systems.
- Development and implementation of financial (compensation) models to align incentives among providers and across provider types;
- Contracting with health plans on some form of value-based payment methodology (e.g., shared savings arrangements); and
- Development of external reporting systems.

Population Health Management. As accountable care organizations evolve, their focus may likewise broaden into the assumption of responsibility for population health management (PHM). There are both broad and narrow definitions of PHM, but from a provider perspective, the term refers to coordination of care delivery across a population through disease management, case management, and demand management.[32] It involves proactive intervention for both preventive and chronic care, both during and between patient encounters.[33]

PHM techniques traditionally have been applied in the treatment of chronic conditions, such as diabetes and asthma, where ongoing monitoring and intervention can help patients control their conditions and avoid acute hospital and emergency department episodes, which in turn reduces the total cost of care across the managed population. However, PHM techniques also can be used to identify individuals within a population who are at heightened risk for developing serious conditions, such as heart disease, and initiate preventive measures designed to maintain the health status of these individuals, which likewise the effect of reducing health care expenditures. Finally, PHM techniques also can be used to assess the benefits of alternative treatments

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[32]*See* population health management (n.d.*) McGraw-Hill Concise Dictionary of Modern Medicine. (2002), available at* http://medical-dictionary.thefreedictionary.com/population+health+management.

[33]*See generally* Felt-Lisk, S. and T. Higgins, *Exploring the Promise of Population Health Management Programs to Improve Health*, Mathematica Policy Research Issue Brief (Aug. 2011), *available at* http://www.mathematica-mpr.com/~/media/publications/PDFs/health/PHM_brief.pdf; Institute for Health Technology Transformation, Population Health Management (2012) at 12, *available at* http://ihealthtran.com/pdf/PHMReport.pdf.

and interventions for individuals with a given medical condition and in some cases identify which individuals in a target population (e.g., diabetics) will benefit from a particular treatment (e.g., a particular drug or assignment of a case manager) and which individuals will not. This leads to treatment choices that are both more efficacious in the individual case and more cost-effective over the population as a whole.[34]

PHM requires significant investment in information technology and data analytics. Providers engaged in PHM require the capability to track and monitor the health of the individuals in their target population on a broad range of clinical variables and the ability to stratify the population into subgroups based on, e.g., medical condition, demographic characteristics, health status, behavioral risk, and financial risk.[35] Disease registries supported by electronic health records systems typically are the main source of actionable data and risk stratification reports.[36]

Unique attributes of provider-based accountable care. The differences between provider-based and payor-based accountable care programs are important to the antitrust efficiency debate. The fact that third party health plans can assemble arrangements resembling an accountable care organization by contracting separately with inde-

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[34]There are numerous sources on clinical predictive modeling and its use in population health management. For a general overview and explanation of predictive modeling techniques, *see* Steyerberg, E., *Clinical Prediction Models: A Practical Approach to Development, Validation, and Updating* (Springer Science & Business Media 2008). For a specific example involving diabetes treatment, *see, e.g.,* Ramsey, G. et al., "Improving Chronic Disease Care Using Predictive Modeling and Data Mining," *available at* http://www.academia.edu/450649/IMPROVING__CHRONIC__DISEASE__CARE__USING__PREDICTIVE__MODELING__AND__DATA__MINING.

[35]Institute for Health Technology Transformation, Population Health Management (2012) at 12, *available at* http://ihealthtran.com/pdf/PHMReport.pdf.

[36]Registries are patient information databases related to a specific condition and targeting interventions. Electronic medical record systems cannot perform this function because they do not provide an easy way to access or assess clinical performance status of an entire patient population. Rather, medical record systems are the source from which registry data is drawn. *See* Patel, P., et al., "Proven Methods to Achieve High Payment for Performance," *Journal of Medical Practice Management* (Jul.-Aug. 2007) at 7.

pendent providers could be construed as evidence that the same efficiencies that are achievable through provider combination also could be achieved without a combination.

However, provider-based organizations have distinct advantages that differentiate the value that they have the ability to create: A single payor has data only for its own insured population whereas a provider organization can assemble and analyze data across all payors. Payors collect data retrospectively; providers collect data in real time. Most importantly, payors have claims data; providers have clinical data, the scope of which includes, for example, laboratory results, patient history, and examination findings that improve the reliability of population health and clinical management tools.[37] Also, provider organizations are likely to be more effective in modifying clinical practice patterns when the incentives, performance measures, and expectations are common to all payors rather than unique to each payor. All of these factors represent potential efficiency gains when provider combinations seek to evolve beyond basic clinical integration and pay-for-performance contracting.[38]

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[37]Patel, P., et al., "Proven Methods to Achieve High Payment for Performance," *Journal of Medical Practice Management* (Jul.-Aug. 2007) at 6.

[38]Theoretically, community-based or state-wide health information exchanges (HIEs) could provide the same data aggregation capabilities as a large provider organization. Presently, however, most HIEs are not positioned to function as the centerpiece of a population health management initiative. Given the voluntary nature of HIE participation, utilization, and governance, many HIEs face financial sustainability challenges and have developed only limited data capabilities—much more limited than an effective population health management organization would require. (The most common HIE capabilities are care summary exchange, lab results reporting, public health reporting, and transmission of admission, discharge, and transfer messages.) *See* Millard, "State HIEs Share Lessons Learned," Healthcare IT News (Jan. 2, 2015), *available at* http://www.healthcareitnews.com/news/state-hies-share-lessons-learned; McCann, E., Most HIEs Still Not Financially Sound, Healthcare IT News (Dec, 3, 2014), *available at* http://www.healthcareitnews.com/news/most-hies-still-not-financially-sound; Office of the National Coordinator for Health Information Technology, Query-Based Exchanges: Key Factors Influencing Success and Failure (Sept. 30, 2012), *available at* http://www.healthit.gov/sites/default/files/query__based__exchange__final.pdf.

Accountable Care and Competition

There is a strong case to be made that, in the context of accountable care, the goal of provider mergers and realignment is not to eliminate competition in traditional provider markets but to create competition in new markets, specifically in health insurance markets.

Traditional Analysis. The fundamental starting assumption in hospital and health system mergers is that an increase in market share (as a surrogate for market power) will drive up the price of inpatient hospital services. The focus on inpatient services is logical—in any given geographic area, inpatient hospital services typically represent the "product market" that is most concentrated, i.e., in which there are the fewest competing firms. Antitrust regulators view inpatient services competition as occurring in two stages. In the first stage, hospitals compete with each other to be included in payor networks. In the second stage, the payors compete with each other to sell health plan products to consumers. Accordingly, to the extent providers gain leverage over payors through consolidation, the prices that payors must pay for hospital services increase, and consumers in turn pay higher health plan premiums.

The hospital merger simulation model used by the FTC to predict the "upward pricing pressure" potentially created by a merger is driven primarily by the closeness of the competition between the merging parties. Merger simulation is built on a "willingness to pay" model that attempts to estimate the value that a hospital adds to a payor's network. If there are good substitutes for that hospital, the added value is relatively small, but if no good substitutes exist, the hospital's value is greater, "giving it the leverage to negotiate a high price."[39]

The mathematics of the analysis are such that the simulation will predict at least some upward pricing pressure in every case involving a merger between direct competitors, no matter how big or small the competitors may be (assuming the competitors are both earning positive margins). Accordingly, any merger between providers that have common zip codes in their service areas will be assumed to generate a

[39]Brand, K. and C. Garmon, *Hospital Merger Simulation*, Member Briefing Paper (American Health Lawyers Association Jan. 2014).

potential price increase, with greater overlap typically predicting a larger price increase.

Shifting Assumptions. The assumptions that underlie the traditional model arise from a payment-for-volume (fee-for-service) marketplace. Providers are assumed to increase their profitability by maximizing the prices that they charge. However, in a mature payment-for-value (accountable care) model, this assumption is wrong. In arrangements that require providers to manage the total cost of care (i.e., the payor's medical loss) and achieve population health goals, inpatient hospitals are cost centers, not revenue centers. Reducing inpatient utilization through improved health status, better management of chronic conditions, and use of protocols that reduce the duration of hospital stays is a central objective of population health management.[40] If providers combine in the pursuit of accountable care, it is illogical to presume that their primary motivation is to raise prices. A mature payment-for-value market is more like a zero-sum game.

Certainly, providers will compete for inpatient volume in this situation—they will have to do so. Provider systems will need to maintain and invest in inpatient hospital resources for patients who require those services. Inpatient facilities are expensive operations, and if utilization declines as expected, and if total spending is constrained by payment-for-value arrangements, every hospital system will seek to capture additional market share to maintain the economic viability of those facilities, which may be facilitated directly or indirectly by provider combinations.[41]

In this context, the advent of the "Cadillac tax" is significant. A major provision of the ACA is a 40% nondeductible excise tax on high-cost health insurance coverage, often referred to as the "Cadillac tax."[42] This provision taxes the amount, if any, by which the monthly cost of an employee's

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[40]Lowrey, A. "A Health Provider Finds Success in Keeping Hospital Beds Empty," *New York Times* (Apr. 23, 2013) (describing a 6% decline in hospital admissions and a 9% reduction in hospital days under an accountable care arrangement implemented by Advocate Health Care).

[41]*See* Shields, M., "From Clinical Integration to Accountable Care," 20 *Annals of Helath Law* 151. 163 (2011).

[42]Internal Revenue Code § 4980I, as enacted by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010), as amended by

applicable employer-sponsored health coverage exceeds a threshold amount specified by the statute ($10,200 for individual coverage and $27,500 for family coverage).[43] The tax attributable to the sum of the excess amounts for a taxable period is determined by the employer and allocated among the coverage providers who provided the employee's coverage. The coverage provider, i.e., the insurer, employer, or plan administrator, as the case may be, is responsible for paying the excise tax. The Cadillac tax is scheduled to become effective for taxable years beginning after 2017.

In addition to raising revenue to offset the costs of other provisions of the ACA, the Cadillac tax is intended to reduce demand for high-cost health insurance coverage and indirectly to encourage coverage providers and consumers to control health care costs. The tax accordingly could be expected to put significant downward pressure on health insurance premiums and increase demand for health plan options that control the total cost of care. It also may be expected, as discussed further below, to shift employer-provided health benefits to private insurance exchanges under fixed contribution arrangements.

One expected response to this market shift will be increased efforts by health plans with the market power to do so to drive down provider reimbursement. This describes a classic "race to the bottom" in which providers (because they need to maintain patient volumes) give price concessions so as to not to be left out of health plan networks. There is some evidence of this strategy in the public health insurance exchange market. For example, Blue Cross Blue Shield of Illinois offered an exchange product ("Blue Choice") in 2013 that paid providers substantially lower rates than any existing Blue Cross product and was sold at a premium approximately 25% lower than Blue Cross' standard PPO product.

But the accountable care model posits that long-term health cost sustainability (and an effective response to the Cadillac tax) will take more than additional price conces-

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the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010) (HCERA).

[43] Internal Revenue Code § 4980I(a) and (b). The threshold amount is subject to a variety of adjustments, including an annual cost-of-living adjustment.

sions from providers. Rather, it will require care management more sophisticated than the traditional utilization review programs of health plans. Accordingly, many expect accountable care arrangements to pursue limited-network options—health plan products built on benefit designs that either require or strongly incentivize covered individuals to obtain their care exclusively from the more limited panel of providers participating in the accountable care arrangement. Such products might be offered in conjunction with a traditional insurer. Such products also might be offered directly by the accountable care organization—through direct contracts with plan administrators for specific employers or through actual entry into the licensed insurance market by the accountable care organization.

Although consumer preferences have long favored PPO plans offering unrestricted access to a broad network of providers (which preferences in turn have influenced employer plan offerings), there is a perception that consumer willingness to trade open access for lower premiums is increasing.[44] Anecdotally, the Illinois Blue Choice product described above captured an estimated 60% of the Illinois exchange market notwithstanding that many marquee health systems declined to participate in that product.

The potential of limited-network products coincides with an increasing interest in private insurance exchanges.[45] A private exchange is an on-line resource operated by brokers, insurance carriers, or benefit consultants on which individuals can compare and enroll in health insurance plans. Private exchanges predate the ACA but are of renewed interest as

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[44]*See, e.g.*, Sammer, J., "Number of Narrow Networks to Increase in 2015," *Managed Healthcare Executive* (Oct. 15, 2014); Eggbeer, B. and D. Morris, *Narrow, Tailored, Tiered and High Performance Networks: An Emerging Trend* (BDC Advisors 2012), *available at* http://www.wellcentive.com/downloads/Narrow%20Tailored%20Tiered%20and%20High%20Performance%20Networks.pdf

[45]*See, e.g.*, Howard, P., "Private Health Insurance Exchanges Unleash 'Transformational Change,' " *Forbes* (Jan. 24, 2014) (noting that 45% of employers in a 2013 survey indicated that they have implemented or are considering use of a private health insurance exchange for their full time employees).

employers comply with ACA coverage mandates and plan for the Cadillac tax.[46]

Employers electing a private exchange option for group coverage provide a fixed subsidy that each employee can use to purchase coverage, a situation that directly confronts the individual employee with the cost consequences of selecting a richer benefit plan.[47] Limited network products are potentially attractive to exchange customers and represent a competitive opportunity for accountable care organizations.

If providers form accountable care arrangements in order to offer limited-network health plans and to take risk (directly or indirectly) for the total cost of care, then (to the extent the arrangements are formed by merger or combination) the antitrust focus logically should shift away from the effect on unit prices (e.g., for inpatient hospital services) toward the effect on premium costs. The emergence of new insurance products (and potential entry of providers or provider-insurer joint ventures into the insurance marketplace) should have a disruptive, procompetitive effect on many insurance markets, particularly markets dominated by a single health plan, to the benefit of consumers.

But there is a catch. At present, most providers have not reached a stage where they are assuming a material amount of risk for managed populations. Indeed, even in markets led by health systems that have advanced population health management programs, some portion of their revenue continues to be received under traditional fee-for-service (payment-for-volume) contracts. One cannot expect the antitrust agencies (in their law enforcement role) to assume that providers will not exploit any increased market power they may gain through combination merely because those providers aspire or expect to move in the direction of accountable care—and indeed, that is exactly what the *St. Luke's* decision seems to say. Yet proponents of accountable

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[46]Norris, L., "What is a Private Exchange?" (Sept. 24, 2013), *available at* http://www.healthinsurance.org/faqs/what-is-a-private-exchange/.

[47]*See* Press Release, "Aon Hewitt: Two Year Enrollment Results Show Private Health Exchanges Can Mitigate Costs and Create Greater Individual Accountability" (Mar. 6, 2014), *available at* http://aon.mediaroom.com/2014-03-06-Aon-Hewitt-Year-Two-Enrollment-Results-Show-Private-Health-Exchanges-Can-Mitigate-Costs-and-Create-Greater-Individual-Accountability.

care models argue that providers cannot manage effectively under both payment-for-volume and payment-for-value incentives—i.e., as if they have two entirely separate patient populations—and that embracing a payment-for-value model requires abandonment of payment-for-volume behavior.[48]

If the nature of competition in health care is evolving, then one must expect that any shifts in antitrust enforcement views will be similarly evolutionary. In effect, this means that providers seeking to assert the benefits of accountable care must present them as transaction efficiencies in rebuttal to the agencies' presumptions about reductions in traditional fee-for-service provider competition.

Accountable Care as an Efficiency

The Federal *Merger Guidelines* discuss the manner in which the FTC and the Antitrust Division of the U.S. Department of Justice (collectively referred to here as "the agencies") assess efficiency claims in making merger enforcement decisions. The *Guidelines*, of course, are not specific to health care industry mergers, but even so, it is difficult to find much accommodation for the types of efficiency claims that may emerge from health care combinations in a post-ACA environment. The *Guidelines* establish four fundamental requirements for an efficiency defense:

Efficiencies must be "cognizable"—meaning "substantiated." The *Guidelines* place the burden on the merging parties to provide evidence that the agencies can use to verify (i) the likelihood and magnitude of each asserted efficiency, (ii) how and when each would be achieved,

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[48]*See* Riddle, C., "How Are Providers Managing the Transition with Conflicting Incentives in Payment Structures?" mcoBLOG (Sept. 7, 2012), *available at* http://www.mcoblog/kcblog/2012/9/7/how-are-providers-managing-the-transition-with-conflicting-i.html; *see also* Larkin, H., "The Rising Risk Tide," *Hospitals & Health Networks* (Aug. 1, 2011); Standard & Poor's Financial Services, *The Outlook for U.S. Not-For-Profit Health Care Providers Is Negative From Increasing Pressures* (Dec. 10, 2013) ("The move from fee-for-service to population health is . . . a difficult transition. Hospitals that move too quickly to implement these reforms run the risk of reducing revenues before the proper payment mechanisms are in place -– which we are seeing. Those that act too slowly and fail to gain a level of expertise in population management may be left behind without the critical skill sets to accept and manage risk.").

(iii) the costs of implementation, and (iv) how each would enhance the merged firm's ability and incentive to compete.[49]

The *Guidelines* reflect the agencies' general skepticism that mergers can produce cognizable efficiencies. A fundamental premise of the Guidelines' efficiency discussion is that efficiencies projected reasonably and in good faith by the merging firms may not be realized."[50] The *Guidelines* go on to discount efficiency estimates prepared in the context of the business combination at issue—a convenient position insofar as it permits the agencies to assert that projections created at the time a business combination is proposed merely constitute a strategic effort to position the merger for antitrust review. However, parties to most business combinations have no reason to estimate efficiencies (at least at a credible level of detail) until they have entered into serious discussions. And in any event, bona fide efficiencies are no less tangible or achievable based on the point in time at which they are identified. Nonetheless, relying on its own "rule" in *ProMedica*, the FTC asserted that "[n]otably, the [defendants'] efficiency claims . . . appear to have been designed and inflated for litigation purposes. ProMedica executives testified that the decision to hire [an efficiency consultant] was motivated, in part, by the need to present an efficiencies analysis to the FTC."[51]

The *Guidelines* also note that "[e]fficiency claims substantiated by analogous past experience are those most likely to be credited." Although this is an intuitively logical statement, it provides little help to organizations seeking to demonstrate the existence of efficiencies in the context of an emerging business model, i.e., accountable care, with which the industry has little prior experience to which it can point. This issue is discussed further below.

Efficiencies must be "merger-specific"—meaning that the realization of the efficiencies through the proposed combination is probable and that the efficiencies are unlikely

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[49]*Merger Guidelines* § 10.

[50]*Merger Guidelines* § 10.

[51]Complaint Counsel's Post-Trial Brief, *In re ProMedica Health System, Inc.* at 83 (Sept. 20, 2011).

to be realized through any less restrictive means.[52] One of the difficulties that parties face when asserting accountable care benefits of a merger is that many ACOs are, in fact, organized as contractual joint ventures, and thus, there is an arguable presumption that the same benefits can be obtained in a less restrictive manner. This of course begs an empirical question as to whether a single legal entity can obtain a higher level of clinical integration and population health management than a contractual partnership.

Efficiencies must be sufficiently large.[53] The *Guidelines* state "the Agencies will not simply compare the magnitude of the cognizable efficiencies with the magnitude of the likely harm to competition absent the efficiencies. The greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies, and the more they must be passed through to customers, for the Agencies to conclude that the merger will not have an anticompetitive effect in the relevant market. When the potential adverse competitive effect of a merger is likely to be particularly substantial, extraordinarily great cognizable efficiencies would be necessary to prevent the merger from being anticompetitive."[54]

Indeed, in litigation, the agencies routinely cite *FTC v. H. J. Heinz Co*.[55] for the proposition that in transactions producing very high market concentration levels, "proof of extraordinary efficiencies" is required.[56] This is a very stringent standard. Of note, other federal decisions have been less strident in this regard.

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[52]*Merger Guidelines* § 10.

[53]*Merger Guidelines* § 10.

[54]*Merger Guidelines* § 10.

[55]F.T.C. v. H.J. Heinz Co., 246 F.3d 708, 2001-1 Trade Cas. (CCH) ¶ 73243 (D.C. Cir. 2001).

[56]246 F. 3d at 720. In *Heinz*, the merging parties were the second and third largest producers of baby food in a market in which there were only three firms of consequence. For a critique of the *Heinz* standard by a former Deputy Assistant Attorney General in the Antitrust Division of the U.S. Department of Justice, *see* William J. Kolasky, "Lessons from Baby Food: The Role of Efficiencies in Merger Review," *Antitrust*, Fall 2001, at 82.

For example, in *FTC v. Tenet Health Care Corp.*,[57] the Eighth Circuit reversed a preliminary injunction blocking the merger of the only two general acute care hospitals in Poplar Bluff, Missouri. The court held that the district court had erred in refusing to consider "evidence of enhanced efficiency in the context of the competitive effects of the merger." The court described that evidence as showing that combining the two hospitals would create a larger and more efficient hospital capable of delivering better medical care and that this would "enhance competition" in a broader Southeastern Missouri market. The court noted that even if commercial health plans "reaped the benefit of a price war in a small corner of the health care market in southeastern Missouri," the loss of that benefit needed to be balanced against the improved quality of health care received by their subscribers.[58] The Eighth Circuit's approach resonates in the context of accountable care to the extent that geographic markets may be expanded by regional networks and by the development of limited-network insurance products.[59]

The *Guidelines* also note that projected efficiencies will be discounted if they will be realized over a longer time period "because they are less proximate and more difficult to predict."[60] This is simply a statement that procompetitive and anticompetitive effects will be weighed based on their present values. But is it truly logical to give more weight to immediate adverse consequences (e.g., putative increases in price for inpatient hospital services) if the long-term

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[57]F.T.C. v. Tenet Health Care Corp., 186 F.3d 1045, 1999-2 Trade Cas. (CCH) ¶ 72578 (8th Cir. 1999).

[58]186 F.3d at 1054.

[59]Even in F.T.C. v. University Health, Inc., 938 F.2d 1206, 1991-2 Trade Cas. (CCH) ¶ 69508 (11th Cir. 1991), a decision widely cited for the proposition that efficiencies may be used to rebut a prima facie showing of anticompetitive effect, the Eleventh Circuit required only that efficiencies would have to be "significant" and "ultimately [to] benefit competition and, hence, consumers," and not "extraordinary." Other cases crediting less than "extraordinary" efficiencies include Federal Trade Commission v. Butterworth Health Corp., 121 F.3d 708, 1997-2 Trade Cas. (CCH) ¶ 71863 (6th Cir. 1997) and U.S. v. Long Island Jewish Medical Center, 983 F. Supp. 121, 137, 1997-2 Trade Cas. (CCH) ¶ 71960 (E.D. N.Y. 1997) (merger must be likely to "enhance rather than hinder competition because of increased efficiency).

[60]*Merger Guidelines* § 10, n. 15.

consumer gains relate to fundamental changes in the nature of competition (e.g., the potential emergence of new, low-cost insurance options)?[61]

The efficiencies (usually) must be market-specific.[62] Market-specificity is a particular consideration for accountable care efficiencies. The *Guidelines* state as a general premise that "the Agencies consider whether cognizable efficiencies likely would be sufficient to reverse the merger's potential to harm customers in the relevant market, *e.g.*, by preventing price increases in that market."[63] But accountable care efficiencies almost always will be realized in markets that are different from the market in which competition putatively will be reduced. For example, a combination of two health systems may be alleged to create market power over inpatient hospital services, but efficiencies may be projected in areas such as increased insurance competition, improved management of chronic diseases, or general overall quality improvements. The defendants in *St. Luke's* made exactly such an argument: "St. Luke's is in the process of transforming the delivery of healthcare by offering the population of southern Idaho clinically integrated, risk-based care."[64]

In a footnote, the *Guidelines* state that "[t]he Agencies

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[61]The immediate past Director of the FTC Bureau of Economics has recommended that economists "devote more attention to the modeling of efficiencies" and that they "step back . . . and consider what the goal of economic analysis of an antitrust matter is. The question that we're really asking is whether a merger or some type of conduct makes consumers better off." Martin Gaynor, Director Bureau of Economics, Fed. Trade Comm'n, 2014 Annual Conference of the American Antitrust Institute, "Efficiencies Analysis: False Dichotomies, Modeling, and Applications to Health Care," at 1 (Aug. 3, 2014), *available at* http://www.ftc.gov/system/files/documents/public_statements/574751/140619efficienciesanalysis.pdf.

[62]*Merger Guidelines* § 10, n. 14.

[63]*Merger Guidelines* § 10.

[64]Pretrial Memorandum, Fed. Trade Comm'n v. St. Luke's Health System, Ltd., Case No. 1:12-CV-00560-BLW-REB, at 12 (D. Idaho Sept. 10, 2013). Out-of-market efficiencies also have been asserted in prominent merger cases in industries other than health care, notably in the U.S. Air-American Airlines merger. *See* Answer to Amended Complaint, United States v. US Airways Group, Case No. 1:13-CV-01236-CKK, at 2 (D.D.C. Sept. 10, 2013) (The merged airlines "would generate enormous direct consumer benefit, most significantly by creating a unified network affording a vastly expanded array of flight options for travelers—taking more

normally assess competition in each relevant market affected by a merger independently and normally will challenge the merger if it is likely to be anticompetitive in *any* relevant market. In some cases, however, the Agencies in their prosecutorial discretion will consider efficiencies not strictly in the relevant market, but so inextricably linked with it that a partial divestiture or other remedy could not feasibly eliminate the anticompetitive effect in the relevant market without sacrificing the efficiencies in the other market(s). Inextricably linked efficiencies are most likely to make a difference when they are great and the likely anticompetitive effect in the relevant market(s) is small so the merger is likely to benefit customers overall."[65] Certainly, this statement opens the door to argue for out-of-market efficiencies, but the suggestion that the agencies will consider them only if the putative anticompetitive effects in any other market are small is quite limiting.[66]

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passengers where they want to go when they want to go there."). The airlines asserted that the economic benefits of these network efficiencies would exceed $500 million net of any adverse effects on airfares. However, the trial court did not decide the validity of this argument because the matter was settled.

[65] *Merger Guidelines* § 10, n. 14.

[66] Of note, FTC Commissioner Joshua Wright is an advocate of the view that "courts [should] adopt an approach to efficiencies analysis that considers the competitive benefits from a merger that are outside the relevant product market." Commissioner Wright states that "doing so would take the important step of updating current merger doctrine with respect to efficiencies analysis so that it is consistent with the modern trend in favor of analyzing actual competitive effects rather than adopting simplified and potentially misleading proxies for harm." In this regard, he also notes that the *Merger Guidelines* advocate narrowly defined product markets and that such definitions "inevitably lead to the atomization of classes of consumers whereby a market may be defined by picking a harmed consumer and defining a relevant market around that individual." Joshua D. Wright, Commissioner, Fed. Trade Comm'n, 2013 Georgetown Global Antitrust Symposium Dinner, "The FTC's Role in Shaping Antitrust Doctrine: Recent Successes and Future Targets," at 13, 18 (Sept. 24, 2013), *available at* http://www.ftc.gov/sites/default/files/documents/public_statements/ftc%E2%80%99s-role-shapingantitrust-doctrine-recent-successes-and-future-targets/130924globalantitrustsymposium.pdf.

Categories of Accountable Care Efficiencies

There are many types of consumer benefits that may be associated with a transaction designed to enable or enhance accountable care strategies. A few of the more significant efficiencies and the challenges posed for such arguments under the *Merger Guidelines* are discussed here.

Product Innovation. If a combination of two health systems results (for example) in the ability to offer a lower-priced, limited-network insurance product that is a benefit to consumers. However, if the fundamental antitrust concern with the combination is, e.g., a loss of inpatient hospital competition, the efficiency will be realized in a different market (i.e., through increased competition in the insurance market). As noted, the agencies have taken a conservative approach to out-of-market efficiency arguments.

Moreover, the intersection of provider price increase concerns and more robust insurance competition requires a different view of provider pricing—i.e., as an input into insurance premiums. In other words, it requires a shift in view from unit pricing to the total cost of care.

Consider, for example, the *St. Luke's* matter, in which the complaint focused on a reduction in competition for (and an expected increase in the price of) primary care physician services. For a typical health plan, only about 11% of premium revenue is paid out for primary care services.[67] This means that a 5% increase in PCP rates (the baseline standard used by the agencies) would have an average effect on premiums (assuming it were fully passed on to customers) of only about 0.6%. Thus, a relatively minuscule gain in overall provider network efficiency, reflected in downward pressure on insurance premiums, would more than offset any rise in PCP rates.

Similarly, a merger in a particular geographic market that would enable the merged firm to serve a broader market more efficiently (as the court found to be the case in *Tenet*) could present a case in which relatively small efficiencies in the larger market would outweigh large potential adverse competitive effects in the original market.

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[67] *See, e.g.*, *Capitation, Rate Setting, and Risk Sharing*, *in* UNDERSTANDING HEALTHCARE FINANCIAL MANAGEMENT 627 (Louis C. Gapenski & George H. Pink, eds., 5th ed. 2007), *available at* http://www.ache.org/pubs/hap_companion/gapenski_finance/online%20chapter%2020.pdf.

These are not paradigms that typically have been seen in health care merger cases. However, as the focus shifts from fees-for-service to the total cost of care, it is arguably a better paradigm for gauging the consumer welfare effects of provider combinations, whether horizontal or vertical.

But are these efficiencies merger-specific, or can the same benefits be achieved without a business combination? This question may need to be answered empirically (through comparative studies of different accountable care structures), but it seems reasonable to believe that there are transactional efficiencies to be realized in business combinations. Specifically, in an enterprise that involves significant investment in information technology, human capital, and intellectual property, and that involves potential assumption of population health risk, a combination may be necessary to mitigate information costs and reduce exposure to opportunistic behavior or "hold-ups" by one's "partners." Common ownership may more fully align firms' incentives and discourage shirking, free-riding, and opportunistic behavior that can be very costly and difficult to police using arm's length transactions.[68] However, evidence of these potential benefits remains to be developed.

Pricing Efficiencies. It may be the case that two organizations proposing to combine in order to create a more integrated accountable care organization will not be complete substitutes for each other. For example, they may, in part, serve different geographies. Indeed, the strategy of the combination may be to take advantage of geographic or service line complementarities, e.g., in order to offer a limited-network insurance product. In such a case, assuming that each has some degree of market power, there will be potential pricing efficiencies due to the elimination of "double marginalization." In practical terms, this means that the organizations can be expected to offer a better price to a contracting health plan as a single firm than the net prices

[68] *See* Kolasky, J. and A. Dick, *The Merger Guidelines and the Integration of Efficiencies into Antitrust Review* (Oct. 2003) at 58–61, *available at* http://www.justice.gov/atr/hmerger/11254.htm.

that the two firms would offer independently. This is a merger-specific benefit.[69]

Population Health Management. Population health management is a "big data" exercise. As previously discussed, it depends on the ability to stratify patient clinical information in ways that will differentiate patients who will benefit from a particular intervention from those that will not. Well-understood statistical principles hold that the precision of this analysis will depend directly on the size of the data sample comprising each stratum. As the sample size increases, the risk of "false positives" (erroneously identifying patients (or groups of patients) as potential beneficiaries of an intervention) and "false negatives" (failing to identify patients (or groups of patients) who would benefit from an intervention) decreases. Both false positives and false negatives have economic costs. In the former case, patients may receive preventive or other services that they do not need. In the latter case, patients may fail to receive services that would reduce the later incidence of more serious complications or hospitalizations. In combination, provider organizations may gain scale economies that permit more effective population health management by reducing the statistical variance (and thereby improve precision) in predictive modeling for population health management.

It is reasonable to think that this would be a merger-specific benefit.[70] There are significant costs to creating data-sharing arrangements, and investment in those arrange-

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[69]In a competitive market, firms are assumed to price at marginal cost. A firm with market power is assumed to price above marginal cost, which produces a welfare loss for consumers. If two complementary health systems each contract with a health plan, each will seek to maintain its price above marginal cost. If the two systems merge and contract with the health plan as a single firm, economic theory holds that the excess marginalization—and the resulting consumer loss—will be reduced or eliminated.

[70]Although it is doubtful that the agencies had accountable care in mind when they wrote the *Guidelines*, it is worth noting that, in regard to research and innovation, the *Guidelines* recognize that benefits in those areas are cognizable efficiencies and may be merger-specific: "When evaluating the effects of a merger on innovation, the Agencies consider the ability of the merged firm to conduct research or development more effectively. Such efficiencies may spur innovation but not affect short-term pricing. The Agencies also consider the ability of the merged firm to ap-

ments requires confidence in the long-term stability of the relationships.[71] The general inertia surrounding Health Information Exchanges suggests that this proposition is true.[72] Moreover, the common production of the intellectual property surrounding population health management (a valuable asset) may be costly, inefficient, and subject to opportunism if undertaken at arm's-length.[73]

Quality Improvement. A fundamental Triple Aim premise is that accountable care raises the level of quality by enhancing clinical processes and population health management. Quality improvements are, at the most basic level, "non-price" benefits. The *Guidelines* state that the Agencies "employ an approach analogous to that used to evaluate price competition" in evaluating nonprice effects.[74] This statement, which is in no way intuitive, is not further explained. Of related significance, to the extent the *Guidelines* discuss nonprice effects at all, the discussion is largely directed to the potential *adverse* consequences of a business combination on incentives for innovation and improved product quality, with almost no discussion of how the Agencies might view the positive effects of the combination on such matters.

The *Guidelines* offer no insight into how the Agencies will resolve cases in which economic analysis predicts upward price effects, but evidence indicates that a transaction nonetheless may have benefits in the areas of product quality or innovation. The FTC has acknowledged the methodological dilemma: "[I]t is more difficult to determine how best to bal-

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propriate a greater fraction of the benefits resulting from its innovations." *Merger Guidelines* § 10.

[71] *See* Millard, M., "ACOs Hamstrung by Poor Data Exchange" *Healthcare IT News* (Dec. 5, 2014), *available at* http://www.healthcareitnews.com/news/acos-hamstrung-poor-data-exchange.

[72] *See* note 35 and accompanying text.

[73] *See* Kolasky, J. and A. Dick, *The Merger Guidelines and the Integration of Efficiencies into Antitrust Review* (Oct. 2003) at 54–55, 58–61, *available at* http://www.justice.gov/atr/hmerger/11254.htm.

[74] *Merger Guidelines* § 1.

ance a possible price increase on the one hand and a quality improvement on the other hand."[75]

And as previously noted, the *Guidelines* state that "the agencies consider whether cognizable efficiencies likely would be sufficient to reverse the merger's potential harm . . ., *e.g.*, by preventing price increases. . . ."[76] In the context of a transaction that provides new services or improved quality, it is difficult to argue that such nonprice benefits would *prevent* a price increase.

The FTC tends to view quality-based efficiencies as subject to challenge on the basis that they are not merger-specific.[77] In truth, the jury is still out on the question of whether highly integrated (e.g., merged) organizations create more effective clinical integration (and therefore better quality) in the long run.[78] But as discussed above with respect to product innovation, there are reasons to believe that transactional relationships that depend on close coordination over a long time period are more effective when undertaken as a business combination due to the ability to control noncompliance and to avoid opportunistic behavior by the participants.

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[75]Deborah L. Feinstein, Director, Bureau of Competition, Fed. Trade Comm'n, Remarks at the Fifth National Accountable Care Organization Summit, Antitrust Enforcement in Health Care, "Proscription, Not Prescription" (June 19, 2014) at 11.

[76]*Merger Guidelines* § 10.

[77]Deborah L. Feinstein, Director, Bureau of Competition, Fed. Trade Comm'n, Remarks at the Fifth National Accountable Care Organization Summit, Antitrust Enforcement in Health Care, "Proscription, Not Prescription" (June 19, 2014) at 11. ("To date, however, [balancing quality improvement against price increases] is not something we have found necessary to do. In the handful of transactions we have challenged, we have determined that the quality improvements were speculative, not substantiated and/or the merger was not necessary to achieve them.").

[78]To be sure, many of the high-functioning examples of integrated clinical delivery are large consolidated systems that employ all or a majority of their physicians (notably, the physician/clinic-based models such as Mayo Clinic, Geisinger Health System, and Billings Clinic) or organizations in which physicians confine their practices to hospitals that are part of the same overall organizational structure (such as Kaiser Permanente). However, those experiences have not been developed into evidence that could be used empirically to predict the benefits of a merger or other combination.

Proving an Efficiency Defense

In *St. Luke's*, the court in effect held the defendants accountable for the lack of empirical evidence as to the effectiveness of employment models in achieving the objectives of clinical integration. This evidentiary hurdle is likely to recur with regularity in future investigations and litigation concerning hospital-physician and hospital system combinations because, to the extent it exists, evidence concerning the results of clinical integration and disease management is conflicting and mainly concerns experiments undertaken in past time periods when the impetus for change in clinical practice arguably was not as strong as it is today.

Recent studies suggest that physician-hospital integration has tended to result in increased costs and prices.[79] There likely are a number of reasons for this result, including the fact that many (perhaps most) hospital-employed physicians continue to practice in a predominantly fee-for-service environment that has inherent incentives to increase the volume of services delivered. Productivity-based compensation arrangements favored by many hospitals reinforce those incentives. In addition, most health plans (including Medicare) continue to pay higher fees for hospital-based services than for the same services performed in physician offices.

Empirical evidence concerning the clinical "tools" associated with integrated care delivery tends to be, at best, mixed. For example, earlier Medicare demonstration projects

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[79] *See, e.g.*, Baker, L., M K. Bundorf, and D. Kessler, "Vertical Integration: Hospital Ownership of Physician Practices Is Associated With Higher Prices and Spending," 33 *Health Affairs* 5 (May 2014) (finding a "mixed, although somewhat negative" picture of vertical integration from the perspective of commercially insured patients); Burns, L. & M. Pauly, "Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s," 31 *Health Affairs* 2407 (2012) (expressing doubt that accountable care will lower costs); O'Malley, A., et al., *Rising Hospital Employment of Physicians: Better Quality, Higher Costs?*, Issue Brief No. 136, Ctr. for Studying Health Sys. Change (Aug. 2011) ("While hospital-employed physicians may spur clinical integration that will ultimately improve efficiency and help control costs, they are more likely to increase costs in the short run."); Berenson, R., et al., "Unchecked Provider Clout in California Foreshadows Challenges to Health Reform," 29 *Health Affairs* 699 (2010); Casalino, L., et al., "Hospital-Physician Relations: Two Tracks and the Decline of the Voluntary Medical Staff Model," 27 *Health Aff*airs 1305 (2008).

concluded that care coordination programs had an appreciable effect on utilization or health care spending.[80] Most of those projects were undertaken 10 years ago, however. Similarly, evaluations of disease management programs funded by Medicare generally have found that net costs increased in most programs, and there was no widespread evidence of improved compliance with evidence-based care and no evidence of behavioral change by patients.[81] The Medicare pay-for-performance demonstration (conducted 2005–2010) yielded mixed results. Although all participating groups reached program benchmarks on most quality measures, only half generated actual savings.[82] In contrast, evaluations of medical home models undertaken by Group Health, for example, report improvement in prevention and chronic disease management and reduced utilization of hospital emergency departments.[83]

Recent evidence from Medicare ACOs is mixed. For the first year of the Pioneer ACO program, most organizations were successful in delivering higher quality care than industry benchmarks and lowering costs overall, but just over a third were able to reduce spending enough to qualify

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[80]*See* Burns L. & M. Pauly, "Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s," 31 *Health Affairs* 2407, 2410–11 (2012). *See also* Nelson, L., *Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination*, Congressional Budget Office Working Paper (January 2012).

[81]*See* Burns L. & M. Pauly, "Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s," 31 *Health Affairs*2407, 2411 (2012). *See also* Nelson, L., *Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination*, Congressional Budget Office Working Paper (January 2012).

[82]*See* Burns L. & M. Pauly, "Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s," 31 *Health Affairs* 2407, 2412 (2012). *See also* Nelson, L., *Lessons from Medicare's Demonstration Projects on Value-Based Payment*, Congressional Budget Office Working Paper (January 2012).

[83]*See* Burns L. & M. Pauly, "Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s," 31 *Health Affairs* 2407, 2411 (2012).

for shared savings.[84] Similar results were reported for the Medicare Shared Savings Program (MSSP), with 54 (of 114) ACOs holding spending below their budget benchmarks but only 29 of which reduced spending by enough to qualify for shared savings. Sixty MSSP participants experienced spending above their benchmark. All but five of the 114 participants "satisfactorily reported" on their quality measures.[85]

Results for commercial accountable care arrangements have not been widely reported, and as yet, there appears to be no broad-based studies. However, reports of favorable outcomes in specific instances can be found.[86]

If the clinical integration model is to provide a basis for a viable antitrust defense, it is certain that courts, like the court in *St. Luke's*, will require evidence of consumer benefits beyond good intentions, but to the extent those benefits exist, that evidence will take time to accumulate. As accountable care proliferates, and as more experience is achieved with risk-sharing and value-based payment arrangements, it should become more feasible to demonstrate that the nature of competition has changed. It also should become possible to objectively demonstrate the value of provider combinations in the attaining the benefits of accountable care (if indeed such value can be demonstrated).

Conclusion: Accountable Care as a Dynamic Efficiency

A well-known antitrust treatise argues that "one cannot formulate rational antitrust rules without considering how they help or hinder more efficient production and more ef-

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[84]L&M Policy Research, *Effect of Pioneer ACOs on Medicare Spending in the First Year* (Nov. 13, 2013), *available at* http://innovation.cms.gov/Files/reports/PioneerACOEvalReport1.pdf.

[85]Press Release, "Medicare's delivery system reform initiatives achieve significant savings and quality improvements—off to a strong start" (U.S. Department of Health and Human Services Jan. 30, 2014), *available at* http://www.hhs.gov/news/press/2014pres/01/20140130a.html.

[86]Wang, A., "Advocate-Blue Cross ACO Sees Improvement in Utilization, Costs," *Modern Healthcare* (Jan. 22, 2014), *available at* http://www.modernhealthcare.com/article/20140122/INFO/301229994 (reporting reduced admission rates, inpatient days, and lengths of stay, and an overall 2.5% reduction in cost trends).

ficient resource allocation."[87] Economists recognize that efficiencies are not static attributes of mergers but have dynamic implications for markets, having the ability to stimulate competition that can create significant spill-over benefits for consumers. Business combinations also can speed the pace of technical progress and reduce prices by facilitating innovations that stimulate technological diffusion and competitive innovations.[88] Cost savings achieved by a newly merged entity generally will diffuse to competing firms over time, which would be expected to enhance competition and the pricing and nonprice benefits to consumers.[89]

The concept of dynamic efficiencies would seem to describe the intended trajectory of accountable care. Achievement of those dynamic efficiencies can be facilitated if antitrust and other public policies take a broader market view of efficient transactions that support of invention.

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[87]Areeda, A. and P. Turner, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* (1980) at 146.

[88]Gary L. Roberts and Steven C. Salop, "Efficiencies in Dynamic Merger Analysis," 19 *World Competition L. & Econ. Rev.* at 5 (1996).

[89]Gary L. Roberts and Steven C. Salop, *Efficiencies in Dynamic Merger Analysis*, 19 *World Competition L. & Econ. Rev*. at 7–8 (1996).