

What Is a Provider to Do? The Perceived Tension Between Health Care Reform and Federal Antitrust Enforcement

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Introduction

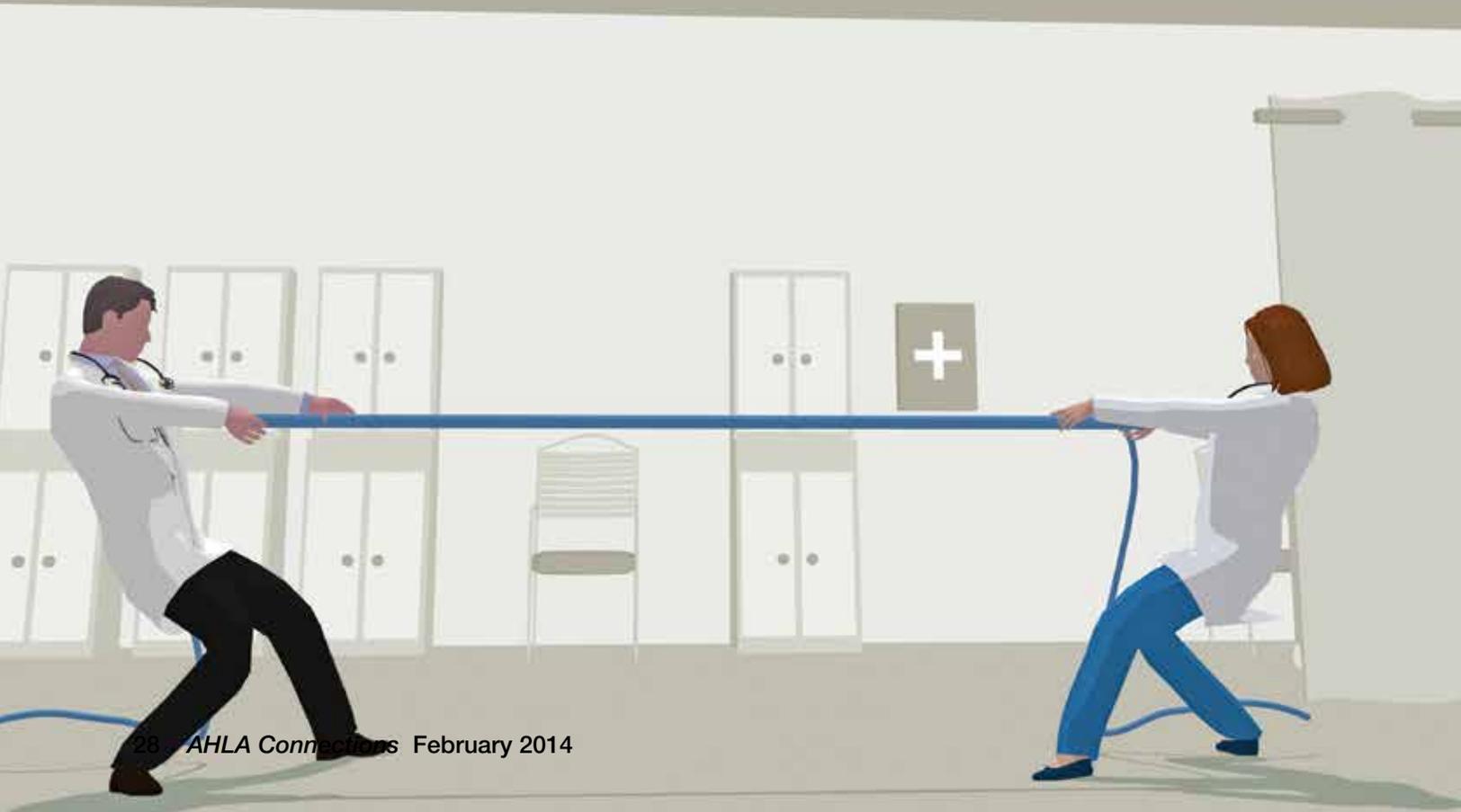
It is hard to imagine a time when health care has dominated the headlines more than the last few years. With the passage of the Affordable Care Act (ACA) on March 23, 2010, we have seen headlines related to health care costs, individual mandates, Supreme Court challenges, health insurance exchange fiascos, and multiple attempts to repeal, defund, and otherwise kill the ACA. Nearly four years later, the ACA has survived and continues to move forward. While politicians have been fighting in Washington, DC over the ACA, providers throughout the country have been working feverishly to understand how the ACA will play out at home, wondering: How will it affect our patients? How will it affect our strategy? And ultimately, and most importantly, how will it affect our ability to provide quality health care to our community in the future?

Routinely, providers are coming to the conclusion that consolidation is needed to meet the goals of the ACA. Those following the industry know this consolidation trend has been

in full swing for the last few years and is showing no signs of slowing down. It seems every week there is a new hospital or health system being acquired by another, larger hospital or health system, or a new physician practice being acquired by a hospital. Invariably, an important reason given for the transaction is the need to prepare for the ACA.

The federal antitrust enforcement agencies, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) (collectively, the Agencies), are keenly aware of the provider consolidation trend and have been increasingly active in investigating and challenging anticompetitive consolidations.¹ With respect to provider consolidation, the Agencies' primary concern is whether a newly created large health system will possess market power. If so, the health system would be able to increase prices without a corresponding increase in quality or otherwise innovative care.

Providers are nervous about the uptick in enforcement actions and have complained about the apparent tension created between the goals of the ACA and these enforcement actions. On



the one hand, the ACA appears to encourage provider consolidation to promote efficiencies and coordinate care. On the other hand, the Agencies are challenging consolidation efforts as anticompetitive. A fair question to ask is whether the goals of the ACA and the goals of the Agencies are on a collision course?

The Goals of the Affordable Care Act

The ACA has a “triple aim” for improving the health care system: (1) improving the patient experience and quality of patient care; (2) improving the health of populations; and (3) reducing the costs of health care.² Despite what is sometimes lost in the political rhetoric, a stated goal of the ACA is to promote competition and create efficient health care delivery systems. As one commentator noted, the ACA “both *depends on* and *promotes* competition in provider and insurance markets.”³ For example, under the ACA, the following four programs are specifically designed to promote competition and innovation: (a) Accountable Care Organizations (ACOs); (b) the Hospital Value-Based Purchasing Program (VBP); (c) Health Insurance Marketplaces; and (d) the Centers for Medicare & Medicaid Services (CMS) Health Care Innovation Awards.

- » The Medicare Shared Savings Program (MSSP), a widely known innovation under the ACA, encourages the development of ACOs. ACOs are meant to be innovative organizations that coordinate care between various stages of the delivery model, leading to cost containment and higher quality outcomes.
- » VBP was established to increase the focus on quality of care and improvement of patient outcomes and to decrease the focus on volume of services provided. It is intended to take the place of traditional fee-for-service payment methods and offers hospitals incentive payments on their performance or performance improvement.⁴
- » Despite the rocky start, the Health Insurance Marketplaces are designed to create efficient markets and allow health plans to compete for enrollees. These exchanges are intended to give consumers information on various insurance products, much like Ebay or Amazon, and then allow the consumer to make an informed purchase.
- » The CMS Health Care Innovation Awards are meant to fund projects around the country that test new payment and service delivery models that deliver better care and lower costs.⁵ The innovative models are to be evaluated and monitored, with the hope that successful models can be shared around the country, leading to improved quality and lower costs.

Overall, the ACA relies heavily on competition and innovation to achieve its triple aim. It encourages the creation of innovative and efficient delivery models, and focuses on creating a health care system that delivers value, not just volume.

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The Goals of the Federal Antitrust Laws

The purpose of the federal antitrust laws is to protect and promote competition by outlawing unfair methods of competition. Another way to put it is “the primary goal of antitrust law is to maximize consumer welfare by promoting competition among firms.”⁶ This is done by promoting low prices, high output, high quality, efficiency in production and distribution, innovation, and choice. Furthermore, in the health care industry, competition encourages market participants to deliver cost-effective, high-quality care and to pursue innovation to further these goals.⁷

Three primary statutory sections are used by the Agencies to protect and promote competition in the health care arena: (1) Section 1 of the Sherman Act;⁸ (2) Section 2 of the Sherman Act;⁹ and (3) Section 7 of the Clayton Act.¹⁰

- » Section 1 of the Sherman Act prohibits agreements unreasonably restraining trade. Sharing competitively sensitive information with a competitor, or otherwise colluding with a competitor, may give rise to a violation of this section. Price fixing, boycotts, or market allocations are all examples of conduct that violates Section 1 of the Sherman Act.
- » Section 2 of the Sherman Act prohibits monopolization, attempted monopolization, and conspiracies to monopolize. Using exclusive agreements or engaging in predatory pricing in order to eliminate competition are examples of conduct that violates Section 2 of the Sherman Act.

The difficulty for providers arises when they employ strategies to meet the challenges of the ACA that give rise to antitrust concerns.

» Section 7 of the Clayton Act prohibits mergers and acquisitions that may reduce the level of competition in the marketplace. If a merger or acquisition is large enough, it may have to be reported to the Agencies pursuant to the Hart-Scott-Rodino premerger notification process.

The Agencies also offer various forms of formal and informational guidance. For example, in October 2011, the Agencies issued a joint statement on ACOs (ACO Statement).¹¹ The ACO Statement provides rule of reason treatment to any ACO meeting CMS' MSSP guidelines and participating in the program. The ACO Statement also creates a safety zone for certain ACOs and offers helpful guidance on conduct ACOs should avoid.

The federal antitrust laws promote competition and innovation to achieve benefits for consumers. In the health care arena, the promotion of competition and innovation leads to lower cost and higher quality care. This shows that the goals of the ACA and the goals of the federal antitrust laws are similar. The difficulty for providers arises when they employ strategies to meet the challenges of the ACA that give rise to antitrust concerns.

Provider Strategies in the Era of the Affordable Care Act

With the advent of the ACA, providers are facing a challenging market environment as the health care industry undergoes an historic change. Not only are providers expected to coordinate care along the entire care spectrum and manage the health of populations, but they also are expected to do so while lowering costs. As if that were not challenging enough, providers are faced with declining reimbursement rates from government payers, expensive capital expenditures on information technol-

ogy systems, and limited access to capital markets.¹² This has led to rating agencies such as Moody's and Standard & Poor's adopting a negative outlook for the health care industry.¹³

In response to these challenges, providers have been looking towards consolidation. The provider consolidation trend has consisted of two distinct categories: (a) hospital-to-hospital mergers and acquisitions, and (b) hospital acquisitions of physician practice groups. According to Irving Levin Associates, a health care research firm, hospital mergers and acquisitions have more than doubled from 50 in 2009 to 105 in 2012.¹⁴ Further, according to Booz & Company, a consulting firm, 1,000 of the roughly 5,000 hospitals across the country could seek out a merger or acquisition in the next five to seven years.¹⁵

The prevailing wisdom is that consolidation will help providers meet the challenges being posed by the ACA. If reimbursement rates are declining, providers must cut costs. Recognizing economies of scale from consolidation is an efficient way for providers to cut costs. If large investments of capital for information technology systems are needed, allocating these large fixed expenses over a large balance sheet as opposed to a small balance sheet is helpful. If access to capital is difficult and costly, a large balance sheet allows for more diversification, less risk, and overall greater access to capital. Many experts and consultants have opined that consolidation will be the only strategic option for many providers. The same ratings agencies that have adopted a negative outlook on the industry as a whole find consolidation to be a positive step.¹⁶

If it is easy to understand why hospitals would want to consolidate, it is even easier to understand why physician practices would want to be acquired by hospitals. Physician practices face the same challenges that hospitals do under the ACA, and more. Not only do physicians face large reimbursement cuts, increasing expenses, and difficulty accessing capital, physicians also are facing a generational divide that is making it harder to recruit young physicians straight out of medical school. In general, younger physicians no longer want to work the grueling hours often required in private practice. Many younger physicians are happy being employed by a local hospital, focusing on patients and not having to worry about the business side or operational risks associated with being an owner of a physician practice. Further, as the industry moves away from traditional fee-for-service payment toward VBP and other risk-based payment methods, physician practices face a growing amount of risk associated with providing medical services. It is one thing for physicians to know they will be paid for the services they provide to patients, it is quite another to know that their payment is at risk based on circumstances that may be out of their hands. The economic incentives for physicians to remain in independent practice are shifting, and the bottom line is that in the era of the ACA, the risks associated with owning a physician practice are rising, but the rewards are not.

The Federal Antitrust Enforcers Response to the Affordable Care Act and the Subsequent Consolidation Trend

The Agencies seem to understand that the ACA is partly responsible for the provider consolidation trend,¹⁷ but are still concerned that such consolidation will lead to market power and increased prices. FTC Commissioner Maureen Ohlhausen, speaking only for herself, recently summed up what could be considered the general view, when she stated, “[u]nfortunately, many people, including health care providers, seem to confuse or misunderstand the [ACA’s] emphasis on clinical integration and pursuit of efficiency and quality gains as a call for increased consolidation without regard to the antitrust laws.”¹⁸

Commissioner Ohlhausen went on to say, “the antitrust laws and the [ACA] are not at odds. The goals of the [ACA] include fostering greater efficiencies for patients—that is, higher quality at lower costs—through increased coordination of care, while FTC challenges to anticompetitive consolidations of hospitals or providers serve to protect competition that creates efficiencies and benefits patients.”¹⁹

Given the Agencies’ goal of promoting competition in an effort to keep prices low and quality high, and given there is some economic evidence to suggest provider consolidation leads to higher prices,²⁰ it is not surprising the Agencies have closely scrutinized the consolidation trend. Still, the Agencies profess to understand that cost savings can result from provider consolidation. FTC Chairwoman Edith Ramirez recently told a U.S. House of Representatives subcommittee, “[w]hile the Commission has concerns about consolidation among health care providers, we do not stand in the way of provider collaborations where there is evidence that the deal will reduce costs, improve the quality of care, and provide net benefits to consumers.”²¹

How Real Is the Perceived Tension Between the Goals of the Affordable Care Act and the Goals of the Federal Antitrust Enforcement Agencies?

Although it is easy to understand providers’ desire to consolidate, as well as the Agencies desire to challenge certain consolidation transactions, the goals of the ACA and the goals of the Agencies are not as much at odds as some providers might perceive.

At its core, the ACA encourages competition and innovation to develop health care delivery models aimed at promoting efficiency and improving quality. To the extent providers create these innovative and efficient delivery models, whether through consolidation or affiliation, the Agencies are not likely to find them problematic. But to the extent providers consolidate and continue to operate in the same manner, only now with increased market share, the Agencies are likely to be skeptical.

In some local markets, provider consolidation may be the answer to addressing the challenges brought on by the ACA. In other local markets, a contractual affiliation between providers

may be the answer. From the viewpoint of the Agencies, each local market is different and each consolidation transaction brings about different competitive consequences. The overall goal is to improve efficiency and prevent the market participants from gaining market power.

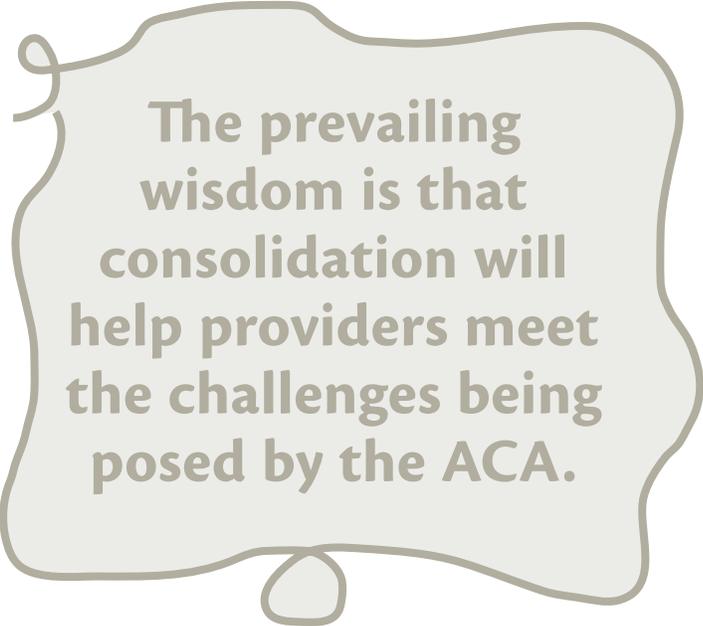
Unanswered Questions for the Future

Although the goals of the ACA and the goals of the Agencies are similar, a number of legitimate unanswered antitrust questions surrounding the ACA still remain.

Chief among these questions is how will the various programs envisioned by the ACA affect competition in local markets? Antitrust law is inherently difficult because it is predictive in nature. To date, all of the arguments by providers and all of the arguments by the Agencies have been a prediction of what will happen. As implementation begins and takes shape, will the strategies being undertaken by providers to meet the challenges of the ACA prove to be procompetitive, leading to lower costs and increased quality, or will they prove to simply create large health systems that can dominate a market without any innovation?

Another key question will be whether providers can coordinate care and manage population health without consolidating into large health systems or acquiring physician practices? If scale matters to implement these goals, but scale leads to market power, will providers be able to come up with a new model that does not involve consolidation yet still achieves these goals?

Finally, the question on everybody’s mind is whether ACOs will be able to live up to their promise of increased quality while simultaneously lowering costs? Or will ACOs simply create a new health care delivery model with large market concentrations and potential market power?



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Practical Takeaways

Although providers routinely turn to consolidation when determining how to meet the challenges brought on by the ACA, it is important to understand that the Agencies are monitoring the health care industry, and are keenly focused on ensuring that such consolidation does not lead to market power.

Providers should keep the following items in mind when determining whether to undertake any consolidation transaction:

- » Be aware of proposed transactions that create large market shares and plan for antitrust scrutiny from the Agencies.
- » Have a deep understanding of the purpose and reason for the proposed transaction. Is the purpose to create a truly procompetitive and innovative care model that will deliver value under the ACA, or is it to create a large market pres-

ence and drive higher prices? Further, are there any ordinary course documents to prove the transaction's purpose? As always, be wary of creating ordinary course documents that include anticompetitive purposes.

- » Discuss whether the goals of the transaction could be achieved through a less anticompetitive structure. For example, could a loose affiliation, as opposed to a consolidation, achieve the goals? Are there ordinary course documents to explain why consolidation is necessary?
- » Engage commercial payers, employers, and other community stakeholders in dialogue to understand the community benefit to be derived from the proposed transaction.
- » Be wary of post-transaction price increases that are not tied to increased quality.

Conclusion

Despite the perceived tension between the goals of the ACA and the goals of the Agencies, both are focused on promoting competition and innovative care models to increase efficiency in the health care industry, leading to higher quality outcomes at lower costs. While it is easy to understand why many providers are consolidating to meet challenges posed by the ACA, providers must keep in mind that consolidations leading to large market shares may be viewed as problematic by the Agencies and may give rise to an investigation and potential challenge. Providers must be prepared to prove definitively to the Agencies that the proposed transaction does not lead to market power and is, in fact, being undertaken in furtherance of the goals of the ACA. Absent such definitive evidence, the Agencies are likely to be skeptical of such a consolidation transaction.

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