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THE NATIONAL IMPERATIVE FOR HEALTH CARE SYSTEM TRANSFORMATION: WHY CERTAIN MERGERS AND ACQUISITIONS ARE APPROPRIATE DESPITE SECTION 7 OF THE CLAYTON ACT

NATHAN D. SARGENT*

ABSTRACT

Integration among health care providers offers a promising solution to the health care crisis. Unfortunately, some efforts to improve the American health care system through integration have been halted by antitrust concerns and the enforcement of section 7 of the Clayton Act. Health care costs could be contained and clinical quality improved by allowing a narrow statutory exemption to enforcement of section 7 for health care integrations that demonstrate cost efficiency and advance patient care. Under such limited circumstances, relaxed antitrust regulation is an appropriate response to health care's current financial crisis that will ultimately benefit America's consumers and economy by transforming the fragmented volume-based health care system to one based on value.

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INTRODUCTION

The American health care system is rapidly transforming.¹ Disruptive forces, such as the evolution of the physician-patient relationship,² payment reform,³ and the continued implementation of the Patient Protection and Affordable Care Act (“Affordable Care Act”),⁴ have only increased the level of complexity in an already multifarious industry. Coupled with long-term financial challenges,⁵ health care’s

¹ See, e.g., Ellen Lee, *5 Ways Technology is Transforming Health Care*, FORBES (Jan. 24, 2013), <http://www.forbes.com/sites/bmoharrisbank/2013/01/24/5-ways-technology-is-transforming-health-care> (showing five key technological advancements in health care); Susan DeVore, *The Changing Health Care World: Trends to Watch in 2014*, HEALTH AFFS. BLOG (Feb. 10, 2014), <http://healthaffairs.org/blog/2014/02/10/the-changing-health-care-world-trends-to-watch-in-2014/> (noting key trends to monitor throughout 2014); Ellis M. Knight, *Transforming Healthcare Delivery Through Value-Based Care Design*, BECKER’S HOSP. REV. (Oct. 17, 2013), <http://www.beckershospitalreview.com/hospital-management-administration/transforming-healthcare-delivery-through-value-based-care-design.html> (highlighting the importance of value-based care redesign).

² See Michael Weiner & Paul Biondich, *The Influence of Information Technology on Patient-Physician Relationships*, 21 (Supp. 1) J. GEN. INTERNAL MED., S35, S36-37 (2006), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1484834/pdf/jgi_307.pdf (examining the evolution of the physician-patient relationship as a result of technology).

³ See, e.g., *Payment Reform and New Models of Care*, RAND CORP., <http://www.rand.org/health/key-topics/aca/payment-reform.html> (last visited Sept. 13, 2015) (reviewing various alternative methods of payment); Suzanne Delbanco, *The Payment Reform Landscape: Overview*, HEALTH AFFS. BLOG (Feb. 6, 2014), <http://healthaffairs.org/blog/2014/02/06/the-payment-reform-landscape-overview> (summarizing the payment reform landscape across the American health care industry).

⁴ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119.

⁵ An understanding of the financial aspects of health care is critical, as it relates to almost any policy discussion focused on reform or improvement. A fundamental overview is provided *infra* Part I.A.2.

evolving state has forced more and more health care providers⁶ to seek out various types of affiliations with other organizations to mitigate the effects of these industry-wide shifts. Examples exist almost everywhere in the United States, from western Pennsylvania to northern California.⁷ Antitrust implications are inevitable given the increased level of system integration.

Though opinions vary, health care provider integration has the potential to deliver real benefits to patients and communities across the United States.⁸ Despite those benefits, strict enforcement of section 7 of the Clayton Act⁹ can prevent such

⁶ Information related to the definition and classification of health care providers is presented *infra* Part I.A.1.

⁷ See e.g., Phil Galewitz, *Is Bigger Better? Idaho Hospital Battle a Microcosm of Debate over Industry Consolidation*, KAISER HEALTH NEWS (Apr. 22, 2014), <http://kaiserhealthnews.org/news/idaho-hospital-health-care-consolidation-hospitals> (summarizing various instances of hospital and health system consolidation, including examples in Idaho, Pittsburgh, and northern California); Anna Wilde Mathews & John W. Miller, *Health-Care Rivals Battle for Patients in Pittsburgh*, WALL ST. J. (Mar. 27, 2012), <http://online.wsj.com/articles/SB10001424052702303812904577295901619123904> (exploring health care market dynamics in western Pennsylvania); Dan Verel, *Prime Healthcare Sues SEIU-UHW Amid Acquisition Talks with Daughters of Charity*, MEDCITY NEWS (Sept. 4, 2014), <http://medcitynews.com/2014/09/prime-healthcare-sues-seiu-uhw-amid-acquisition-talks-daughters-charity> (summarizing a proposed transaction between California health care providers and a union's efforts to prevent it); *Managing and Evaluating Rapid-Cycle Process Improvements as Vehicles for Hospital System Redesign*, AGENCY FOR HEALTHCARE RES. & QUALITY (2007), <http://archive.ahrq.gov/research/findings/final-reports/rapidcycle/rapidcycle1.html> (providing examples of innovation and change at one health system as a microcosm of the entire health care industry).

⁸ See *infra* Part II.

⁹ 15 U.S.C. § 18 (2012). The statute's text reads as follows:

No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

No person shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of one or more persons engaged in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition, of such stocks or assets, or of the use of such stock by the voting or granting of proxies or otherwise, may be substantially to lessen competition, or to tend to create a monopoly.

....

Nothing contained in this section shall be held to affect or impair any right heretofore legally acquired:

Provided,

That nothing in this section shall be held or construed to authorize or make lawful anything heretofore prohibited or made illegal by the antitrust laws, nor to exempt any person from the penal provisions thereof or the civil remedies therein provided.

mergers and acquisitions if the Federal Trade Commission predicts anticompetitive effects.¹⁰ In an effort to balance antitrust enforcement and the high-level priorities associated with health care reform, strict enforcement of section 7 should be reevaluated when health care transactions fall under scrutiny. The FTC's antitrust enforcement should be adjusted to support government and industry efforts to contain rising health care costs¹¹ and improve clinical quality.¹² Congress can accomplish this by passing legislation that allows for a narrow statutory exemption to enforcement of section 7 of the Clayton Act for health care transactions that (1) demonstrate likely cost savings or efficiencies, (2) are focused on enhancing quality or patient outcomes, and (3) are aimed at enhancing or maintaining existing health care service offerings. Such a statutory exemption would permit transactions similar to the example¹³ discussed later in this Note but would avoid substantial degradation of antitrust regulatory authority and its associated consumer protections.

This Note is set forth in four parts. Part I.A begins with background information related to the health care industry, including key concepts and terms, industry trends, and an overview of the health care provider response to health care reform. Part I.B provides a summary of antitrust law and enforcement, including applicable statutes that create FTC jurisdiction and how the FTC conducts antitrust analysis. Part I.C is an in-depth review of a recent health care transaction in Idaho, in which the FTC won the dissolution of the transaction in federal court. This case exemplifies how health care providers are attempting to integrate and how the FTC's authority can curtail such ventures.

Part II.A begins with the financial rationale in support of a statutory exemption to section 7 enforcement and cites the current and past performance of the health care industry, the industry's capital needs, and the difficult transition from volume-to-value-based compensation as support. Part II.B continues with quality-based rationale, including the existing fragmentation of the current health care system and emphasizing effective and efficient health care as a critical consumer protection. Part II.C presents additional support regarding the maintenance of existing health care services and the value of integrated health care delivery as it relates to government-sponsored innovation projects. Finally, Part II.D, sets forth a new standard for FTC evaluation should the proposed statutory exemption be adopted. The Note concludes with a brief summation and conclusion.

Id.

¹⁰ The FTC's ability to investigate and potentially prevent transactions from occurring based on predicted anticompetitive effects is a critical component of the agency's regulatory authority. *See infra* Part I.B.

¹¹ Key trend information is presented *infra* Part I.A.2.

¹² Improved clinical quality remains a constant focus among health care providers as well as government entities. *See, e.g., About the National Quality Strategy (NQS)*, AGENCY FOR HEALTHCARE RES. & QUALITY, <http://www.ahrq.gov/workingforquality/about.htm> (last visited Sept. 13, 2015); Martha Hostetter & Sarah Klein, *In Focus: Improving Patient Flow – In and Out of Hospitals and Beyond*, COMMONWEALTH FUND: QUALITY MATTERS (Oct./Nov. 2013), <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2013/october-november/in-focus-improving-patient-flow>; *see also infra* Part II.B.

¹³ For an example of the FTC's scrutiny involving the acquisition of Saltzer Medical Group by St. Luke's Health System, *see infra* Part I.C.

I. THE HEALTH CARE INDUSTRY AND ANTITRUST LAW AND ENFORCEMENT

A. The Health Care Industry

1. Essential Concepts and Terminology

Before examining current and emerging health care trends, it is necessary to develop a fundamental understanding of core industry-specific concepts and terminology. An appropriate starting point is the definition of a health care provider. According to the HIPAA Privacy Rules, “health care provider means a . . . provider of medical or health services, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.”¹⁴ For the purposes of this Note, the term “provider” will be used in reference to organizations or institutions as opposed to individual clinicians.

One provider group that has grown substantially throughout the United States is the integrated delivery system. An integrated delivery system is often a provider or group of providers that come together under some legal structure in an effort to better manage health care delivery.¹⁵ Though there is no specific organizational model, integrated delivery systems often partner or contract with a health plan to further coordinate the full continuum of care.¹⁶ Integrated delivery systems vary in scope and size, but are widely considered to be a tool capable of controlling health care costs, increasing efficiency, and improving clinical quality.¹⁷ As will be examined in Part I.C, St. Luke’s Health System is an example of an integrated delivery system, along with many others across the United States.¹⁸

¹⁴ 45 C.F.R. § 160.103 (2015) (internal citations omitted).

¹⁵ See Wenke Hwang et al., *Effects of Integrated Delivery System on Cost and Quality*, 19 AM. J. MANAGED CARE e175, 176 (May 10, 2013), <http://www.ajmc.com/journals/issue/2013/2013-1-vol19-n5/effects-of-integrated-delivery-system-on-cost-and-quality>.

¹⁶ Eric R. Wagner & Peter R. Kongstvedt, *Types of Managed Care Organizations and Integrated Health Care Delivery Systems*, in ESSENTIALS OF MANAGED CARE 36 (Peter R. Kongstvedt, ed., 6th ed. 2013); see also ESSENTIAL HOSPS. INST., INTEGRATED HEALTH CARE LITERATURE REV. 1-2 (2013), <http://essentialhospitals.org/wp-content/uploads/2013/12/Integrated-Health-Care-Literature-Review-Webpost-8-22-13-CB.pdf> (listing definitions for integrated delivery systems). Additional common characteristics include shared economic and clinical accountability, increased alignment and efficiency, and coordinated and patient-centered care processes. See *id.* All of the aforementioned organizational and clinical qualities imply a somewhat sizable scale within the integrated delivery system’s geographic market and breadth of available services. The example outlined *infra* Part II.C is an example of two providers attempting to integrate for similar purposes and results.

¹⁷ See, e.g., *How CHI is Building and Buying Its Own Insurance Plan*, ADVISORY BD. CO. (Mar. 27, 2013), <http://www.advisory.com/daily-briefing/2013/03/27/how-chi-is-building-and-buying-its-own-insurance-plan> (citing an example of a large, multi-state health system launching an insurance product in an effort to improve costs).

¹⁸ See St. Luke’s Health System, Return of Organization Exempt from Income Tax (Form 990), <http://news.stlukesblogs.org/files/2013/04/SLHS-Form-990-FY-13-PI-Copy.pdf> (last visited Sept. 30, 2015) (indicating the health system’s corporate structure, as filed with the Internal Revenue Service); see also Leigh Page, *50 Integrated Delivery Systems to Know*, BECKER’S HOSP. REV. (Oct. 14, 2010), <http://www.beckershospitalreview.com/hospital->

In addition to common organizational structures, a basic overview of the payment system is of equal importance. Generally, a payer is an “entit[y] other than the patient that finance[s] or reimburse[s] the cost of health services.”¹⁹ In most cases, a payer is an insurance carrier, other third-party payer, or health plan sponsor, such as an employer or union. Notwithstanding commercial insurers,²⁰ the Centers for Medicare and Medicaid Services (“CMS”) is the single largest insurance payer in the United States.²¹ CMS provides insurance coverage for nearly 123 million Americans.²² That number is estimated to grow following the Affordable Care Act’s expansion of insurance coverage under Medicare and Medicaid.²³ CMS’s importance in health care cannot be understated. On top of the fact that it covers a substantial portion of the United States’ insured population,²⁴ it sets an important fee schedule for health services.²⁵ Formally referred to as the Medicare Physician Fee Schedule, private insurance payers often base their own payment rates on these CMS benchmarks.²⁶

The Medicare Physician Fee Schedule and other payer fee schedules have been the primary drivers of health care’s financial outlook under the fee-for-service payment model that has been in place for the last several decades.²⁷ Fee-for-service

physician-relationships/50-integrated-delivery-systems-to-know.html (listing numerous integrated delivery systems across the United States and reviewing their corresponding organizational models).

¹⁹ *Payer*, MOSBY’S DENTAL DICTIONARY 497 (2d ed. 2008).

²⁰ Examples of large private insurers include UnitedHealth Group, Kaiser Foundation Group, Aetna Group, and many others. See Evi Heilbrunn, *Top Health Insurance Companies*, U.S. NEWS & WORLD REP. (Nov. 5, 2014), <http://health.usnews.com/health-news/health-insurance/articles/2013/12/16/top-health-insurance-companies> (listing the largest health insurers in the United States in terms of market share).

²¹ CTRS. FOR MEDICARE & MEDICAID SERVS., CMS ROADMAPS OVERVIEW 1, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/downloads/RoadmapOverview_OEA_1-16.pdf (last visited Oct. 28, 2015).

²² CTRS. FOR MEDICARE & MEDICAID SERVS., JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES 2 (2014), <http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2015-CJ-Final.pdf> (reviewing CMS’s scope and financial needs).

²³ See *id.* at 1.

²⁴ See *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., <http://kff.org/other/state-indicator/total-population> (last visited Sept. 13, 2015).

²⁵ See *Overview of the Medicare Physician Fee Schedule Search*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/apps/physician-fee-schedule/overview.aspx> (last visited Sept. 13, 2015).

²⁶ See Cristina Boccuti & Marilyn Moon, *Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades*, 22 HEALTH AFFS. 230, 231-33 (Mar./Apr. 2003), <http://content.healthaffairs.org/content/22/2/230.full.pdf>.

²⁷ See James C. Capretta, *The Role of Medicare Fee-for-Service in Inefficient Health Care Delivery*, AM. ENTER. INST. & ROBERT WOOD JOHNSON FOUND., 3 (2013), https://www.aei.org/wp-content/uploads/2013/04/-the-role-of-medicare-fee-for-service-in-inefficient-health-care-delivery_141413376272.pdf; see also Jeffrey Clemens, *How Medicare*

is a fairly straightforward payment methodology. Providers bill and are compensated by insurance payers for the procedures they conduct based on a predetermined rate.²⁸ Despite its prevalence, fee-for-service is being pushed to the side to make room for value-based payment models.

Value-based models often compensate providers a predetermined amount for delivering a desired outcome, regardless of the particularized services needed to do so.²⁹ As expected, this drastic shift is causing considerable disruption across the industry and forcing health care providers to take on additional financial risk.³⁰ Despite the challenges involved with its adoption, value-based reimbursement is the most promising way to drive down health care costs.³¹ Examples currently being piloted include capitation,³² accountable care organizations,³³ and bundled payments.³⁴

2. Key Health Care Trends

As outlined previously, the administrative and financial aspects of the American health care system clearly illustrate the industry's complexity. Tension between consistent and emerging trends further complicates matters. The intersection of

Shapes the US Health Sector, ECON. IN ACTION (May 6, 2014), <http://economics.ucsd.edu/economicsinaction/issue-10/headline.php> (emphasizing Medicare's impact on private payment systems).

²⁸ *Fee for Service*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/fee-for-service> (last visited Sept. 13, 2015).

²⁹ For further discussion of this concept, see *infra* Parts II.A.2, 3.

³⁰ This concept will be further reviewed *infra* Part II.A.

³¹ See HEALTHCARE FIN. MGMT. ASS'N, VALUE IN HEALTH CARE: CURRENT STATE AND FUTURE DIRECTIONS 28-29 (2011), <https://www.hfma.org/ValueProject/Phase1> (download "Value in Health Care").

³² Capitation is a method of reimbursement where the provider, hospital, or health plan is paid a fixed amount per patient and is expected to provide all necessary covered services at no additional charge. BARRY D. ALEXANDER ET AL., FUNDAMENTALS OF HEALTH LAW 3 (Am. Health Lawyers Ass'n ed., 4th ed. 2008). Total or global capitation describes when an organization receives capitation for all medical services, institutional and professional. *Id.* at 30.

³³ "Accountable Care Organizations (ACOs) are groups of . . . providers, who come together voluntarily to give coordinated high quality care to their . . . patients. The goal of coordinated care is to ensure that patients . . . get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves." *Accountable Care Organizations (ACO)*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO> (last visited Sept. 13, 2015) (emphasis omitted).

³⁴ Bundled payments "assign[] a fixed payment to cover a set of services, such as a surgery or a patient's diabetes care, over a defined time period. Bundled payments encourage providers to manage costs, while meeting standards of high-quality care." *Bundled Payment: The Quest for Simplicity in Pricing and Tying Payment to Quality*, ROBERT WOOD JOHNSON FOUND. (June 2013), <http://www.rwjf.org/en/library/research/2013/06/bundled-payment--the-quest-for-simplicity-in-pricing-and-tying-p.html>.

health care reform, antitrust law, and provider consolidation underscore the significance of three primary trend categories. First, as with any topic involving health care, spending and financial trends top the list in order of importance. Second, care coordination and quality follow accordingly. Third, the category driving much of the industry's disruption, is the transition from volume to value.

When it comes to American health care costs, there is widespread agreement that the industry is not financially sustainable.³⁵ As of October 1, 2015, the U.S. Census Bureau estimated the national resident population to be roughly 321,862,610.³⁶ The World Bank estimated that American gross national income per capita was \$55,200³⁷ and the United States' gross domestic product ("GDP") was \$17.42 trillion.³⁸ Looking specifically at health care, per capita spending is estimated at \$9,146.³⁹ Further, aggregated health care expenditures account for approximately 17.1% of the United States' GDP.⁴⁰ Experts forecast that number to reach 19.3% by 2023.⁴¹

For purposes of comparison, the United States is often ranked at or near the bottom in terms of health care costs and efficiency among industrialized nations. For example, per capita health care spending in Canada (\$5,718), France (\$4,864), Germany (\$5,006), and the United Kingdom (\$3,598) is, on average, close to fifty

³⁵ See generally SOC. SEC. ADVISORY BD., *THE UNSUSTAINABLE COST OF HEALTH CARE* (2009), http://ssab.gov/portals/0/documents/TheUnsustainableCostofHealthCare_graphics.pdf; Loren Adler & G. William Hoagland, *What is Driving U.S. Health Care Spending? America's Unsustainable Health Care Cost Growth*, BIPARTISAN POLICY CTR. (Sept. 20, 2012), <http://bipartisanpolicy.org/library/report/what-driving-us-health-care-spending-america%E2%80%99s-unsustainable-health-care-cost-growth>; *Rising Health Care Costs Are Unsustainable*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/workplacehealthpromotion/businesscase/reasons/rising.html> (last updated Oct. 23, 2013).

³⁶ *Monthly Population Estimates for the United States*, U.S. CENSUS BUREAU (last visited Oct. 1, 2015), <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>.

³⁷ *GNI Per Capita, Atlas Method*, WORLD BANK, <http://data.worldbank.org/indicator/NY.GNP.PCAP.CD> (last visited Oct. 1, 2015).

³⁸ *United States*, WORLD BANK, <http://data.worldbank.org/country/united-states> (last visited Oct. 1, 2015).

³⁹ *Health Expenditure Per Capita*, WORLD BANK, <http://data.worldbank.org/indicator/SH.XPD.PCAP/countries> (last visited Oct. 1, 2015). "Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation." *Id.*

⁴⁰ *Health Expenditure, Total (% of GDP)*, WORLD BANK, <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries> (last visited Dec. 12, 2014).

⁴¹ Andrea M. Sisko et al., *National Health Expenditure Projections, 2013-23: Faster Growth Expected with Expanded Coverage and Improving Economy*, 33 HEALTH AFFS. 1841 (Sept. 2014), <http://content.healthaffairs.org/content/early/2014/08/27/hlthaff.2014.0560>.

percent lower.⁴² Aggregated health care expenditures as a percent of GDP are similarly low for the same countries.⁴³

From a budgetary perspective, the United States' deficit has decreased over the last few years; however, if current tax laws and federal spending remain the same, that trend will reverse as a result of revenue growing at a slower rate than spending.⁴⁴ Though progress has been made related to the federal deficit, President Barack Obama's proposed budget for 2014 contained a \$744 billion shortfall.⁴⁵ Within that budget, federal funds allocated for Social Security, Medicare, and health spending were \$866 billion, \$531 billion, and \$443 billion, respectively.⁴⁶ Aside from the raw numbers, total health care expenditures have steadily increased over the last several decades.⁴⁷ In most cases, the annual percentage growth of health care expenditures has outpaced growth of the national economy.⁴⁸

Despite such drastic spending rates, the United States is consistently mediocre compared with many of its industrialized peers in terms of health outcomes.⁴⁹ The United States has lower adult life expectancy, higher infant mortality rates, and higher rates of obesity than a host of European countries.⁵⁰ Several factors contribute

⁴² See *Health Expenditure Per Capita*, *supra* note 39.

⁴³ Aggregated health care expenditures as a percent of GDP: Canada (10.9%), France (11.7%), Germany (11.3%), and United Kingdom (9.4%). See *id.*

⁴⁴ See CONG. BUDGET OFF., AN UPDATE TO THE BUDGET AND ECONOMIC OUTLOOK: 2014 TO 2024, 2, 16 (2014), https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45653-OutlookUpdate_2014_Aug.pdf (summarizing updates to the federal budget and deficit forecasts).

⁴⁵ *Breaking Down the 2014 Budget*, WASH. POST (Apr. 10, 2013), <http://www.washingtonpost.com/wp-srv/special/politics/presidential-budget-2014>.

⁴⁶ *Id.*

⁴⁷ See EXEC. OFFICE OF THE PRESIDENT OF THE U.S., TRENDS IN HEALTH CARE COST GROWTH AND THE ROLE OF THE AFFORDABLE CARE ACT 1 (2013), http://www.whitehouse.gov/sites/default/files/docs/healthcostreport_final_noembargo_v2.pdf (reviewing trends in health care, including multiple decades of increased health care spending prior to the Affordable Care Act's passage).

⁴⁸ See Jean P. Drouin et al., *Health Care Costs: A Market-Based View*, MCKINSEY Q., Sept. 2008, at 1, 3.

⁴⁹ Generally speaking, health outcomes data are used to measure and compare either the prevalence of certain disease processes or the rate of treatment success across various patient populations. Common outcome measures include cardiovascular deaths, diabetes, infant mortality, obesity, and cancer deaths. See, e.g., *America's Health Rankings*, UNITED HEALTH FOUND., <http://www.americashealthrankings.org> (last visited Feb. 20, 2015).

⁵⁰ See Tae Kuen Kim & Shannon R. Lane, *Government Health Expenditure and Public Health Outcomes: A Comparative Study Among 17 Countries and Implications for U.S. Health Care Reform*, 3 AM. J. CONTEMP. RES. No. 9, 10-11 (2013); David A. Squires, *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality*, COMMONWEALTH FUND (May 2012), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf.

to the rising price of American health care – including pharmaceuticals⁵¹ and medical technology⁵² – but the inverse relationship between spending and the quality of patient health and outcomes is problematic. Rising costs and lagging quality have resulted in CMS ratcheting down payment rates in an effort to control spending.⁵³ Private payers have followed suit,⁵⁴ making financial performance in a fee-for-service setting more difficult for health care providers. This trend continued following the passage of the Affordable Care Act.⁵⁵

3. Provider Response to Health Care Reform

At a high level, the Affordable Care Act is aimed at accomplishing three things: (1) increased individual access to insurance and health care services, (2) improved quality of care provided to individuals, and (3) accomplishing both at an overall lower cost.⁵⁶ In an effort to advance those three aims, the Affordable Care Act includes various provisions and components to promote the delivery of value-based

⁵¹ See Parija Kavilanz, *6 Reasons Health Care Costs Keep Going Up*, CNN MONEY (July 12, 2012), <http://money.cnn.com/2012/07/12/news/economy/health-care-costs>.

⁵² *Id.*; see also Louis Goodman & Timothy Norbeck, *Who's to Blame for Our Rising Healthcare Costs?* FORBES (Apr. 3, 2013), <http://www.forbes.com/sites/realspin/2013/04/03/whos-to-blame-for-our-rising-healthcare-costs>.

⁵³ Helen Adamopoulos, *100 Things to Know About Medicare Reimbursement*, BECKER'S HOSP. CFO (Aug. 19, 2014), <http://www.beckershospitalreview.com/finance/100-things-to-know-about-medicare-reimbursement.html>; see also Merrill Matthews, *Doctors Face a 24% Pay Cut in Both Medicare and Medicaid Reimbursements*, FORBES (Dec. 2, 2013), <http://www.forbes.com/sites/merrillmatthews/2013/12/02/doctors-facing-a-24-pay-cut-in-both-medicare-and-medicaid-reimbursements>.

⁵⁴ See Jeffrey Bendix, *Private Payers Re-Examining Reimbursement*, MEDICAL ECON. (Feb. 25, 2013), <http://medicaleconomics.modernmedicine.com/medical-economics/news/modernmedicine/modern-medicine-feature-articles/private-payers-re-examining-r?page=full>.

⁵⁵ See generally CTRS. FOR MEDICARE & MEDICAID SERVS., AFFORDABLE CARE ACT UPDATE: IMPLEMENTING MEDICARE COST SAVINGS, <http://www.cms.gov/apps/docs/aca-update-implementing-medicare-costs-savings.pdf> (last visited Oct. 28, 2015); *Medicare Hospital Readmissions Reduction Program*, HEALTH POL'Y BRIEFS, HEALTH AFFS. (Nov. 12, 2013), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=102_.

⁵⁶ See *Key Features of the Affordable Care Act*, DEP'T OF HEALTH & HUM.SERVS., <http://www.hhs.gov/healthcare/facts/timeline/index.html> (last updated Nov. 18, 2014) (summarizing the key features of the Affordable Care Act). This tripartite framework is commonly referred to as the Triple Aim. *The IHI Triple Aim*, INST. FOR HEALTHCARE IMPROVEMENT, <http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx> (last visited Feb. 15, 2015). Donald Berwick, M.D., a physician who went on to lead both the Institute for Healthcare Improvement and the Centers for Medicare and Medicaid Services under President Barack Obama, initially developed this concept. *Profiles in Leadership: Don Berwick*, INST. FOR HEALTHCARE IMPROVEMENT, <http://www.ihl.org/education/ihlopenschool/resources/pages/profilesinleadershipdonberwick.aspx> (last visited Oct. 28, 2015). The Triple Aim is a recurring theme in health care policy development, analysis, and reform. *Key Features of the Affordable Care Act*, *supra*.

care.⁵⁷ From a provider's prospective, this further emphasizes the move away from a fee-for-service business model to a value-based compensation business model. This kind of transition has proven difficult for many health care providers, especially stand-alone hospitals,⁵⁸ smaller health systems, and independent physician practices.⁵⁹ To minimize the financial risks associated with the volume-to-value transition, many providers need to broaden the patient populations they serve, spread their financial risks as much as possible, and invest in more powerful information technology.⁶⁰ The result has been a significant increase in the number of mergers, acquisitions, and joint ventures among hospitals, health systems, and other types of health care providers.⁶¹

B. Antitrust Law and Enforcement

1. Key Statutes and Purposes

The increase in provider merger and acquisition activity has caught the attention of federal and state antitrust regulators.⁶² Before reviewing the standard approach to antitrust analysis and enforcement, a brief review of the FTC's authority is appropriate. The FTC's jurisdiction derives from multiple federal statutes, including the Federal Trade Commission Act ("FTC Act") and the Clayton Act.

The FTC was created in September of 1914 when President Woodrow Wilson signed the FTC Act into law.⁶³ The purpose of the legislation was to create an agency to protect consumers and promote marketplace competition.⁶⁴ For purposes of enforcement, the FTC Act provides the FTC with investigative power and the authority to protect various forms of consumer activities, such as prohibiting unfair business practices.⁶⁵ The Clayton Act was ratified less than a month later in October of 1914.⁶⁶ Specifically, section 7 of the Clayton Act proscribes contracts, mergers,

⁵⁷ See *Summary of the Affordable Care Act*, KAISER FAM. FOUND. (Apr. 25, 2013), <http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act>.

⁵⁸ See Kenneth L. Davis, Opinion, *Hospital Mergers Can Lower Costs and Improve Medical Care*, WALL ST. J. (Sept. 15, 2015), <http://www.wsj.com/articles/kenneth-l-davis-hospital-mergers-can-lower-costs-and-improve-medical-care-1410823048>.

⁵⁹ See David C. Pate, *Hospital-Physician Relations in a Post-Health Care Reform Environment*, 33 J. LEGAL MED. 7, 18-19 (2012).

⁶⁰ See *id.* at 14-16.

⁶¹ Ayla Ellison, *Should Hospitals Merge to Improve Care, Lower Costs?* BECKER'S HOSP. REV. (Sept. 16, 2014), <http://www.beckershospitalreview.com/hospital-transactions-and-valuation/should-hospitals-merge-to-improve-care-lower-costs.html>.

⁶² For an example resulting from increased attention, see *infra* Part I.C.

⁶³ *About the FTC*, FED. TRADE COMM'N, <http://www.ftc.gov/about-ftc/our-history> (last visited Oct. 1, 2015).

⁶⁴ *Id.*

⁶⁵ See 15 U.S.C. § 45 (2012).

⁶⁶ *About the FTC*, *supra* note 63.

and acquisitions that decrease competition and enhance the likelihood of monopoly.⁶⁷

Essential to understanding the Clayton Act's enforcement, the Supreme Court of the United States held that Congress intentionally used the word "may" in section 7 "to indicate that its concern was with probabilities, not certainties."⁶⁸ Lower courts expanded upon that notion and hold that section 7 requires a prediction of anticompetitive effects with doubts to be resolved against the transaction.⁶⁹ Though the agency and its enacting laws are more than one hundred years old, the FTC has as much authority as ever. Further, section 7 remains a substantial source of federal authority to prevent or dissolve mergers and acquisitions considered anticompetitive.

2. Antitrust Analysis and Enforcement

As a subdivision of the larger agency, the Bureau of Competition leads FTC enforcement of antitrust laws.⁷⁰ The Bureau of Competition investigates and seeks legal remedies in both federal court and in front of administrative law judges.⁷¹ The FTC and the Bureau of Competition typically exercise their authority by reviewing pre-merger and post-merger transactions, by issuing advisory opinions, and by conducting administrative rulemaking.⁷² Aside from the procedural aspects of

⁶⁷ See 15 U.S.C. § 18 (2012).

⁶⁸ *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962).

⁶⁹ See, e.g., *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989) (Posner, J.).

⁷⁰ *About the Bureau of Competition*, FED. TRADE COMM'N, <http://www.ftc.gov/about-ftc/bureaus-offices/bureau-competition/about-bureau-competition> (last visited Oct. 28, 2015). The Department of Justice maintains certain authority to enforce antitrust laws, but FTC enforcement will remain the primary focus of this Note.

⁷¹ *Id.* The Administrative Procedure Act of 1946 made possible the appointment of administrative law judges. See 5 U.S.C. § 556 (2012) (listing the process and authority for conducting hearings and presiding employees). A significant number of federal and state administrative agencies employ administrative law judges, including the FTC, the Department of Health and Human Services, the Department of Veterans Affairs, and the Drug Enforcement Agency. See *Agencies Employing Administrative Law Judges*, ASS'N OF ADMIN. LAW JUDGES, <http://www.aalj.org/agencies-employing-administrative-law-judges> (last visited Feb. 20, 2015). The U.S. Office of Personnel Management has a non-delegable responsibility to administer the administrative law judge examination, the method by which various government agencies make administrative law judge service appointments. *Administrative Law Judges*, U.S. OFF. OF PERS. MGMT., <http://www.opm.gov/services-for-agencies/administrative-law-judges/> (last visited Feb. 21, 2015). Administrative law judges "serve as independent impartial triers of fact in formal proceedings requiring a decision on the record after the opportunity for a hearing." *Classification & Qualifications*, U.S. OFFICE OF PERS. MGMT., <https://www.opm.gov/policy-data-oversight/classification-qualifications/general-schedule-qualification-standards/specialty-areas/administrative-law-judge-positions> (last visited Oct. 28, 2015). Though referred to as "impartial triers of fact," the objectivity of administrative law judges is sometimes called into question because the employing agency can initially function as both prosecutor and judge. See, e.g., Ann Wise, *Louisiana's Division of Administrative Law: An Independent Administrative Hearings Tribunal*, 68 LA. L. REV. 1169, 1198 (2008).

⁷² See generally *Enforcement*, FED. TRADE COMM'N, <http://www.ftc.gov/enforcement> (last visited Feb. 13, 2015).

enforcement, the FTC and Department of Justice lay out their principal analytical techniques in their jointly published Horizontal Merger Guidelines (“Guidelines”).⁷³

The principles in the Guidelines are simply a framework for analysis as opposed to a defined step-by-step procedure. According to the document itself, the merger review process is “fact-specific” and guided by the agencies’ collective experience.⁷⁴ “The Agencies . . . apply a range of analytical tools to the reasonably available and reliable evidence to evaluate competitive concerns in a limited period of time.”⁷⁵ Even though much of the analysis is uniform, the FTC’s approach is based on the unique facts and circumstances of each individual transaction. Most importantly, recall that the Supreme Court held that the FTC and the Bureau of Competition are able to base their analysis on probabilities as opposed to certainties.⁷⁶ Likewise, any doubts arising from the analysis are to be resolved against the transaction in question.⁷⁷

When reviewing pre-merger competitive effects, the FTC considers enhanced market power in the form of increased price, reduced output, or other harms to consumers that typically result from decreased competition.⁷⁸ The FTC also considers non-price related adverse market effects of mergers, including reduced product quality, reduced variety, reduced service, or diminished innovation.⁷⁹ If the FTC analysis takes place after a merger, similar to the example presented in the following section,⁸⁰ actual as well as potential adverse effects are taken into account.⁸¹ Whether pre- or post-merger, the FTC’s level of regulatory scrutiny remains the same.

Another key aspect of the Bureau of Competition’s analysis is the definition of the relevant market.⁸² The definition of a market is comprised of the following

⁷³ U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, HORIZONTAL MERGER GUIDELINES (2010), <http://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf> [hereinafter GUIDELINES]. “These Guidelines should be read with the awareness that merger analysis does not consist of uniform application of a single methodology.” *Id.* at 1.

In addition to the Guidelines, the FTC and Department of Justice have published policy statements specific to health care transactions. Interestingly, the most recent publication date is 1996 and does not include specific guidance for integrated delivery systems despite their prevalence across the United States. *See generally* U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), <http://www.justice.gov/sites/default/files/atr/legacy/2007/08/14/0000.pdf>.

⁷⁴ GUIDELINES, *supra* note 73, at 1.

⁷⁵ *Id.* “The Agencies consider many sources of evidence in their merger analysis. The most common sources of reasonably available and reliable evidence are the merging parties, customers, other industry participants, and industry observers.” *Id.* at 4.

⁷⁶ *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962).

⁷⁷ *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (1989) (Posner, J.).

⁷⁸ GUIDELINES, *supra* note 73, at 2.

⁷⁹ *Id.*

⁸⁰ *See infra* Part I.C.

⁸¹ *Guidelines*, *supra* note 73, at 3.

⁸² *See id.* at 7-8.

elements: (1) the line of commerce, (2) the geographic section of the country, (3) the market participants, and (4) market concentration.⁸³ These elements “illuminate” the merger’s competitive effects.⁸⁴ Looking specifically at the product market, the Bureau of Competition reviews the merging firms’ primary product, or service, and defines a relevant group or substitute of products to analyze the competitive effects.⁸⁵ Just as important, the Bureau of Competition conducts a geographic market review, which establishes limits related to consumer willingness or ability to travel to find an alternative product or service or substitute.⁸⁶ Product and geographic market analyses are of great importance when it comes to the health care sector because of the limited availability of certain health care services and the breadth of the involved providers’ service areas.

As a potential mitigating factor, the Bureau of Competition entertains evidence related to gains in efficiency presented by the merging parties. The Bureau of Competition weighs potential efficiencies against anticompetitive effects that may result from mergers because the merged entities often have the ability to achieve significant improvements in terms of price, quality, service offerings, and product offerings.⁸⁷ From time to time, the Bureau of Competition acknowledges that “efficient” mergers even enhance the competitive landscape by combining complementary assets.⁸⁸ However, the agencies only credit likely or resulting efficiencies if they are improbable in absence of the merger.⁸⁹ Thus, the efficiencies must be “merger specific.”⁹⁰ Further, according to the Guidelines, vague or speculative efficiency claims are not considered valid unless they can be verified by reasonable means.⁹¹ Still, the FTC views such efficiency claims with considerable skepticism.⁹²

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.* at 8-12.

⁸⁶ *Id.* at 13.

⁸⁷ *Id.* at 29-31.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*; see also *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 722 (D.C. Cir. 2001) (holding that efficiencies resulting from mergers “must be efficiencies that cannot be achieved by either company alone because, if they can, the merger’s asserted benefits can be achieved without the concomitant loss of a competitor”).

⁹¹ GUIDELINES, *supra* note 73, at 30.

⁹² See *id.* As presented in the Guidelines, efficiencies are viewed with such skepticism because

Efficiencies are difficult to verify and quantify, in part because much of the information relating to efficiencies is uniquely in the possession of the merging firms. Moreover, efficiencies projected reasonably and in good faith by the merging firms may not be realized. Therefore, it is incumbent upon the merging firms to substantiate efficiency claims so that the Agencies can verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved

C. An Example of When Law and Policy Collide

Taking into account the concepts, trends, legal and regulatory authority set forth in the preceding part, there are multiple examples of antitrust enforcement blocking or dissolving mergers and acquisitions across the health care industry.⁹³ One example took place in Idaho, recently. This example clearly illustrates the challenges present throughout the American health care industry and how those challenges can be exacerbated by strict enforcement of section 7.

St. Luke's Health System ("St. Luke's") is the only Idaho-based not-for-profit health system.⁹⁴ Headquartered in Boise, St. Luke's is comprised of seven hospitals⁹⁵ and multiple freestanding health centers.⁹⁶ St. Luke's also employs or contracts with approximately five hundred physicians across various clinical specialties.⁹⁷ St. Luke's service area includes a majority of southern Idaho as well as parts of eastern Oregon,⁹⁸ and is by far Idaho's largest provider of health care services.⁹⁹

Roughly twenty miles east of Boise, Saltzer Medical Group ("Saltzer") is based in the picturesque suburb of Nampa.¹⁰⁰ Historically known for high-quality patient care, Saltzer is Idaho's largest independent physician practice.¹⁰¹ In addition to its main clinic and headquarters in Nampa, Saltzer maintains multiple practice locations

(and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific.

Id.

⁹³ In addition to the forthcoming in-depth case review, another recent example of the FTC's exercise of antitrust authority in the health care field involved ProMedica Health System in Toledo, Ohio. *See ProMedica Health Sys. v. FTC*, 749 F.3d 559, 561 (6th Cir. 2014) (denying ProMedica's petition to review the FTC's order for ProMedica to divest a local community hospital in a nearby suburb). Note that this *ProMedica* case included the use of an FTC administrative law judge. *Id.*

⁹⁴ *About St. Luke's Health System*, ST. LUKE'S HEALTH SYS., http://www.stlukesonline.org/about_us (last visited Aug. 31, 2015).

⁹⁵ *See List of Locations*, ST. LUKE'S HEALTH SYS., http://www.stlukesonline.org/about_us/locations.php (last visited Aug. 31, 2015).

⁹⁶ *See id.*

⁹⁷ *Saint Alphonsus Med. Ctr.—Nampa, Inc. v. St. Luke's Health Sys.*, Nos. 1:12-CV-00560-BLW, 1:13-CV-00116-BLW, 2014 WL 407446, at *3 (D. Idaho Jan. 24, 2014), *aff'd*, 778 F.3d 775 (9th Cir. 2015).

⁹⁸ *Id.*

⁹⁹ *See Galewitz, supra* note 7 (referring to St. Luke's as Idaho's largest not-for-profit health system).

¹⁰⁰ *Location & Clinics*, SALTZER MED. GRP., <http://www.saltzmed.com/locations> (last visited Sept. 2, 2015).

¹⁰¹ *St. Luke's*, 2014 WL 407446, at *3.

in Meridian, Caldwell, and Boise.¹⁰² Slightly more than forty physicians work across Saltzer facilities, and most of them practice primary care medicine.¹⁰³

For years, and in line with industry trends,¹⁰⁴ senior leadership at St. Luke's and Saltzer saw the increasing need for more integrated health care delivery at an overall lower cost.¹⁰⁵ Saltzer believed it needed to make multiple modifications to its long-standing administrative practices, including a transition to a value-based compensation model and an upgrade to its electronic health record ("EHR") system.¹⁰⁶ Unfortunately, Saltzer did not have the resources necessary to take on that level of financial risk.¹⁰⁷ Nor could Saltzer make its needed level of investment in technology infrastructure without partnering with a larger organization.¹⁰⁸

Following multiple failed attempts to informally collaborate with other health care providers—including one with an out-of-state parent—Saltzer determined that an affiliation with a local partner would likely yield positive results.¹⁰⁹ In 2008, Saltzer and St. Luke's executed a memorandum of understanding to establish an informal partnership focused on five specified areas of improvement.¹¹⁰ The five improvement areas were rooted in three overarching concepts: (1) improved access to high-quality medical care, (2) enhanced coordination of medical services, and (3) a streamlined care delivery model in two counties.¹¹¹

Although their collaboration was well intentioned, both parties admitted to minimal success because the "informal" relationship proved difficult to manage.¹¹²

¹⁰² *Location & Clinics*, *supra* note 100.

¹⁰³ *St. Luke's*, 2014 WL 407446, at *3. In terms of policy and patient care management, the importance of primary care medicine cannot be understated. Primary care providers are often considered the keystone for real and lasting health care reform and industry-wide improvement. *See, e.g.*, Naomi Freundlich, *Primary Care: Our First Line of Defense*, COMMONWEALTH FUND (June 12, 2013), <http://www.commonwealthfund.org/publications/health-reform-and-you/primary-care-our-first-line-of-defense>. Collaboration or integration between primary care medicine providers and other health care providers is essential. *See id.* "U.S. adults who have a primary care physician have 33 percent lower health care costs and 19 percent lower odds of dying than those who see only a specialist. As a nation, we would save \$67 billion each year if everybody used a primary care provider as their usual source of care." *Id.*

¹⁰⁴ *See supra* Part I.A.2.

¹⁰⁵ *St. Luke's*, 2014 WL 407446, at *3.

¹⁰⁶ *Id.* at *3, *18. "EHRs are, at their simplest, digital (computerized) versions of patients' paper charts. But EHRs, when fully up and running, are so much more than that. EHRs are real-time, patient-centered records. They make information available instantly, 'whenever and wherever it is needed.'" *Learn EHR Basics*, OFFICE OF THE NAT'L COORDINATOR FOR HEALTH INFO. TECH., <http://www.healthit.gov/providers-professionals/learn-ehr-basics> (last visited Sept. 2, 2015).

¹⁰⁷ *St. Luke's*, 2014 WL 407446, at *3.

¹⁰⁸ *Id.* at *3, *18.

¹⁰⁹ *Id.* at *4.

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

In 2009, Saltzer approached St. Luke's to explore a closer, more formal affiliation.¹¹³ After nearly three years of extensive negotiations, St. Luke's acquired Saltzer effective December 31, 2012.¹¹⁴ As part of the transaction, Saltzer, on behalf of its physicians, entered into a professional services agreement with St. Luke's that included an exclusivity provision, an open referral policy,¹¹⁵ and a production-based compensation model intended to convert to a value-based model.¹¹⁶

Saltzer's leadership indicated that its primary motivation for approaching St. Luke's was "to provide the best possible health care to the community."¹¹⁷ Saltzer further emphasized that the transaction would result in St. Luke's investment of time and resources in Canyon County and that St. Luke's accepted the risk needed for Saltzer to convert to capitation.¹¹⁸ Last, Saltzer's leadership noted that the affiliation with St. Luke's would result in increased patient access to health care services, especially for the Medicare and Medicaid populations throughout its geographic service area.¹¹⁹

Despite the emphasis on improvement of patient care, investment in infrastructure, and enhanced patient access, St. Luke's acquisition of Saltzer quickly fell under scrutiny. In early 2013, two of St. Luke's local competitors filed a joint complaint in federal court claiming the transaction had anticompetitive effects; a second complaint was filed soon after, this time by the Idaho Attorney General and the FTC.¹²⁰ According to an FTC press release filed the same day as the complaint, "the combination of St. Luke's and Saltzer would give it the market power to demand higher rates for health care services . . . ultimately leading to higher costs for health care consumers."¹²¹ The FTC's primary authority for making such an assertion: section 7 of the Clayton Act.¹²²

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.* at *5. "Buying" physician referrals of patients and services is illegal under the fraud and anti-kickback statutes. *See* 42 U.S.C. § 1320a-7b (2012) (listing criminal penalties for acts involving federal health care programs); 42 U.S.C. § 1395nn(a) (2010) (listing the limitations on certain physician referrals). The inclusion of such clear language in the Saltzer physicians' professional services agreement supports the argument that the acquisition was intended to improve quality and patient care—even if it meant certain referrals leaving the St. Luke's delivery system.

¹¹⁶ *See St. Luke's*, 2014 WL 407446, at *5.

¹¹⁷ *Id.*

¹¹⁸ *Id.*; *see also* ALEXANDER, *supra* note 32, at 3 and accompanying text.

¹¹⁹ *St. Luke's*, 2014 WL 407446, at *6.

¹²⁰ *Id.* at *1.

¹²¹ Press Release, Fed. Trade Comm'n, FTC and Idaho Attorney General Challenge St. Luke's Health System Acquisition of Saltzer Medical Group as Anticompetitive (Mar. 12, 2013), <https://www.ftc.gov/news-events/press-releases/2013/03/ftc-idaho-attorney-general-challenge-st-lukes-health-systems>.

¹²² 15 U.S.C. § 18 (2012).

As previously indicated, section 7 makes mergers and acquisitions unlawful that “may . . . substantially . . . lessen competition, or tend . . . to create a monopoly.”¹²³ Thus, it is no real surprise that the U.S. District Court for the District of Idaho ruled in favor of the FTC and summarily ordered St. Luke’s to divest itself of Saltzer.¹²⁴ Notwithstanding the district court’s decision to unwind the transaction, Chief Judge B. Lynn Winmill included the following in his conclusion:

Health care is at a crisis point. Nationally, quality lags far behind the inexorable rise in prices. This has created a groundswell of demand for change. One change universally recommended is to move away from fee-for-service reimbursement and toward integrated care and risk-based reimbursement, where payment is made on the basis of patient outcomes, not the volume of services. This is a major change and is slowly being implemented. This period of change might be best described as being in an experimental stage, where hospitals and other providers are examining different organizational models, trying to find the best fit. To be part of this experimental wave moving toward integrated care, St. Luke’s and Saltzer agreed on the Acquisition. The Acquisition is an attempt by St. Luke’s and Saltzer to improve the quality of medical care. . . . In a world that was not governed by the Clayton Act, the best result might be to approve the Acquisition and monitor its outcome to see if the predicted price increases actually occurred. In other words, the Acquisition could serve as a controlled experiment. But the Clayton Act is in full force, and it must be enforced. The Act does not give the Court discretion to set it aside to conduct a health care experiment.¹²⁵

St. Luke’s appealed the district court’s decision, but the Ninth Circuit Court of Appeals affirmed the district court’s decision.¹²⁶ On the first page of its opinion, the Ninth Circuit echoed the district court’s reasoning that it is not the job of the courts to shape the desired or optimal future of the national health care system.¹²⁷ A court’s role is simply to determine whether the merger in question violates the Clayton Act.¹²⁸ It remains to be seen whether St. Luke’s will petition the Supreme Court of the United States for a writ of certiorari.

¹²³ *Id.*

¹²⁴ *St. Luke’s*, 2014 WL 407446, at *26.

¹²⁵ *Id.* at *25 (paragraph breaks omitted).

¹²⁶ *Saint Alphonsus Med. Ctr.—Nampa, Inc. v. St. Luke’s Health Sys.*, 778 F.3d 775, 793 (9th Cir. 2015).

¹²⁷ *Id.* at 781.

¹²⁸ *Id.* The decision from the Ninth Circuit Court of Appeals further underscores that competition remains the primary focus of section 7 enforcement. Even when industry-specific benefits or improvements are possible or likely, market competition remains paramount:

But even if we assume that the claimed efficiencies were merger-specific, the defense would nonetheless fail. At most, the district court concluded that St. Luke’s might provide better service to patients after the merger. That is a laudable goal, but the Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations. The district court did not clearly err in concluding that whatever else St. Luke’s proved, it did not demonstrate

II. WHY AN EXEMPTION TO SECTION 7 IS APPROPRIATE

On its face, the district court's *St. Luke's* decision likely appears to be a straightforward and appropriate result of section 7 enforcement. However, this case and its surrounding facts do much more than provide a recent example of how the FTC approaches antitrust enforcement in the health care sector. This case illustrates the market and regulatory challenges impacting health care.¹²⁹ Chief Judge Winmill, in his district court opinion, paraphrases pervading public opinion.¹³⁰ He underscores the need for change, experimentation, and innovation when it comes to organizational models in the health care space.¹³¹ But the court's ultimate decision—divestiture—is inconsistent with current federal health policy initiatives, including the Affordable Care Act.

The Affordable Care Act is aimed at accomplishing three things: (1) increased individual access to health insurance and health care services, (2) improved quality of care provided to individuals, and (3) accomplishing both at an overall lower cost.¹³² By reviewing the facts and conclusions reached by the district court and the Ninth Circuit, the rationale for *St. Luke's* acquisition of Saltzer is directly in line with these overarching goals. Yet the FTC's enforcement of section 7 prevented the business relationship between *St. Luke's* and Saltzer from coming to fruition and producing its intended results. This dichotomy presents a significant problem.

Although opinions vary, this type of provider integration has the potential to deliver real benefits to patients and communities across the United States. Despite this potential, section 7's enforcement can prevent mergers and acquisitions intended to coordinate care delivery, increase efficiency, and drive cost savings if the FTC "predicts" potential anticompetitive effects. In an effort to balance antitrust enforcement and the high-level priorities associated with health care reform, strict enforcement of section 7 should be reevaluated. FTC enforcement should support government and industry efforts to contain rising health care costs and improve clinical quality. This can be accomplished by Congress enacting legislation that allows for a narrow statutory exemption to enforcement of section 7. Such a statutory exemption would permit transactions similar to *St. Luke's* attempted acquisition of Saltzer, while avoiding substantial degradation of antitrust regulatory authority and its associated consumer protections.

Given the information presented, strict enforcement of section 7 does not align with federal and industry efforts to improve health care in terms of cost and quality. Mergers and acquisitions capable of delivering benefits to patients and the industry as a whole run the risk of being prevented or unwound unless legislative action is taken. A statutory exemption to enforcement of section 7 would allow certain appropriate transactions to occur. However, each transaction should have to meet the

that efficiencies resulting from the merger would have a positive effect on competition.

Id. at 791-92.

¹²⁹ See *St. Luke's*, 2014 WL 407446, at *25.

¹³⁰ See *id.*

¹³¹ See *id.*

¹³² *Key Features of the Affordable Care Act*, *supra* note 56 (summarizing the key features of the Affordable Care Act).

following criteria: (1) demonstrate likely cost savings or efficiencies, (2) focus on enhancing quality or patient outcomes, and (3) aim to enhance or maintain existing health care service offerings (hereinafter “Proposed Exemption Criteria”). Despite arguments to the contrary, substantial rationale support this approach.

A. Financial Rationale

1. The Health Care Industry’s Current and Past Performance

More than anything, the health care industry’s current and past financial performance provide the strongest support for exploring alternatives to bend the cost curve downward. As indicated, health care accounts for a substantial portion of per capita spending and gross domestic product in the United States.¹³³ That is partially due to the current fee-for-service business model, where providers are incentivized to conduct more procedures, as opposed to delivering a specific patient outcome at the best possible financial value.¹³⁴ Despite the proliferation of spending, lowered reimbursement rates have increased financial pressure on health care providers of all sizes.¹³⁵ Such decreases are likely necessary for substantial cost savings across the industry; however, not all providers will be able to remain solvent without the help of larger, more financially stable organizations. Allowing mergers and acquisitions that meet the Proposed Exemption Criteria could help financially strained health care providers stabilize and move to more sustainable operating structures and reimbursement models.¹³⁶ This could, in turn, drive improvement across the industry.

2. Capital Requirements for Reinvestment in the System

In addition to systemic financial challenges, health care has been and will continue to be a capital-intensive industry.¹³⁷ Advancements in health care delivery,

¹³³ See *supra* discussion Part I.A.2.

¹³⁴ See *supra* notes 25-28 and associated text related to fee-for-service payment.

¹³⁵ See *supra* notes 53-54 and accompanying text.

¹³⁶ See, e.g., Michael E. Porter & Thomas H. Lee, *The Strategy That Will Fix Health Care*, HARV. BUS. REV. (Oct. 2013), <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>. The authors indicate that a new industry-wide health care strategy should be focused on the following:

At its core is maximizing value for patients: that is, achieving the best outcomes at the lowest cost. We must move away from a supply-driven health care system organized around what physicians do and toward a patient-centered system organized around what patients need. We must shift the focus from the volume and profitability of services provided—physician visits, hospitalizations, procedures, and tests—to the patient outcomes achieved. And we must replace today’s fragmented system, in which every local provider offers a full range of services, with a system in which services for particular medical conditions are concentrated in health-delivery organizations and in the right locations to deliver high-value care.

Id.

¹³⁷ See Rene Letourneau, *Capital Spending Reflects New Era in Healthcare*, HEALTHLEADERS MEDIA (Feb. 10, 2014), <http://www.healthleadersmedia.com/content/FIN-300783/Capital-Spending-Reflects-New-Era-in-Healthcare> (referencing infrastructure enhancements and information technology as two examples of major capital expenditures among health care providers); John Marcille, *A Conversation with Paul H. Keckley, PhD*:

as well as technology, constantly require providers to make significant and frequent investments in new medical equipment, technology, and infrastructure.¹³⁸ As exhibited by the St. Luke's and Saltzer merger, Saltzer was incapable of investing in a new electronic health record system without the financial support of a larger organization.¹³⁹ Such financial limitations are commonplace, but substantial investment is necessary for providers to transition to emerging value-based reimbursement models.¹⁴⁰ Exempting mergers and acquisitions that meet the Proposed Exemption Criteria would give smaller or less financially capable health care providers greater opportunity to partner with larger organizations to deliver greater value to patients and communities as a whole.

3. Transition from Volume to Value and the Realignment of Incentives

Arguments for moving from volume- to value-based reimbursement can be found almost anywhere across the United States, including Chief Judge Winmill's conclusion in *St. Luke's*.¹⁴¹ To make this kind of transition, access to significant amounts of capital funding is required,¹⁴² as is institutional knowledge, and a population base that allows for financial risk to be spread appropriately.¹⁴³ The volume-to-value transition presents a novel opportunity to align financial incentives for both payers and providers. Providers will be incentivized to provide quality and medically necessary care to patients as efficiently as possible. Payers, in turn, will

Clinical Perspective Critical to Health Care Reform, *MANAGED CARE MAG.* (Feb. 2012), http://www.managedcaremag.com/archives/1202/1202.qna_keckley.html (referencing the capital needs among health plans and managed care organizations, which parallels the capital intensive nature of providers).

¹³⁸ See, e.g., Beth Kutscher, *UPMC Issuing \$400 Million in Bonds to Fund Ongoing Projects*, *MODERN HEALTHCARE* (Sept. 15, 2014), <http://www.modernhealthcare.com/article/20140915/NEWS/309159939/upmc-issuing-400-million-in-bonds-to-fund-ongoing-projects> (indicating the health system's capital spending will be focused on outpatient centers and technology upgrades in western Pennsylvania).

¹³⁹ *Saint Alphonsus Med. Ctr.—Nampa, Inc. v. St. Luke's Health Sys.*, Nos. 1:12-CV-00560-BLW, 1:13-CV-00116-BLW, 2014 WL 407446, at *3, *18 (D. Idaho Jan. 24, 2014) *aff'd*, 778 F.3d 775 (9th Cir. 2015).

¹⁴⁰ See *The State of Value-Based Reimbursement and the Transition from Volume to Value in 2014*, *MCKESSON* (Sept. 1, 2014), <http://www.mckesson.com/bps/bps-knowledge-center/the-state-of-value-based-reimbursement-and-the-transition-from-volume-to-value-in-2014> (noting several trends that point to the importance of information technology).

¹⁴¹ “Health care is at a crisis point. Nationally, quality lags far behind the inexorable rise in prices. This has created a groundswell of demand for change. One change universally recommended is to move away from fee-for-service reimbursement and toward integrated care and risk-based reimbursement, where payment is made on the basis of patient outcomes, not the volume of services.” *St. Luke's*, 2014 WL 407446, at *25.

¹⁴² See *supra* Part II.A.2.

¹⁴³ See generally *Population Health Solutions: Support for the Journey to Value-based Care*, *ADVISORY BD. CO.*, <http://www.advisory.com/solutions/population-health> (last visited Feb. 13, 2015) (detailing the firm's approach to population health consulting and priorities providers should consider for success in value-based care delivery).

compensate those providers based on the value of their services. As a result, the patient receives better, more cost effective care. This could result in a renewed focus on patient outcomes that actually benefits all involved parties. Allowing transactions that meet the Proposed Exemption Criteria could advance these efforts by giving providers greater access to needed resources.

B. Quality Rationale

1. Fragmentation of the Current System and Misalignment of Providers

Part of the reason for the United States' rising health care costs and mediocre quality is the fragmented system.¹⁴⁴ Care delivery is often conducted in "silos," where various caregivers do not communicate effectively or share critical patient information.¹⁴⁵ This can be partially improved through the use of robust technology systems as well as growing the size of a given provider network to include more clinicians who are vested in and working for a single entity.¹⁴⁶ Granted, classical mergers and acquisitions are not the only ways to align caregivers of varying specialties;¹⁴⁷ however, given the financial conditions of the health care industry as a whole, any opportunity for improved alignment and coordination should be thoroughly explored. Transactions that satisfy the Proposed Exemption Criteria support greater integration and coordination of care.

2. Improved Health Care Quality as a Consumer Protection

The federal antitrust laws were enacted as a form of consumer protection.¹⁴⁸ To build on that lasting and meaningful principle, exploring new opportunities to afford Americans better access to and improved quality of health care services are substantial consumer protection efforts. Further, providing better care at an improved overall value is another substantial consumer benefit. These ideals align with the fundamental purposes of health care reform;¹⁴⁹ however, the industry disruption caused by the Affordable Care Act has health care providers desperately trying to find new ways to improve financial and clinical performance. Even though some transactions might be considered anticompetitive from a pure section 7 perspective, transactions that meet the Proposed Exemption Criteria could be just as consumer-oriented as the ideals encompassed by the antitrust laws themselves.

¹⁴⁴ See Alan C. Enthoven & Laura A. Tollen, *Competition in Health Care: It Takes Systems to Pursue Quality and Efficiency*, HEALTH AFFS. W5-420 (Sept. 7, 2005), <http://content.healthaffairs.org/content/early/2005/09/07/hlthaff.w5.420>.

¹⁴⁵ See *id.* at W5-428.

¹⁴⁶ See generally *id.*

¹⁴⁷ See, e.g., ESSENTIAL HOSPS. INST., INTEGRATED HEALTH CARE LITERATURE REVIEW 1-2, <http://essentialhospitals.org/wp-content/uploads/2013/12/Integrated-Health-Care-Literature-Review-Webpost-8-22-13-CB.pdf> (May 2013) (listing various definitions for integrated delivery systems). In addition, accountable care organizations are often considered a method for providers to align – but not necessarily merge – in an effort to control health spending and delivery quality health outcomes. See *supra* note 34 and accompanying text.

¹⁴⁸ See *supra* notes 63-67 and accompanying text.

¹⁴⁹ Recall the overarching principles of health care reform, as indicated *supra* Part I.A.3. Likewise, the idea of government-supported consumer protection clearly aligns with the concept of the Triple Aim. See *supra* note 57 and accompanying text.

C. Access and Innovation Rationale

1. Maintenance of Existing Services

Because of health care's financial pressures, maintaining existing health care services and resources will be a challenge for many providers in the future.¹⁵⁰ Some will consolidate or be forced out of practice due to market forces.¹⁵¹ However, in rural or underserved areas, maintaining existing services is critical to community health.¹⁵² The Proposed Exemption Criteria may prove most beneficial in rural or underserved health care markets or those with minimal competition. This underscores the importance of the Proposed Exemption Criteria, especially the criterion related to the maintenance or enhancement of available health services.

2. The Value of Integration and Government-sponsored Innovation Projects

As briefly noted, the federal government values and promotes integration and coordination of health care delivery through various programs and projects.¹⁵³ Some examples include accountable care organizations and bundled payment initiatives.¹⁵⁴ It is these types of programs that are designed to lower costs and drive value in health care delivery. If successful, they may be used on a broader scale or be implemented to a greater extent by private payers and organizations.¹⁵⁵ Preventing transactions, like St. Luke's, stifles organizational innovation and limits the opportunities for providers to participate and collaborate in government-sponsored and market-driven reimbursement experiments. Governmental as well as market-driven efforts are equally imperative for lasting improvement across the industry.

¹⁵⁰ See *supra* notes 35, 44-48 and accompanying text.

¹⁵¹ See generally PHYSICIANS FOUND., HEALTH REFORM AND THE DECLINE OF PHYSICIAN PRIVATE PRACTICE (2010), http://www.physiciansfoundation.org/uploads/default/Health_Reform_and_the_Decline_of_Physician_Private_Practice.pdf; Peter Pavarini & Matt Lindsay, *Health Care Reform Going Forward: What's the Impact on Providers?* BECKER'S HOSP. REV. (Dec. 6, 2012), <http://www.beckershospitalreview.com/hospital-management-administration/health-care-reform-going-forward-whats-the-impact-on-providers.html>.

¹⁵² See generally NAT'L CONFERENCE OF STATE LEGISLATURES, IMPROVING RURAL HEALTH: STATE POLICY OPTIONS (2013), http://www.ncsl.org/documents/health/RuralHealth_PolicyOptions_1113.pdf; Joseph R. Betancourt et al., *Cultural Competence and Health Care Disparities: Key Perspectives and Trends*, 24 HEALTH AFFAIRS 499 (Mar. 2005), <http://content.healthaffairs.org/content/24/2/499.short>.

¹⁵³ See, e.g., *supra* note 12 and accompanying text.

¹⁵⁴ See *supra* notes 33-34.

¹⁵⁵ See NAT'L COMM. ON QUALITY ASSURANCE, NCQA ACCREDITATION OF ACCOUNTABLE CARE ORGANIZATIONS 1-3 (2013), <http://www.ncqa.org/Portals/0/ACO%20Press%20Conference/ACO%20White%20Paper%20Feb.%202013.pdf> (noting how accountable care organizations can demonstrate readiness for accreditation).

D. A New Standard for Exemption

As part of the recommended statutory exemption, certain existing antitrust concepts should be revised. For one, when the FTC's Bureau of Competition, administrative law judges, or courts review efficiency defenses, efficiencies presented by merging entities should no longer be required to be "merger specific."¹⁵⁶ Given the health care industry's financial challenges and issues with fragmentation, any benefits that might result from transactions that meet the Proposed Exemption Criteria should be viewed favorably because such transactions would support the overarching goals of bending the cost curve downward and improving care delivery. Therefore, when merging parties present potential efficiency defenses, they should be considered without regard to being merger specific.

In addition, as long as the transaction aligns with the Proposed Exemption Criteria, the FTC, administrative law judges, and courts should weigh facts and resolve doubts related to anticompetitive effects in favor of the transaction. This is in contrast to the current approach where any uncertainties are resolved against the transaction.¹⁵⁷ Similar to the comments made by Chief Judge Winmill in his district court opinion, favoring transactions that meet the Proposed Exemption Criteria would allow for controlled experiments and innovation in terms of organizational models.¹⁵⁸ The elimination of the "merger specific" requirement for efficiencies and a new approach to resolving factual uncertainties would allow for only certain types of transactions to occur without undermining section 7's larger purpose and authority.

CONCLUSION

The American health care system is in a prolonged financial crisis. As a country, the United States is spending more on health care and getting less value and positive health outcomes. Several policies and efforts are underway in an effort to drive costs downward and improve clinical quality.¹⁵⁹ Some may prove successful, while others may not. Regardless, it is the responsibility of the federal government and the health care industry itself to pursue every opportunity to innovate and improve performance. Further, the federal government must respond to the call for change and permit industry participants to explore all methods of achieving success. Allowing the integration of certain health care providers focused on producing cost savings or efficiencies, enhancing quality and patient outcomes, and enhancing or maintaining existing health care service offerings is a significant opportunity to

¹⁵⁶ See GUIDELINES, *supra* note 73, at 10.

¹⁵⁷ See *FTC v. Elders Grain, Inc.*, 868 F.2d 901, 906 (7th Cir. 1989) (Posner, J.) (holding that doubts related to anticompetitive effects are to be resolved against the transaction at issue).

¹⁵⁸ See *Saint Alphonsus Med. Ctr.—Nampa, Inc. v. St. Luke's Health Sys.*, Nos. 1:12-CV-00560-BLW, 1:13-CV-00116-BLW, 2014 WL 407446, at *25 (D. Idaho Jan. 24, 2014) *aff'd*, 778 F.3d 775 (9th Cir. 2015). "In a world that was not governed by the Clayton Act, the best result might be to approve the Acquisition and monitor its outcome to see if the predicted price increases actually occurred. In other words, the Acquisition could serve as a controlled experiment." *Id.*

¹⁵⁹ See, e.g., *supra* note 12 and accompanying text.

advance the ideals of meaningful health care reform. Antitrust enforcement in the health care sector should reflect those ideals. Thus, a statutory exemption to strict enforcement of section 7 of the Clayton Act should be considered a viable opportunity to promote and advance health system transformation for the better, as long as the merging providers satisfy the Proposed Exemption Criteria.¹⁶⁰

¹⁶⁰ Health care provider transactions should be exempt from Section 7 enforcement as long as they meet the following criteria: (1) demonstrate likely cost savings or efficiencies, (2) focus on enhancing quality or patient outcomes, and (3) aim to enhance or maintain existing health care service offerings.

