Comments of Professors of Law and Economics, Economists, and Health Policy Researchers on the Draft Merger Guidelines

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The Draft Merger Guidelines (DMGs) constitute a major step forward in providing economically sound guidance to practitioners and courts for evaluating the potential competitive impact of mergers and acquisitions. These comments are offered by a group of law professors, economists, and policy experts who have devoted most of their professional careers to issues concerning market and regulatory issues involving health care providers and payors. The comment focus on several proposed changes that are of particular importance to improving oversight of consolidation in the health care sector.

The experience of the health care sector offers a prime example of why an update of the federal merger guidelines is much needed. Although over the last twenty years virtually every newly-appointed Commissioner of the Federal Trade Commission and Assistant Attorney General of the Antitrust Division of the U.S. Department of Justice has identified health care as a primary focus of enforcement under their watch, provider market concentration has grown exponentially and price increases continue to exceed those of most other sectors.[1] The majority of hospital markets are highly concentrated, with many dominated by one or two large hospital systems with no close competitors.[2] Likewise, two-thirds of metropolitan statistical areas (MSAs) have highly concentrated physician specialty markets and hospitals now employ over half of all physicians.[3] Numerous economic studies confirm that elevated levels of market concentration are associated with high and increasing prices over time in physician, hospital, and insurance markets.[4] At the same time, many studies also demonstrate that there is little, if any,

[1] *Examining the Impact of Health Care Consolidation: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 115th Cong. 16-41 (2018) (statement of Martin Gaynor, Ph.D., E.J. Barone University Professor of Economics and Health Policy, Carnegie Mellon University); *see also*, Anna Wilde Mathews, *Health-Insurance Costs are Taking the Biggest Jumps in Years*, WALL ST. J (Sept. 7, 2023), https://www.wsj.com/health/healthcare/health-insurance-cost-increase-5b35ead7; Emily Gee, *The High Price of Hospital Care*, CTR. FOR AM. PROGRESS (2019), https://www.americanprogress.org/wp-content/uploads/sites/2/2019/06/HospitalCosts-report.pdf.

[2] Gaynor, supra note 1.

[3] Carol K. Kane, *Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022*, AM. MEDICAL ASS'N (2023); Rachel M. Machta et al., Health system integration with physician specialties varies across markets and system types, HEALTH SERV. RSCH. (2020); MEDPAC, *March 2020 Report to the Congress: Medicare Payment Policy* (Mar. 13, 2020), https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar20_entirereport_sec-pdf/.

[4] Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, 36 HEALTH AFF. 9 (2017);; Zack Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, Q J ECON. 134(1): 51–107 (2019) (monopoly hospitals have prices 12% higher than those in competitively structured markets); Martin Gaynor & Robert J. Town, *The Impact of Hospital Consolidation— Update*, ROBERT WOOD JOHNSON FOUND. (2012); Laurence Baker et al., *Vertical Integration:*

correlation between size and quality of care.[5] In short, as one leading health care economist summarized the literature, "There is widespread agreement that [health care] markets do not work as well as they could, or should."[6]

While deficiencies in antitrust enforcement are certainly not the sole cause of the poor performance of health care markets, there are ample opportunities to improve the law's oversight of consolidations and thereby slow the sector-wide trend toward oligopolistic or monopolized markets. For example, the DMGs are to be applauded for adjusting the structural presumption back to the 1800 HHI level set forth in the 1982 guidelines and further stating that "a merger that significantly increases concentration and creates a firm with a share over thirty percent presents an impermissible threat of undue concentration regardless of the overall level of market concentration." (DMG 1). This change is consistent with economic studies finding price effects at lower HHI levels than permitted under the permissive standards contained in the 2010 guidelines[7] and would restore the agencies' proper focus on the incipiency risks of increasing concentration.[8] The DMGs also appropriately cabin consideration of efficiencies, stating "cognizable efficiencies must be of sufficient magnitude and likelihood that no substantial lessening of competition is threatened by the merger in any relevant market." (DMG 4.3). Consistent with well-established case law, to be cognizable, efficiencies must be verifiable, merger specific, and procompetitive. The DMGs echo judicial skepticism of claims of potential quality improvements,[9] which are common in health care merger cases.[10]

Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending, 33 HEALTH AFF. 5 (2014).

[5] Lawton Robert Burns & Mark V. Pauly, *Big Med's Spread*, MILLBANK Q. 101(2)0330 (2023); INSTITUTE OF MEDICINE (US) COMM. ON QUALITY OF HEALTH CARE IN AMERICA, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE TWENTY-FIRST CENTURY (National Academies Press, Washington, D.C., 2001); Zack Cooper et al., *Do Higher-Priced Hospitals Deliver Higher-Quality Care? (*Nat'l Bureau of Econ. Rsch., Working Paper No. 29809, 2023*);* Daniel P. Kessler & Mark B. McClellan, *Is Hospital Competition Socially Wasteful?* 115 QUARTERLY JOURNAL OF ECONOMICS 577 (2000).

[6] Gaynor, supra note 1.

[7] *See* John Kwoka, *Closing the Gap in Merger Enforcement*, PROMARKET (Jun. 22, 2023) (retrospective studies of "close call" mergers—those investigated but then cleared by antitrust agencies—indicate that 83% resulted in significant price increases).

[8] United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 362 (1963) (emphasizing that "the amended section 7 was intended to arrest anticompetitive tendencies in their 'incipiency.'").

[9] *See* FTC v. ProMedica Health Syst., Inc., 2011 WL 1219281 (N.D. Ohio 2011) ("No court … has found efficiencies sufficient to rescue an otherwise illegal merger.")

[10] *See e.g.*, St. Alphonsus Medical Ctr-Nampa Inc. v. St. Luke's Health Syst., Ltd., 778 F.3d 775, 790 (9th Cir. 2015) ("We remain skeptical about the efficiencies defense in general and about its scope in particular."); FTC. v. Univ. Health, Inc., 938 F.2d 1206, 1223 (11th Cir. 1991) ("measurement of efficiency. . . [is] an intractable subject for litigation"); *see also*, Mary L. Azcuenaga, F.T.C. Comm'r, Hospitals and Competition Policy, Remarks Before the American Protestant Health Association Washington Leadership Forum (May 11, 1992) ("parties often

We also endorse the following three important provisions that are of particular significance in evaluating health care transactions.

Serial Acquisitions (DMG 9)

The DMG break new ground by specifically focusing on firms engaging in "an anticompetitive pattern or strategy of multiple small acquisitions in the same or related business lines … even if no single acquisition on its own would risk substantially lessening competition or tending to create a monopoly." In contrast to the prevailing practice of evaluating every acquisition separately, DMG 9 indicates that the agencies will consider the cumulative competitive impact of serial acquisitions. This change is particularly important in health care markets in which private equity (PE) firms have often acquired significant market power through piecemeal acquisitions of specialty physician practices.[11] An important recent study found that in 28% of MSAs, a single PE firm has more than 30% market share by full-time-equivalent physicians, and in 13% of MSAs, the single PE firm market share exceeds 50%.[12] A similar problem exists regarding hospitals' incremental acquisitions of physician practices, discussed below, which has been generally overlooked as most go undetected because they fall below Hart-Scott-Rodino (HSR) reporting requirements.

Vertical Mergers (DMG 6)

Although federal and state antitrust enforcement agencies have long devoted an extraordinary proportion of their resources to the health care sector, attention to vertical mergers has been lacking. The reasons for this are several, including the dearth of legal precedents and the ascendancy of Chicago School generalizations that modern scholarship has largely refuted.[13] This legal vacuum has produced anticompetitive consequences in health care. Hospitals around the country have engaged in a feeding frenzy, acquiring physician practices at an unprecedented pace. Today, forty-one percent of physicians work in practices that are at least partly owned by a hospital or health system, an increase of almost forty percent since 2012.[14] Economic studies

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come in with vague and ill-defined 'synergies'…[lacking a] clear demonstration of how specific economies will follow from a merger.").

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

[12] Richard Scheffler et al., *Monetizing Medicine: Private Equity and Competition in Physician Markets,* AM. ANTITRUST INST. & U.C. BERKELEY SCHOOL OF PUBLIC HEALTH PETRIS CTR. (2023).

[13] *See* Steven C. Salop & Daniel P. Culley, *Potential Competitive Effects of Vertical Mergers: A How-To Guide for Practitioners*, GEORGETOWN UNIV. LAW CTR. (2014) (preconditions underlying Chicago School's critique of vertical mergers "rarely hold, and the broad claim that there is a single monopoly profit can obscure how a particular merger may raise real competitive concerns."); Steven C. Salop, *Invigorating Vertical Merger Enforcement,* 127 YALE LAW J. 1962 (2018).

[14] AM. MEDICAL ASS'N, *Physician Practice Benchmark Survey* (2022), https://www.ama-assn.org/about/research/physician-practice-benchmark-survey#benchmark-survey.

have documented serious anticompetitive effects: prices of *both* acquired physician practices and acquiring hospitals tend to increase post-merger.[15] Moreover, consumer choice has been affected: hospitals' ownership of a physician practices dramatically increases the probability that the physician's patients will choose a high-cost, low-quality hospital when their physician's practice is owned by that hospital.[16]

The DMGs address the problem in several ways. Most importantly, they establish a "foreclosure share" presumption for evaluating the effect of possible harm to competition resulting from the acquiring firm's denial to rivals of access to any related product it acquired. This presumption is notable because courts have tended to insist on quantitative analysis for plaintiffs to establish a prima facie case and relevant data is difficult to obtain in litigation from rival firms.[17] The DMGs' recommended presumptive foreclosure share is 50 percent; where lower foreclosure shares are shown, the DMGs offer a number of sensible "plus factors" such as a trend toward vertical integration, the degree of concentration in the relevant market, barriers to entry, and the nature and purpose of the merger. Finally, DMG 6 sets a high standard for defendants to rebut the presumption that alleged benefits are cognizable only if they do not "result from the anticompetitive worsening of the terms for the merged firm's trading partners… or accelerate a trend toward concentration… or vertical integration." All in all, these changes appropriately raise the bar for proposed vertical mergers.

Cross-Market Mergers (DMG 7)

A significant and growing number of empirical studies have documented the price-elevating impact of some non-horizontal, non-vertical mergers.[18] Although something of a misnomer, so-called "cross-market mergers" are those combinations in which an entity acquires another in a geographic or product market in which it does not directly compete. Although antitrust analyses have for many years ruled out the possibility of competitive harm where there is neither a horizontal nor vertical relationship between the merging parties, these studies have found that geographic expansions by health systems sometimes result in higher prices in the

[15] Cory Capps et al., *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending,* 59 J. HEALTH ECON. 139 (2018); Thomas Greaney, *The New Health Care Merger Wave: Does the "Vertical, Good" Maxim Apply?,* 46 J. L. MED. & ETHICS 918 (2018); Corey Capps et al., *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending* (Inst. for Policy Rsch., Northwestern Univ., Working Paper No. WP-15-02, 2015) (finding that vertical integration was associated with a 13.7% increase in physician prices).

[16] Laurence Baker et al., *The Effect of Hospital/Physician Integration on Hospital Choice,* 50 J. HEALTH ECON. 1 (2016).

[17] Salop, *Invigorating Vertical Merger Enforcement*, supra note 13.

[18] Leemore Dafny, Kate Ho & Robin Lee, *The Price Effects of Cross-Market Mergers,* 50 RAND J. OF ECON. 286, 286 (2019); Matt Schmitt, *Multimarket Contact in the Hospital Industry*, 10 AM. ECON. J.: ECON. POL'Y 361, 361 (2018); Matthew S. Lewis & Kevin E. Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, 48 RAND J. OF ECON. 579, 579 (2017); *see generally* Jaime King et al., *Antitrust's Health Care Conundrum: Cross-Market Mergers and the Rise of System Power,* 74 HASTINGS L.J. 1057; Emilio E. Varanini, *Addressing the Red Queen Problem: A Proposal For Pursuing Antitrust Challenges To Cross-Market Mergers in Health Care Systems*, 83 ANTITRUST L. J. 509, 516 (2020).

acquiring system, the acquired hospitals, or both. While the precise mechanisms enabling these price increases is still being studied, they are likely to occur through at least three possible mechanisms. First, a cross-market hospital system may be able to exercise bargaining leverage by threatening to create multiple "holes" in an employer or insurer provider network where there are "common customers" (insurance plans or employees) across regions and thereby extract excess profits.[19] Alternatively, a health system may tie contracts with some or all of its hospitals to others (e.g., so-called "all-or-nothing contracting").[20] A third mechanism explaining price increases arising from cross-market mergers is based on a "mutual forbearance" hypothesis which posits that firms competing against one another in many markets may not compete vigorously in any given market out of fear of triggering intense competition across all markets. These empirical findings suggest that cross-market mergers resulting in increased multimarket contact between health systems may lead to higher prices and merit closer scrutiny in the future.

The DMGs specifically raise the possibility of challenging mergers involving "an already dominant firm" that "may extend that dominant position into new markets, thereby substantially lessening competition in those markets." DMG 7 cites the potential consumer harms that can arise from firms "entrenching or extending an already dominant position into new markets." One notable example offered in that guideline is the possibility that "a merger might lead the merged firm to leverage its position by tying, bundling, conditioning, or otherwise linking sales of two products, excluding rival firms and ultimately substantially lessening competition in the related market." While only a handful of cases thus far have relied on potential harms from cross-market mergers,[21] the agencies are fulfilling their duty to investigate the implications of evolving economic learning concerning non-horizontal mergers.

Overall, the DMGs respond to growing economic evidence of harm from consolidation in the health care industry and constitute a significant step forward that will enable the agencies to respond to the complexities and emerging trends in the healthcare industry. Specifically, the DMGs provide reasonable guidance to practitioners and courts in evaluating the potential competitive impacts of vertical integration, serial acquisitions, and cross-market mergers that have been largely overlooked by past enforcement efforts.

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[19] Gregory S. Vistnes & Yianis Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79 ANTITRUST LAW J. 253, 255 (2013).

[20] Although one court declined to recognize potential tying as a cognizable theory under Section 7 of the Clayton Act, *see* St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 787 (9th Cir. 2015): its brief analysis relied on erroneous assumptions that ex post enforcement of tying law principles made Clayton Act enforcement superfluous and invited speculation by courts. Refuting this contention, *see* King et al., *Antitrust's Health Care Conundrum*, supra at 1094-1099.

[21] The California attorney general has brought several cases that rely in part on cross-market theories. *See e.g.,* ATTORNEY GENERAL'S DECISION CONDITIONALLY APPROVING THE PROPOSED CHANGE IN CONTROL AND GOVERNANCE OF HUNTINGTON HOSPITAL, STATE OF CAL. DEPT. OF JUSTICE (Dec. 10, 2020), https://oag.ca.gov/sites/all/files/agweb/pdfs/charities/nonprofithosp/ag-decision-huntington-121020.pdf; *see also,* In the Matter of Amgen Inc. and Horizon Therapeutics plc, FTC File No. D09414 (proposed consent order) (Sept. 1, 2023).

Respectfully submitted,

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