



**United States of America  
FEDERAL TRADE COMMISSION  
WASHINGTON, DC 20580**

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**Remarks of Commissioner Rebecca Kelly Slaughter  
As Prepared for Delivery**

**Antitrust and Health Care Providers  
Policies to Promote Competition and Protect Patients  
Center for American Progress  
May 14, 2019**

**Introduction**

I would like to begin by noting that my remarks do not represent the views of the Federal Trade Commission or any other Commissioner.

Thank you to the Center for American Progress for hosting today's important event. I applaud the work that CAP has done in healthcare policy generally, and specifically on competition in healthcare provider markets.<sup>1</sup> It is an honor to join you, and I am excited to talk about competition in healthcare provider markets. There is a lot to say—or to bemoan—about the state of our healthcare markets. In the interest of focusing my comments on an area of expertise for the FTC (and of concluding my remarks before the end of the century), I am going to focus on questions of hospital consolidation in particular.

Too often, we are confronted with distressing healthcare stories. Recent news reports described the fallout from a dispute between insurer Anthem and Hartford HealthCare, a large Connecticut regional health system.<sup>2</sup> Anthem's contract with Hartford had expired and, as a result, Anthem-insured patients at Hartford facilities were facing crippling out-of-network healthcare prices.<sup>3</sup> One Storrs, Connecticut woman told state lawmakers that she had no alternatives to Hartford in eastern Connecticut.<sup>4</sup> Some patients postponed treatment, rationed medication, or were stuck with sky-high bills.<sup>5</sup>

These on-the-ground concerns are reinforced by troubling healthcare market trends. In 2017, spending on healthcare in the United States reached \$3.5 trillion, or more than \$10,000 per

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<sup>1</sup> See, e.g., Emily Gee & Ethan Gurwitz, Provider Consolidation Drives Up Health Care Costs, Center for American Progress (Dec. 2018).

<sup>2</sup> See Reed Abelson, *When Hospitals Merge to Save Money, Patients Often Pay More*, N.Y. TIMES (Nov. 14, 2018), <https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html>; Russell Blair & Rebecca Lurye, *Anthem-Hartford HealthCare Contract Dispute Leaves Patients Caught in the Middle*, HARTFORD COURANT (Nov. 12, 2017), <https://www.courant.com/politics/hc-biz-anthem-hhc-stories-20171109-story.html>.

<sup>3</sup> See Blair & Lurye, *supra*, note 2.

<sup>4</sup> See Abelson, *supra*, note 2.

<sup>5</sup> See Blair & Lurye, *supra*, note 2.

person.<sup>6</sup> One of the chief drivers of increasing healthcare expenditures is the increasing prices of healthcare services,<sup>7</sup> particularly hospital prices.<sup>8</sup> In addition, a recent report on healthcare workers finds that real wages for medical technicians and health aides at hospitals and outpatient facilities have stagnated or declined despite increased worker educational attainment and increased job growth.<sup>9</sup> These troubling trends demand that all stakeholders take a step back, reevaluate their policies and tactics, and consider what enhancements or changes each of us can make to improve our healthcare provider markets.

Competition in healthcare provider markets plays a significant role in helping to deliver high quality, affordable care and to pay healthcare workers fair wages. The Federal Trade Commission, and other enforcers, work tirelessly within their existing authority to promote competitive healthcare markets, but with help from Congress and state governments, more can, and should, be done. When considering whether and how to expand or improve upon existing enforcement policy, we should first ask: what role does the FTC play and how well are we performing? I will begin today by describing the FTC's role and track record in healthcare provider antitrust enforcement and the concerns that remain despite the best efforts of the FTC staff and other enforcers.

### **The FTC's Track Record in Healthcare Provider Markets and Recent Concerns**

The Commission has a long history of challenging anticompetitive mergers in the healthcare industry. By one estimate, nearly half of all FTC merger challenges between 2000 and 2018 involved the healthcare industry,<sup>10</sup> a significant portion of which focused on healthcare providers generally and hospitals in particular.<sup>11</sup>

But the FTC has had to overcome significant obstacles. After successfully challenging several mergers in the late 1980s and early 1990s,<sup>12</sup> the Commission and other antitrust enforcers suffered a string of seven hospital merger litigation defeats.<sup>13</sup> In many of these cases, courts

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<sup>6</sup> See Centers for Medicare and Medicaid Services, National Health Expenditure Fact Sheet, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>.

<sup>7</sup> See Gary Claxton et al., *How Have Healthcare Prices Grown in the U.S. Over Time?*, Peterson-Kaiser Health System Tracker (May 8, 2018), <https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-prices-grown-in-the-u-s-over-time/#item-start>; Rabah Kamal & Cynthia Cox, *How do Healthcare Prices and Use in the U.S. Compare to Other Countries?*, Peterson-Kaiser Health System Tracker (May 8, 2018), <https://www.healthsystemtracker.org/chart-collection/how-do-healthcare-prices-and-use-in-the-u-s-compare-to-other-countries/#item-start>; Henry J. Kaiser Family Foundation, Initiative 18|11: What Can We Do About the Cost of Health Care, 5–6 (2019); Gee & Gurwitz, *supra*, note 1, at 1.

<sup>8</sup> See Zach Cooper et al., *Hospital Prices Grew Substantially Faster than Physician Prices for Hospital-Based Care in 2007-14*, 38 HEALTH AFF. 184 (2019).

<sup>9</sup> See Eileen Appelbaum & Rosemary Batt, *Organizational Restructuring in U.S. Healthcare Systems: Implications for Jobs, Wages, and Inequality*, Center for Economic and Policy Research, 22–36 (Sept. 2017).

<sup>10</sup> See Nathan E. Wilson, *Editor's Note: Some Clarity and More Questions in Healthcare Antitrust*, 82 ANTITRUST L.J. 435 (2019).

<sup>11</sup> See Fed. Trade Comm'n, *Overview of FTC Actions in Health Care Services and Products*, 50–98 (Aug. 2018).

<sup>12</sup> See *id.*

<sup>13</sup> See Cory Capps, et al., *The Continuing Saga of Hospital Merger Enforcement*, 82 ANTITRUST L. J. 441, 443–44 (2019).

credited the parties' approach to defining the relevant geographic market or the argument that the parties' non-profit status meant that the merger was unlikely to have anticompetitive effects.<sup>14</sup>

Under the leadership of former Chairman Tim Muris, then-Bureau of Competition Director Joe Simons, and Michael Vita from the Bureau of Economics, the FTC undertook reforms, including a merger litigation task force and a merger retrospective program, that helped the agency revamp its approach to hospital merger enforcement and successfully challenge anticompetitive hospital mergers. In particular, through our merger retrospective program, we were able to show that the approach to defining the relevant geographic market credited in past cases was flawed and that mergers involving non-profits, in fact, could result in anticompetitive effects.<sup>15</sup> The Commission also identified insurer testimony as a compelling way to illustrate the price effects of hospital mergers, since insurers are the direct payors to healthcare providers and their data and testimony can effectively demonstrate expected merger outcomes.

Since then, the Commission has successfully challenged numerous hospital and physician mergers,<sup>16</sup> but has faced some resistance, with two of these recent victories only coming after district court setbacks.<sup>17</sup> These results indicate to me that we continue to face significant litigation risks in our hospital merger cases, but even with those risks, the agency looks to stay aggressive.

Despite the FTC's and other enforcers' efforts, recent research raises significant concerns that hospitals and other providers do not face sufficient competition and that some mergers are harming competition. One study evaluated mergers between nearby hospitals from 2007 and 2011 and found that they resulted in significant price increases.<sup>18</sup> In another study, researchers found that some hospital mergers between 2000 and 2010 resulted in lower wages for some

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<sup>14</sup> See *id.*; *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 146 (E.D.N.Y. 1997); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1222 (W.D. Mo. 1995).

<sup>15</sup> See, e.g., Christopher Garmon & Deborah Haas-Wilson, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 INT'L J. ECON. BUS. 17 (2011); Aileen Thompson, *The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover – Cape Fear Transaction*, 18 INT'L J. ECON. BUS. 91 (2011); Orley Ashenfelter, Daniel Hosken, Michael Vita & Matthew Weinberg, *Retrospective Analysis of Hospital Mergers*, 18 INT'L J. ECON. BUS. 5 (2011); Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter–Summit Transaction*, 18 INT'L J. ECON. BUS. 65, 79 (2011), <http://www.tandfonline.com/doi/full/10.1080/13571516.2011.542956> (finding evidence of post-merger price increases ranging from 28-44%, and concluding that “[o]ur results demonstrate that nonprofit hospitals may still raise price quite substantially after they merge. This suggests that mergers involving nonprofit hospitals should perhaps attract as much antitrust scrutiny as other hospital mergers.”); see also Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. INDUS. ECON. 63 (2001), <http://onlinelibrary.wiley.com/doi/10.1111/1467-6451.00138/epdf> (finding substantial price increases resulting from a merger of non-profit, community-based hospitals, and determining that mergers involving non-profit hospitals are a legitimate focus of antitrust concern).

<sup>16</sup> See Fed. Trade Comm'n, Overview of FTC Actions in Health Care Services and Products, 50–98 (Aug. 2018).

<sup>17</sup> See *Fed. Trade Comm'n v. Advocate Health Care*, No. 15-cv-11473, 2016 WL 3387163 (N.D. Ill. June 20, 2016); *Fed. Trade Comm'n v. Advocate Health Care Network*, 841 F.3d 460 (7th Cir. 2016); *Fed. Trade Comm'n v. Penn State Hershey Medical Center*, 185 F.Supp.3d 552 (M.D. Penn. May 9, 2016); *Fed. Trade Comm'n v. Penn State Hershey Medical Center*, 838 F.3d 327 (3d Cir. 2016).

<sup>18</sup> See Zack Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 QUARTERLY J. OF ECON. 1, 96–102, (2019).

healthcare workers.<sup>19</sup> Recent surveys have also found only mixed evidence that mergers between competing hospitals realize cognizable efficiencies.<sup>20</sup>

### **Continuing Challenges to Enforcement in Healthcare Provider Markets**

Compounding the concerns raised by recent studies, the FTC and other enforcers continue to face challenges to their enforcement and other competition promotion efforts. These challenges include resource constraints, pre-merger reporting limitations, a legal shield for anticompetitive conduct by non-profit hospitals, high evidentiary burdens, threatened loss of high quality public data, and state laws or actions that inhibit enforcement. I will take each of these (briefly) in turn.

One significant challenge has been that merger activity and merger enforcement resources have been moving in opposite directions. In other words, we have more mergers to review and fewer resources with which to review (and challenge) them.

Since 2010, average annual hospital merger volume has surged by at least 50% compared to the prior decade.<sup>21</sup> This merger wave does not show clear signs of cresting. One industry observer described 2017 as “the year M&A shook the healthcare landscape” and 2018 as the year mergers “are beginning to fundamentally reshape the healthcare landscape.”<sup>22</sup>

Meanwhile, between 2010 and 2016, FTC and DOJ funding stagnated in nominal terms, and, in real terms, effectively declined.<sup>23</sup> In 2017 and 2018, the FTC’s full time employee headcount declined, and it remains roughly 50% less than it was at the beginning of the Reagan Administration.<sup>24</sup> And since the 1980s, the scope of investigation and litigation discovery has expanded exponentially,<sup>25</sup> with voluminous electronic submissions demanding substantial staff

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<sup>19</sup> See Elena Prager and Matthew Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, Washington Center for Equitable Growth Working Paper Series, 29 (2019).

<sup>20</sup> See Hannah T. Neprash & J. Michael McWilliams, *Provider Consolidation and Potential Efficiency Gains: A Review of Theory and Evidence*, 82 ANTITRUST L. J. 551 (2019); see also Stuart Craig, Matthew Grennan & Ashley Swanson, *Mergers and Marginal Costs: New Evidence on Hospital Buyer Power*, (NBER Working Paper No. 24926, Aug. 2018), [www.nber.org/papers/w24926](http://www.nber.org/papers/w24926); Matthew Schmitt, *Do Hospital Mergers Reduce Costs?*, 52 J. HEALTH ECON. 74 (2017).

<sup>21</sup> See Kaufman Hall, *2018 M&A in Review: A New Healthcare Landscape Takes Shape*, (2018), [https://mnareview.kaufmanhall.com/the-year-in-numbers?\\_ga=2.155234107.1645983602.1554227710-655997828.1554227710](https://mnareview.kaufmanhall.com/the-year-in-numbers?_ga=2.155234107.1645983602.1554227710-655997828.1554227710); Kaufman Hall, *2017 in Review: The Year M&A Shook the Healthcare Landscape*, (2017), <https://www.kaufmanhall.com/ideas-resources/research-report/2017-review-year-ma-shook-healthcare-landscape>; American Hosp. Ass’n, *Trendwatch Chartbook 2018 Trends Affecting Hospitals and Health Systems*, 25 (2018) (citing Irving Levin Associates, Inc., *The Health Care Services Acquisition Report*, 24<sup>th</sup> ed., (2018)).

<sup>22</sup> See Kaufman Hall, *2018 M&A in Review: A New Healthcare Landscape Takes Shape*, (2018), [https://mnareview.kaufmanhall.com/the-year-in-numbers?\\_ga=2.155234107.1645983602.1554227710-655997828.1554227710](https://mnareview.kaufmanhall.com/the-year-in-numbers?_ga=2.155234107.1645983602.1554227710-655997828.1554227710).

<sup>23</sup> See Fed. Trade Comm’n, FTC Appropriation and Full-Time Equivalent (FTE) History, <https://www.ftc.gov/about-ftc/bureaus-offices/office-executive-director/financial-management-office/ftc-appropriation>; Dep’t of Justice, Appropriation Figures for the Antitrust Division, <https://www.justice.gov/atr/appropriation-figures-antitrust-division>; Washington Center for Equitable Growth, Merger Enforcement Statistics, (Jan. 19, 2018), <https://equitablegrowth.org/presentation-merger-enforcement-statistics/>.

<sup>24</sup> See Fed. Trade Comm’n, FTC Appropriation and Full-Time Equivalent (FTE) History, <https://www.ftc.gov/about-ftc/bureaus-offices/office-executive-director/financial-management-office/ftc-appropriation>.

<sup>25</sup> Cf. Tracy Greer, E-Discovery Initiatives at the Antitrust Division (Mar. 25, 2009), <https://www.justice.gov/atr/e-discovery-initiatives-antitrust-division> (“Like the rest of the bar, the Antitrust Division experienced exponential

resources. Not only is our staffing crunched, the resources we have to devote to objectives beyond pay and benefits—such as economic research and litigation costs—have also declined. This is especially concerning since economic analysis has become more prominent in antitrust litigation.<sup>26</sup> Put bluntly, economic experts commanding significant fees have stretched agency resources to an alarming extent.<sup>27</sup> While the FTC has taken advantage of technological advancements and other productivity enhancements to do significantly more with less staff, just think of what we could accomplish today with 50% more staff.

The FTC’s efforts are also constrained by limitations on merger reporting requirements. For example, under current law, many relatively small transactions need not be reported to the FTC and DOJ. This means that parties can consummate potentially anticompetitive mergers before the antitrust agencies can review and, if necessary, challenge them. While each unreported merger may have a small value, recent research indicates that the cumulative scope of such transactions represent roughly \$30-40 billion in U.S. output since 2000, and that healthcare transactions make up a disproportionate share of all exempt transactions over this period.<sup>28</sup>

Although the FTC has a track record of suing to unwind consummated hospital mergers, challenging a merger after-the-fact can significantly delay relief, prolong anticompetitive harm in the form of higher prices or reduced quality and innovation, and make effective remedies more difficult to achieve.<sup>29</sup> Moreover, we have an obligation to stop anticompetitive mergers in their incipiency.<sup>30</sup> Pre-merger reporting helps realize this mandate by providing the FTC and DOJ an opportunity to investigate and root-out problematic mergers *before* they substantially lessen competition.

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growth in the amount of documents and information responsive to its Second Requests and CIDs. Recently, the Antitrust Division has completed several investigations with productions just under or slightly above one million records. As a result, Antitrust Division spending on its electronic storage capacity has increased substantially.”); The Sedona Conference, *The Case for Cooperation*, 10 SEDONA CONF. J. 339, 356 (William Butterfield ed., Supp. 2009) (“While a 1983 study found relatively little discovery occurs in the ordinary lawsuit and no evidence of discovery in over half our cases, a lawsuit between corporations may now involve more than one hundred million pages of discovery documents, requiring over twenty terabytes of server storage space.” (citations omitted)); John H. Beisner, *Discovering a Better Way: The Need for Effective Civil Litigation Reform*, 60 DUKE L.J. 547, 563–73 (2010); see also Seth Katsuya Endo, *Technological Opacity & Procedural Injustice*, 59 B.C. L. REV. 821, 839–41 (2018).

<sup>26</sup> See John E. Lopatka & William H. Page, *Economic Authority and the Limits of Expertise in Antitrust Cases*, 90 CORNELL L. REV. 617, 620 (2005); see also Herbert Hovenkamp, *Economic Experts in Antitrust Cases*, in 3 *Modern Scientific Evidence: The Law and Science of Expert Testimony*, 111, 112 (David L. Faigman et al. eds., 2002); Andrew I. Gavil, *After Daubert: Discerning the Increasingly Fine Line Between the Admissibility and Sufficiency of Expert Testimony in Antitrust Litigation*, 65 ANTITRUST L.J. 663, 663 (1997).

<sup>27</sup> See Prepared Statement of the Fed. Trade Comm’n, Before the Committee on Commerce, Science, and Transportation Subcommittee on Consumer Protection, Product Safety, Insurance, and Data Security, United States Senate, 19 (Nov. 27, 2018) (“While the agency thus far has managed to find sufficient resources to fund the experts needed to support its cases, the FTC is reaching the point where it cannot meet these needs without compromising its ability to fulfill other aspects of the agency’s mission.”).

<sup>28</sup> See Thomas Wollmann, *Stealth Consolidation: Evidence From an Amendment to the Hart-Scott-Rodino Act*, Manuscript, 13–14 (Feb. 15, 2018), [http://faculty.chicagobooth.edu/thomas.wollmann/docs/stealth\\_consolidation\\_2\\_19.pdf](http://faculty.chicagobooth.edu/thomas.wollmann/docs/stealth_consolidation_2_19.pdf).

<sup>29</sup> See William J. Baer, *Reflections on Twenty Years of Merger Enforcement Under the Hart-Scott-Rodino Act*, 65 ANTITRUST L. J. 825, 829–31 (1997).

<sup>30</sup> See *United States v. Philadelphia National Bank*, 374 U.S. 321, 362 (1963); Baer, *supra*, note 29, at 827.

Exemptions in our enforcement authority also poses problems. Although the FTC has jurisdiction to review all hospital mergers, it is prohibited from enforcing the antitrust laws against any anticompetitive practices of non-profit entities, which make up more than 45% of all U.S. hospitals.<sup>31</sup> So, for example, if a non-profit hospital merger itself is not anticompetitive, but the newly merged entity engages in anticompetitive practices, the FTC is stuck on the sidelines. In effect, this means that all of the healthcare industry expertise that the FTC has worked for decades to, and continues to, develop cannot be deployed alongside the DOJ and state enforcers to stop anticompetitive practices by roughly half of all hospitals nationwide. This is a significant lost opportunity.

Another challenge for the agency is the high evidentiary burden we face to challenge a merger. Given the recent research regarding the effects of hospital mergers, I think many Americans would be surprised by the types and extent of evidence that courts often expect the FTC to produce in order to block them.<sup>32</sup> This evidence includes rigorous economic analysis, the merging parties' own documents, and testimony from insurance companies.<sup>33</sup> The importance of reliance on insurer testimony is what strikes me as especially surprising. To be sure, economic analysis, insurer testimony, and party documents are all critical to our enforcement efforts, and insurer testimony in particular has proven to be the best third-party proxy for competitive effects that we have developed to date. However, there may be anticompetitive effects that insurers are not best positioned to observe. There may also be circumstances where insurers are reluctant to provide fully candid testimony for fear of retaliation by healthcare providers with whom they must engage on an ongoing basis, particularly by providers who already occupy a dominant position in the market.<sup>34</sup>

We also face challenges to our ability to study healthcare provider markets. Current law prevents the FTC from studying the insurance industry absent an explicit request from Congress.<sup>35</sup> In the 1970s, the FTC undertook a broad program of insurance-related studies, some of which resulted in highly publicized reports with significant recommendations for industry reform.<sup>36</sup> In 1980, months after former Chairman Pertschuk's testimony to Congress on a range of life insurance industry concerns and proposed solutions,<sup>37</sup> the FTC was stripped of its

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<sup>31</sup> See American Hosp. Ass'n, *Fast Facts on U.S. Hospitals*, (2019), <https://www.aha.org/statistics/fast-facts-us-hospitals>.

<sup>32</sup> See, e.g., Cooper et al., *supra*, note 18; Neprash & McWilliams, *supra*, note 20.

<sup>33</sup> See Cory Capps et al., *The Continuing Saga of Hospital Merger Enforcement*, 82 ANTITRUST L. J. 441, 485 (2019).

<sup>34</sup> See, e.g., D. Bruce Hoffman, *It Only Takes Two to Tango: Reflections on Six Months at the FTC*, 7 (Feb. 2, 2018).

<sup>35</sup> See 15 U.S.C. § 46 ("Nothing in this section (other than the provisions of clause (c) and clause (d)) shall apply to the business of insurance, except that the Commission shall have authority to conduct studies and prepare reports relating to the business of insurance. The Commission may exercise such authority only upon receiving a request which is agreed to by a majority of the members of the Committee on Commerce, Science, and Transportation of the Senate or the Committee on Energy and Commerce of the House of Representatives. The authority to conduct any such study shall expire at the end of the Congress during which the request for such study was made.").

<sup>36</sup> See Larry Kramer, *Insurance Hit*, WASHINGTON POST (July 11, 1979); *F.T.C. Cites Abuse of 'Debit' Life Insurance*, N.Y. TIMES (Jan. 29, 1979); *The Whole Truth About Life Insurance*, N.Y. TIMES (July 22, 1979); S. Rep. No. 96-500 at 13-14.

<sup>37</sup> See Testimony of Chairman Michael Pertschuk, Before the Senate Committee on Commerce, Science, and Transportation, United States Senate, 1-9 (July 10, 1979).

independent authority.<sup>38</sup> Today, this restriction continues to constrain FTC research and advocacy activities.

Our research and advocacy opportunities may also be hampered by a lack of rich and reliable data. Today, the Health Care Cost Institute has significantly improved our understanding of healthcare provider markets by gathering claims data from insurance companies and making the data available to independent researchers, including several of those to whom I referred earlier.

However, HCCI depends in part upon voluntary participation by insurance companies. While these voluntary efforts are laudable, they are also vulnerable. In fact, one of the largest cooperating insurers—United—is now backing out of its HCCI partnership, and Humana has also signaled that it will end its HCCI partnership.<sup>39</sup> Given the importance of such data and the urgent need to better understand healthcare provider markets, this is a troubling development. I urge United and Humana to maintain their engagements with HCCI.

Finally, we periodically face challenges imposed at the state level. To be sure, states play a vital role in antitrust enforcement today. States like Pennsylvania, Idaho, North Dakota, Illinois, Virginia, Ohio, California, and Washington have joined the FTC in seeking to block hospital and provider mergers or have brought independent enforcement actions. States also gather and share hospital and, in some cases, insurer data that has proven crucial for FTC enforcement efforts.

But, sometimes, our enforcement efforts are not in sync with the states. Occasionally, state level enforcers adopt resolutions to mergers that could inhibit more aggressive federal action. And, action by state legislatures can also shield hospital mergers from antitrust scrutiny. Several states have passed laws and regulations that allow merging hospitals to enter into certificates of public advantage (known as “COPAs”) to immunize them from antitrust scrutiny. In recent years, COPAs undermined the FTC’s ability to challenge two hospital mergers that created near monopolies, including one that the FTC had already filed suit to block.<sup>40</sup> Today, Texas is considering legislation that could exempt future rural hospital mergers in the state from antitrust scrutiny.<sup>41</sup>

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<sup>38</sup> See Pub. L. No. 96-252, 94 Stat. 374 (1980).

<sup>39</sup> See Health Care Cost Institute Press Release, HCCI Announces End of Data Sharing Agreement with United Healthcare (Jan. 30, 2019), <https://www.healthcostinstitute.org/news/entry/hcci-announces-end-of-data-agreement-with-united-healthcare>; Bob Herman, UnitedHealthcare Stops Sharing Data with Research Group, AXIOS (Jan. 30, 2019), <https://www.axios.com/unitedhealthcare-stops-sharing-data-hcci-babe0290-d1d3-46b8-b308-3ab2fb845343.html>; Jim Mueller, Open Data is Essential to Fixing Healthcare, BIZ TIMES (Mar. 26, 2019), <https://www.biztimes.com/2019/biz-insights/open-data-is-essential-to-fixing-health-care/>.

<sup>40</sup> See Erin C. Fuse Brown, Hospital Mergers and Public Accountability: Tennessee and Virginia Employ a Certificate of Public Advantage, 8–9, Milbank Memorial Fund (Sept. 2018); Statement of the Commission, In the Matter of Cabell Huntington Hospital, Inc., 1 (July 6, 2016); Fed. Trade Comm’n, FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments, 1–2 (Mar. 27, 2019), [https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa\\_assessment\\_public\\_notice\\_11-1-17\\_revised\\_3-27-19.pdf](https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa_assessment_public_notice_11-1-17_revised_3-27-19.pdf).

<sup>41</sup> See Texas Senate Bill 1529, <https://capitol.texas.gov/tlodocs/86R/billtext/html/SB01529I.htm>; Texas House Bill 3301, <https://capitol.texas.gov/tlodocs/86R/billtext/html/HB03301H.htm>.

States adopt COPAs with the intention of tackling legitimate concerns,<sup>42</sup> and they often require conditions to mitigate the relevant merger's anticompetitive effects.<sup>43</sup> However, in many cases, COPAs eventually lapse or are repealed, leaving the merged hospital without regulatory oversight.<sup>44</sup> Moreover, there are too few empirical studies about whether COPAs actually perform better than a competitive market.

### **Opportunities with Existing Resources and Authority**

The challenges I have identified are significant, but they should not and do not deter the FTC's efforts and creative use of its current authority and resources. Indeed, the FTC has done important work to police healthcare provider competition and competition among hospitals in particular. That work has given us good perspective with which to continually ask ourselves: what can and should we do better or differently with our existing resources and authority? Where do we need to turn to Congress or others for additional help? The FTC's recent hearings have elicited a range of responses, and I would like to share some of my views.

Some of the most significant contributions and improvements to our understanding of industries and market practices have been made when the Commission uses its authority to study markets, such as former Chairman Muris's hospital merger retrospective program. Retrospectives can help us hone our understanding of how to resolve tough cases and pursue consummated enforcement if any specific merger is found to be anticompetitive in hindsight.

I believe that the FTC should conduct a new round of retrospectives of healthcare provider mergers. Consistent with a recent Commission statement, the FTC should target some recently cleared, close-call hospital mergers,<sup>45</sup> as well as hospital mergers that raised significant antitrust concerns but were shielded from antitrust scrutiny by COPA interventions. In addition, the FTC should consider conducting retrospectives of vertical healthcare provider mergers, such as hospital-physician transactions.<sup>46</sup>

Finally, we should be as aggressive as possible in challenging the mergers we encounter today, especially where the proposed consolidation involves new structural arrangements rather

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<sup>42</sup> See Erin C. Fuse Brown, *Hospital Mergers and Public Accountability: Tennessee and Virginia Employ a Certificate of Public Advantage*, 13, *Milbank Memorial Fund* (Sept. 2018).

<sup>43</sup> See *id.* at 26–30.

<sup>44</sup> See Erin C. Fuse Brown, *To Oversee or Not to Oversee? Lessons from the Repeal of North Carolina's Certificate of Public Advantage Law*, *Milbank Memorial Fund* (Jan. 2019); Fed. Trade Comm'n, *Staff Submission to the Tennessee Department of Health Regarding the Certificate of Public Advantage Application of Mountain States Health Alliance and Wellmont Health System*, 67–70 (Nov. 21, 2016).

<sup>45</sup> See, e.g., *Statement of the Commission, Concerning the Proposed Affiliation of CareGroup, Inc.; Lahey Health System, Inc.; Seacoast Regional Health System, Inc.; BIDCO Hospital LLC; and BIDCO Physician LLC* (Nov. 29, 2018).

<sup>46</sup> See Zarek C. Brot-Goldberg & Mathijs de Vaan, *Intermediation and Vertical Integration in the Market for Surgeons*, Manuscript (Nov. 19, 2018); Cory Capps et al., *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, 59 *J. HEALTH ECON.* 139 (2018); Laurence Baker, M. Kate Bundorf & Daniel Kessler, *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 35 *HEALTH AFF.* 756 (2014); Laurence Baker et al., *The Effect of Hospital/Physician Integration on Hospital Care*, 50 *J. HEALTH ECON.* 1 (2016); Thomas Koch et al., *How Vertical Integration Affects the Quantity and Cost of Care for Medicare Beneficiaries*, 52 *J. HEALTH ECON.* 19 (2017); see also *Statement of Martin Gaynor before the Committee on the Judiciary, Subcommittee on Antitrust, Commercial, and Administrative Law, United States House of Representatives*, 19 (Mar. 7, 2019).



than traditional horizontal concerns. It is important for parties considering mergers to know we will not shy away from challenging, for example, anticompetitive vertical organizations. I am sensitive to the concern that we might lose litigation, but our obligation is to identify the right outcome and fight for it.

### **A Legislative Opportunity: More Resources and More Authority**

Given the scope of competitive concerns with hospital prices, quality, and wages, and the persistently high volume of hospital merger activity, Congress and the FTC are also presented with an opportunity to rethink the FTC's resource base and the current scope of its authority.

*Regarding resources, reporting limitations, and data:* As a starting point, Congress should increase the FTC's annual appropriations to bring staff levels to those at the beginning of the Reagan Administration. Congress should also increase merger reporting fees, which have not kept pace with inflation. In addition, Congress and the FTC should evaluate tools to better measure agency workload and consider measures that would allow enforcement resources to increase as merger and other work demands increase.

Once the FTC has received additional resources commensurate with its workload volume, Congress should consider merger reporting revisions that would permit efficient pre-merger reporting and review for smaller transactions. The pre-merger reporting process is very resource intensive, so any expansion of the FTC's reporting authority should not be made without a significant increase in resources. And we should all give thought as to whether the traditional merger reporting triggers—such as size of the transaction—should be augmented or modified; perhaps there are better ways to ensure that smaller-value anticompetitive mergers are reported without flooding the agency with additional work reviewing mergers that do not end up meriting challenge.

In addition, if insurers insist on terminating their partnerships with HCCI and eliminating that important data pool, Congress should consider policies to facilitate ongoing access to the data, such as creating an insurer data clearinghouse and mandating that insurers submit their claims data.<sup>47</sup> Such data would be maintained, consistent with privacy protections, to serve the public interest in better functioning healthcare provider markets. The data should be accessible not only to public enforcers, but also to academics and other researchers seeking to address important questions involving healthcare markets.

*Regarding authority:* Congress should also repeal the FTC's non-profit exemption and limitation on insurance industry studies. Eliminating the non-profit exemption would allow the agency to go after anticompetitive conduct involving nearly half of the nation's hospitals, including conduct uncovered in the course of FTC hospital merger investigations, which now must be policed by DOJ and state agencies alone. Also, by removing the limitation on insurance industry studies, the FTC could proactively study market trends and practices that affect healthcare provider markets, regardless of the industry in which such practices took place.

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<sup>47</sup> See generally Dep't of Health and Human Services, All-Payer Claims Databases, <https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/apcd/index.html>.

**Regarding evidentiary burdens:** Finally, Congress should also consider legislation that would simplify the evidentiary burden on the government and heighten the evidentiary burden on parties in merger litigation generally and hospital merger litigation in particular.<sup>48</sup> Altering the legal burdens could strengthen the agencies' position when they find significant evidence of anticompetitive harm without offsetting efficiencies and reduce the risk that impediments to evidence gathering would permit anticompetitive mergers.

## **The Role of States**

States can and should continue to play an important supplemental and complementary role to federal enforcement. Recently, several states asked the FTC for training and support to evaluate and litigate hospital mergers and we answered.<sup>49</sup> In April, the FTC convened the first of several healthcare litigation workshops and we hosted representatives from 40 states. States should continue to work as active partners in blocking anticompetitive healthcare mergers, and make sure their actions to resolve competition concerns are consistent with the most pro-competitive enforcement goals.

Wherever possible, states should resist efforts to immunize anticompetitive hospital mergers. Recently, Montana Governor Steve Bullock signed a bill to repeal the state's COPA laws and thereby prevent hospitals from seeking COPAs in the future. I hope other states that do not have active COPAs will follow Montana's lead. States that have implemented COPAs should work with the FTC to rigorously study how hospital mergers approved pursuant to COPA agreements and associated regulations have affected prices, quality, and wages. The FTC's ongoing COPA Assessment Project welcomes input from states and other stakeholders.<sup>50</sup> In June, the FTC will hold a workshop to assess the effects of COPAs,<sup>51</sup> and I encourage all stakeholders to participate and to further explore this pressing topic.

State authorities should also consider adopting other competition-enhancing policies. States can establish state-level pre-merger reporting requirements, as has been passed in Connecticut<sup>52</sup> and is under consideration in Washington and Florida.<sup>53</sup> States can lower barriers

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<sup>48</sup> See Statement of Martin Gaynor before the Committee on the Judiciary, Subcommittee on Antitrust, Commercial, and Administrative Law, United States House of Representatives, 20 (Mar. 7, 2019).

<sup>49</sup> See Prepared Remarks of Chairman Joseph J. Simons, National Association of Attorneys General Winter Meeting, 3–4 (Mar. 5, 2019).

<sup>50</sup> Fed. Trade Comm'n, FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments (Mar. 27, 2019), [https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa\\_assessment\\_public\\_notice\\_11-1-17\\_revised\\_3-27-19.pdf](https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa_assessment_public_notice_11-1-17_revised_3-27-19.pdf).

<sup>51</sup> See Fed. Trade Comm'n Press Release, FTC to Hold Workshop on Certificates of Public Advantage in Healthcare Markets, (Apr. 12, 2019), <https://www.ftc.gov/news-events/press-releases/2019/04/ftc-hold-workshop-certificates-public-advantage-healthcare>.

<sup>52</sup> See James M. Burns, Connecticut Law Imposes New Merger Regulations on Physician Combinations (Oct. 21, 2014), <https://www.dickinson-wright.com/~media/Documents/Documents%20linked%20to%20attorney%20bios/JBurns%20Connecticut%20Law%20Imposes.pdf>.

<sup>53</sup> See James M Burns, Proposed Florida House Legislation Advances, Requiring Reporting to the State Proposed Hospital, and Group Practice Acquisitions (Mar. 21, 2019), <https://www.akerman.com/en/perspectives/hrx-proposed-florida-house-legislation-advances-requiring-reporting-to-the-state-proposed-hospital-and-group-practice-acquisitions.html>; Washington State Hospital Association, Inside Olympia: Bills that Have Passed Their Chamber of Origin, <https://www.wsha.org/articles/inside-olympia-bills-that-have-passed-their-chamber-of-origin/>.

to entry or expansion, including, where applicable, by repealing certificate of need laws.<sup>54</sup> States can also promote alternative forms of care delivery, such as by adopting regulations to facilitate telemedicine services.<sup>55</sup> Finally, states can implement insurer claims data collection programs and work with the FTC, other agencies, and researchers to share such data to support competition-enhancing enforcement and research activities.<sup>56</sup>

## **Conclusion**

Affordable, quality healthcare is vital to American patients, and fair wages are important for all workers. We cannot deliver these goods without competitive markets, and, to secure this goal, antitrust enforcers must remain vigilant and Congress and states must outfit our antitrust law enforcers with the necessary resources, capabilities, and authority. Thank you for your time today.

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<sup>54</sup> See, e.g., Fed. Trade Comm'n Press Release, FTC Staff Testifies in Favor of Repealing Alaska Laws that Limit Competition in the Health Care Sector (Mar. 28, 2019), <https://www.ftc.gov/news-events/press-releases/2019/03/ftc-staff-testifies-favor-repealing-alaska-laws-limit-competition>.

<sup>55</sup> See Maureen K. Ohlhausen, *Beyond Law Enforcement: The FTC's Role in Promoting Health Care Competition and Innovation*, Health Affairs Blog (Jan. 26, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20150126.044035/full/>.

<sup>56</sup> See Robert Wood Johnson Foundation, *The Basics of All-Payer Claims Databases* (Jan. 2014); All-Payer Claims Database Council, <https://www.apcdouncil.org/>.