

NOTES

EXCEPTIONAL EFFICIENCIES: A VALUABLE DEFENSE FOR HEALTHCARE MERGERS

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Various forces are driving healthcare providers to pursue integration to reduce prices and improve efficiency. Right now, the dominant payment model for healthcare is fee-for-service, in which a patient is charged for each individual service, test, or visit. An alternative model is value-based care, in which the emphasis is on value as opposed to volume. But to provide value-based care, health systems generally must be integrated enough to connect a patient with all of the physicians they might need. This incentivizes certain health systems to seek consolidation by merging with other hospitals or physician groups. The merging of these entities runs the risk of antitrust scrutiny.

Antitrust law in the United States largely measures anticompetitive harm by short-term price increases. There is reason to believe that this emphasis on short-term price increases will stand in the way of otherwise beneficial mergers that pursue the provision of value-based care. This is because it is almost an inherent aspect of the model that consumers may pay greater prices in the short term, but costs are lowered down the line (since patients ideally will need fewer costly treatments). This Note argues that anticompetitive concerns, especially patient costs and quality outcomes, must now be analyzed differently when focusing on the long-term horizon of value-based care.

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INTRODUCTION

The United States spends about twice as much per person on healthcare costs as other high-income countries.¹ Despite this massive spending, compared to other Organisation for Economic Co-operation and Development (OECD) countries, Americans have the lowest life expectancy, the highest chronic disease burden, the highest rates of hospitalization from certain preventable causes, and the fewest doctor visits.² Meanwhile, the number of Americans who lack health insurance is growing while affordability is falling.³ Healthcare is a top policy concern for politicians and voters alike,⁴ prompting the landmark Patient Protection and Affordable Care Act of 2010 (ACA)—as well as more than sixty Congressional attempts to repeal it and five Supreme Court cases seeking to strike it down.⁵ In July 2020, the CEO of the American Medical Association announced that the American healthcare system is failing to

1. Roosa Tikkanen & Melinda K. Abrams, U.S. Health Care From a Global Perspective, 2019: Higher Spending, Worse Outcomes?, Commonwealth Fund (Jan. 30, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019> [<https://perma.cc/8E4N-UA3W>] (comparing the United States with other “high-income countries” including Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom).

2. *Id.* But note, the U.S. healthcare system is distinct due to its fragmented payor market, which contributes to structural financial problems. OECD, Private Health Insurance Spending 1 (2022), <https://www.oecd.org/health/Spending-on-private-health-insurance-Brief-March-2022.pdf> [<https://perma.cc/4VFT-393Y>] (“Private health insurance accounts for a third of all health spending in the United States . . . [but in] around half of OECD countries it accounts for 5% or less of health spending.”).

3. William H. Shrank, Nancy-Ann DeParle, Scott Gottlieb, Sachin H. Jain, Peter Orszag, Brian W. Powers & Gail R. Wilensky, Health Costs and Financing: Challenges and Strategies for a New Administration, 40 *Health Affs.* 235, 235 (2021).

4. Ashley Kirzinger, Audrey Kearney & Mollyann Brodie, KFF Health Tracking Poll—February 2020: Health Care in the 2020 Election, Kaiser Fam. Found. (Feb. 21, 2020), <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-february-2020/> [<https://perma.cc/BC69-87K7>] (reporting that in anticipation of the 2020 election, voters listed healthcare first and then the economy as their top priorities when choosing their presidential vote).

5. Ezekiel J. Emanuel & Abbe R. Gluck, Introduction to *The Trillion Dollar Revolution: How the Affordable Care Act Transformed Politics, Law, and Health Care in America* 7, 7, 9 (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020).

serve the public and called for a disruption of the status quo.⁶ In such a troubled yet tremendously important industry, one promising path toward improving the efficiency of healthcare is eliminating the fee-for-service reimbursement model and replacing it with value-based care.

Healthcare is typically operated under a fee-for-service structure, in which providers charge for each service, including visits, exams, and tests.⁷ A fundamental flaw of this model in an industry like healthcare is that it incentivizes high outputs, since profit is directly linked to the provision of discrete services.⁸ It further runs the risk that patients may receive unnecessary or duplicative treatments that they nonetheless have to pay for.⁹ Value-based programs instead prioritize the quality of care that people receive along with the health of the populations around them.¹⁰ In short, value-based care is concerned with *value* rather than volume.

This model is expanding in the United States, and hospitals and healthcare providers are pursuing consolidation to accomplish this transition.¹¹ There are two major reimbursement models worth noting here: shared risk and shared savings. In both models, assuming a patient receives care over a period of time and from multiple providers with varied specialties, the departments collaborate to determine the most efficient care and reduce cost. Meanwhile, a payor sets a cost-containment goal. Under a

6. James L. Madara, *America's Health Care Crisis Is Much Deeper Than COVID-19*, Am. Med. Ass'n (July 22, 2020), <https://www.ama-assn.org/about/leadership/america-s-health-care-crisis-much-deeper-covid-19> [<https://perma.cc/8XRB-VV2Y>].

7. Fee for Service, HealthCare.gov, <https://www.healthcare.gov/glossary/fee-for-service/> [<https://perma.cc/UZ7Y-SZQ2>] (last visited July 27, 2022).

8. How and Why the Value Based Payment (Pay for Performance) Model Is Trending in the Healthcare Industry, Insider Intel. (Apr. 15, 2022), <https://www.insiderintelligence.com/insights/value-based-care-pay-for-performance-healthcare-model> [<https://perma.cc/W7QP-ERRR>].

9. Heather Lyu, Tim Xu, Daniel Brotman, Brandan Mayer-Blackwell, Michol Cooper, Michael Daniel, Elizabeth C. Wick, Vikas Saini, Shannon Brownlee & Martin A. Makary, *Overtreatment in the United States 5* (2017), <https://doi.org/10.1371/journal.pone.0181970> [<https://perma.cc/8JLA-TH8D>] (reporting that from a study of over 2,000 physicians, almost 65% believe that up to 30% of medical care is unnecessary); Jacqueline LaPointe, *Driven by Fee-For-Service, Docs Say Up to 30% of Care Unnecessary*, RevCycle Intel. (Sept. 15, 2017), <https://revcycleintelligence.com/news/driven-by-fee-for-service-docs-say-up-to-30-of-care-unnecessary> [<https://perma.cc/9GD5-E2ZY>] (reporting on the Lyu et al. survey, *supra*, finding that “fee-for-service payment structures played a major role in overtreatment”).

10. Value Based Programs, Ctrs. for Medicare & Medicaid Servs., <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs> [<https://perma.cc/4HH2-GWL4>] (last visited Aug. 7, 2022).

11. See Monica Noether & Sean May, Charles River Assocs., *Hospital Merger Benefits: Views From Hospital Leaders and Econometric Analysis 3* (2017), <https://www.aha.org/system/files/2018-04/Hospital-Merger-Full-Report-FINAL-1.pdf> [<https://perma.cc/3RSJ-V2JM>] (“Hospital leaders also recognize that such fundamental changes to the payment system require them to integrate . . . to form systems that achieve the scale necessary to make the substantial investments required to . . . bear the financial risk inherent in value-based payment systems.”).

shared-risk reimbursement plan, providers are incentivized to monitor spending because they may be required to pay back a portion of any financial overrun or loss they incur above the anticipated budget.¹² Similarly, a shared-savings system incentivizes providers because they may receive a portion of any savings they generate when the cost of quality care comes out under the goal.¹³

Healthcare entities purport to seek consolidation to offer important benefits to patient care and population health,¹⁴ yet mergers often risk drawing the scrutiny of market regulators.¹⁵ Proponents of consolidation in the healthcare industry, including the industry trade group the American Hospital Association, explain that mergers are often designed to integrate the delivery of care, provide new services, lower costs, share technology, and bear the financial risk of value-based care.¹⁶ But positive outcomes must be balanced against the reality that merged organizations tend toward monopoly in certain markets and risk increasing prices for consumers.¹⁷ These anticompetitive harms to the market are regulated by

12. Wendy Gerhardt, Leslie Korenda, Mitch Morris & Guarav Vadnerkar, Deloitte, *The Road to Value-Based Care: Your Mileage May Vary* 4 (2015), https://www2.deloitte.com/content/dam/insights/us/articles/value-based-care-market-shift/DUP-1063_Value-based-care_vFINAL_5.11.15.pdf [<https://perma.cc/GQG2-HQSC>].

13. *Id.*

14. Noether & May, *supra* note 11, at 8–9.

15. Healthcare markets are often already highly concentrated, meaning that only a few firms compete in the relevant geographic market, so a merger of any kind may automatically trigger antitrust review. See Zack Cooper & Martin Gaynor, *Addressing Hospital Concentration and Rising Consolidation in the United States, 1% Steps for Health Care Reform* 2, <https://onepercentsteps.com/wp-content/uploads/brief-hc-210208-1700.pdf> [<https://perma.cc/U999-7KPB>] (last visited July 27, 2022) (calculating that more than 80% of hospital markets in the United States qualify as “highly concentrated” under the FTC and DOJ’s merger review criteria).

16. *Id.* at 6–10; Kaufman Hall, *The Benefits of Integration: Healthcare in a Time of Rapid Transformation* 2 (2021), https://www.kaufmanhall.com/sites/default/files/2021-10/kh-cha-benefits-of-integration-report_d9-reduced.pdf [<https://perma.cc/6P7R-8TMW>] (explaining that healthcare systems seek mergers that “preserve access to care in underserved communities, enhance the quality and affordability of care, and strengthen the resiliency of the healthcare system”); Bryan Sung, Chris Harris, Mary Beth Mikols & Sam Vos, Deloitte, *Health Care Mergers and Acquisitions: The IT Factor* 3 (2018), <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-health-care-mergers-and-acquisitions-final.pdf> [<https://perma.cc/PZ3U-SBW6>] (“[T]he movement toward . . . the ability to offer services in all phases of patient care . . . has primarily been achieved through M&A as smaller [firms] fuse into larger health care systems to realize economies of scale.”).

17. See *Examining the Impact of Healthcare Consolidation: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Com.*, 115th Cong. 22–26 (2018) (statement of Martin Gaynor, Professor of Economics and former Director of the FTC’s Bureau of Economics) (citing a range of studies that found post-merger price increases ranging from 20% to 30% and some up to 50%); Cooper & Gaynor, *supra* note 15, at 3 (citing evidence that hospital consolidation has raised consumer prices and can reduce clinical quality); Karyn Schwartz, Eric Lopez, Matthew Rae & Tricia Neuman, *What We Know About Provider Consolidation*, Kaiser Fam. Found. (Sept. 3, 2020), <https://>

federal and state antitrust laws. The federal laws specifically are enforced by the Federal Trade Commission (FTC), the Department of Justice (DOJ), and private parties.¹⁸

The measurable outcomes of these mergers both in terms of price and quality of care are hotly contested.¹⁹ Opponents, including the Biden Administration, argue that healthcare mergers are increasingly anticompetitive and result in higher costs for patients.²⁰ Industry leaders, however, dispute these conclusions and further argue that mergers are a necessity for survival after the passage of the ACA and its new regulatory burdens.²¹

Healthcare entities continue to refine commercial and legal arguments to persuade regulators to approve proposed mergers, including arguments that increased efficiencies may benefit the public.²² These efficiencies are more important than ever in a healthcare landscape that is fundamentally changing.²³ And the standard metrics for healthcare evaluation are changing as a result. Anticompetitive concerns, especially patient costs and quality outcomes, must now be analyzed differently when considering the long-term horizon of value-based care.²⁴

www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/ [<https://perma.cc/WML3-7Z4Z>] (“A wide body of research has shown that provider consolidation leads to higher health care prices for private insurance . . .”).

18. The Enforcers, FTC, <https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/enforcers> [<https://perma.cc/BK9M-Q8WT>] [hereinafter *FTC, Enforcers*] (last visited July 27, 2022).

19. See *infra* section II.C.

20. See Exec. Order No. 14,036, 86 Fed. Reg. 36,987, 36,988 (July 9, 2021) (“Hospital consolidation has left many areas, especially rural communities, with inadequate or more expensive healthcare options.”); Fact Sheet: Executive Order on Promoting Competition in the American Economy, The White House (July 9, 2021), <https://www.whitehouse.gov/briefing-room/statements-releases/2021/07/09/fact-sheet-executive-order-on-promoting-competition-in-the-american-economy/> [<https://perma.cc/6Y39-N24K>] (“Thanks to unchecked mergers, the ten largest healthcare systems now control a quarter of the market.”).

21. See, e.g., Noether & May, *supra* note 11, at 13 (“[All of the hospital system leaders interviewed by the AHA] articulated the compelling need for scale and breadth of services in order to meet the demands of health care reform initiatives.”); Traci Prevost, Wendy Gerhardt, Ion Skillrud & Debanshu Mukherjee, The Potential for Rapid Consolidation of Health Systems, Deloitte (Dec. 10, 2020), <https://www2.deloitte.com/us/en/insights/industry/health-care/hospital-mergers-acquisition-trends.html> [<https://perma.cc/7SHH-82GC>] (“One can never accurately predict what may happen in a decade; however, transformation of care delivery models and, therefore, hospital consolidation will likely continue.”).

22. See *infra* section I.B.

23. See, e.g., John Henning Schumann, How Health Care in the U.S. May Change After COVID: An Optimist’s Outlook, NPR (May 13, 2021), <https://www.npr.org/sections/health-shots/2021/05/13/996233365/how-health-care-in-the-u-s-may-change-after-covid-an-optimists-outlook> [<https://perma.cc/2HNY-U6ZC>] (addressing paradigm-shifting factors like COVID-19, the transition to telemedicine, and the decentralization of care or “meeting patients where they are”).

24. See *infra* section III.C.

Today, the prevailing policy of antitrust law, as applied to hospital mergers, is to obstruct market concentration that has the potential to result in harm to consumer welfare, measured principally by the elevation of prices charged to customers in the short term.²⁵ This Note argues that the focus on short-term price effects is incorrect as a normative matter because the consumption of healthcare is not readily analogous to that of conventional commodities.²⁶ Instead, courts and antitrust regulators should factor in a new theory of the healthcare market and efficiencies analysis that focuses on the qualitative value of care provided under longer-term, value-based arrangements rather than the quantitative volume of traditional fee-for-service models.²⁷ This analysis is defensible doctrinally. That is, under circuit precedent, courts continue to recognize the efficiencies defense which affirms that consumers can benefit from merger-specific outcomes that sufficiently counteract anticompetitive price effects.²⁸

This Note makes several contributions. Part I explains the foundation of American antitrust law at the federal level as well as the normative evolution of antitrust priorities. In particular, it engages with the exceptions within antitrust law that are reserved for the healthcare industry before providing an up-to-date primer on the use of the efficiencies defense in district and circuit courts. Part II describes the challenges the healthcare industry faces, including the structural changes to the field, the complicated nature of health insurance payors as consumers, and the complex economic analysis necessary for understanding the commercial side of medicine. Finally, Part III of this Note identifies three areas where greater antitrust clarity could advance the process of transitioning to value-based care. These proposals include accounting for the distinct payor mix when evaluating impacts on consumers who are insulated from price changes, prioritizing quality as a procompetitive dimension, and clarifying the timeframe for analyzing post-merger cost and quality outcomes.

25. See DOJ & FTC, Horizontal Merger Guidelines § 1 (2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf [<https://perma.cc/XM3U-DL8V>] [hereinafter Horizontal Merger Guidelines]; see also *Kirtsaeng v. John Wiley & Sons, Inc.*, 568 U.S. 519, 539 (2013) (“[T]he principal objective of antitrust policy is to maximize consumer welfare by encouraging firms to behave competitively.” (quoting Phillip E. Areeda & Herbert Hovenkamp, 1 *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 100 (3d ed. 2006))); Herbert J. Hovenkamp, *Antitrust: What Counts as Consumer Welfare?*, Penn Law: Legal Scholarship Repository 1 (July 20, 2020), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=3196&context=faculty_scholarship [<https://perma.cc/859T-KWGC>] (“The dominant view of antitrust law today is its rules should be based on a ‘consumer welfare’ principle. We assume that consumers are best off when prices are low.”).

26. See *infra* section III.C.

27. See *infra* section III.B.

28. See *infra* section I.B.

I. HEALTHCARE ANTITRUST

Federal antitrust law in the United States is designed to promote competition in the market by prohibiting unfair market or trade practices.²⁹ In part, existing laws target monopolization as well as conduct like price-fixing and market allocation that could result in higher prices or lower quality for consumers. Federal antitrust law traces back to 1890 with the passage of the Sherman Act, which outlawed every contract, combination, or conspiracy in restraint of trade or commerce.³⁰ This broad power was soon tempered by the Supreme Court's ruling that allegations of Sherman Act violations must demonstrate *unreasonable* restraints of trade.³¹ Congress later authorized more extensive antitrust protections through the Federal Trade Commission Act³² and the Clayton Act.³³

Today, Section 7 of the Clayton Act specifically prohibits mergers and acquisitions when the effect “*may* be substantially to lessen competition, or to tend to create a monopoly.”³⁴ The word “*may*” is read to reflect Congress's concern “with probabilities, not certainties.”³⁵ This analysis requires “not merely an appraisal of the immediate impact of the merger upon competition, but a prediction of its impact upon competitive conditions in the future.”³⁶ Plaintiffs pursuing a Section 7 action have the initial burden of establishing a *prima facie* case that the proposed merger is anticompetitive.³⁷ A plaintiff's case seeks to prove that as a result of the merger, a firm will gain control of an undue share of the relevant market

29. See Horizontal Merger Guidelines, *supra* note 25, § 1.

30. Sherman Antitrust Act of 1890, ch. 647, 26 Stat. 209 (codified as amended at 15 U.S.C. §§ 1–7 (2018)).

31. *Standard Oil Co. of N.J. v. United States*, 221 U.S. 1, 66 (1911) (establishing the rule of reason standard of analysis); see also *The Antitrust Laws*, FTC, <https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws> [https://perma.cc/E3JQ-Z7CV] (last visited July 27, 2022).

32. Federal Trade Commission Act of 1914, ch. 311, 38 Stat. 717 (codified as amended at 15 U.S.C. §§ 41–58).

33. Clayton Antitrust Act of 1914, ch. 323, 38 Stat. 730 (codified at 15 U.S.C. §§ 12–27).

34. 15 U.S.C. § 18 (emphasis added); see also Herbert Hovenkamp, *The Looming Crisis in Antitrust Economics*, 101 B.U. L. Rev. 489, 504 (2021) [hereinafter Hovenkamp, *Looming Crisis*] (“The relevant question for antitrust analysis is whether one firm's output exerts sufficient pressure on another firm's output to hold that firm's prices reasonably close to its costs. That is, competition is what limits the market power of a rival firm.”).

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

36. *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 362 (1963).

37. *Fed. Trade Comm'n v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 337–38 (3d Cir. 2016); see also *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 785 (9th Cir. 2015) (“[A] *prima facie* case is established if the plaintiff proves that the merger will probably lead to anticompetitive effects in that market.”).

Private plaintiffs, the DOJ, and the FTC all have authority to take action against federal antitrust violations. While hospitals and healthcare providers are at risk of antitrust violations under any of the federal antitrust laws, the FTC has developed expertise in health and pharmaceuticals and is primarily responsible for enforcing Section 7 of the Clayton Act and regulating the healthcare industry. FTC, *Enforcers*, *supra* note 18.

and that it would result in a significant increase in the concentration of firms in that market.³⁸

Defining the relevant product and geographic markets is a pragmatic and factual exercise that must “correspond to the commercial realities of the industry.”³⁹ Plaintiffs that successfully prove this element thus establish a presumption that the merger will be anticompetitive and unlawful.⁴⁰ The burden then shifts to the defendant to rebut the *prima facie* case.⁴¹ Statistics indicating an increase of market concentration are not necessarily outcome determinative nor “conclusive indicators of anticompetitive effects.”⁴² On rebuttal, especially in the healthcare context, defendants seek to establish that the anticompetitive effects of the merger will be offset by merger-specific efficiencies resulting from the union of the two entities.⁴³

Although the Supreme Court does not frequently rule on the substantive aspects of antitrust mergers, the law continues to develop in the lower courts.⁴⁴ This Part proceeds to analyze how antitrust law is understood by the FTC and applied by the lower courts. Section I.A will consider the origins of antitrust theory, describing a body of law driven by evolving economic policy goals. Then, section I.B will focus on the elements of the efficiencies defense to merger challenges and how parties seeking to rebut the presumption of anticompetitive harms have employed it. This context informs how antitrust regulators and the courts evaluate such efficiencies today.

38. Fed. Trade Comm’n v. H.J. Heinz Co., 246 F.3d 708, 715 (D.C. Cir. 2001) (citing *Nat’l Bank*, 374 U.S. at 363). Increased concentration in the market is assumed to raise the risk of “interdependent anticompetitive conduct.” Fed. Trade Comm’n v. PPG Indus., 798 F.2d 1500, 1503 (D.C. Cir. 1986) (quoting *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 497 (1974)). Market concentration is measured by the Herfindahl-Hirschman Index, which sums the squares of the individual firms’ market shares. Horizontal Merger Guidelines, *supra* note 25, § 5.3.

39. *Brown Shoe*, 370 U.S. at 336 (footnote omitted) (internal quotation marks omitted) (quoting *Am. Crystal Sugar Co. v. Cuban-Am. Sugar Co.*, 152 F. Supp. 387, 398 (S.D.N.Y.), *aff’d*, 259 F.2d 524 (2d Cir. 1958)); see also Horizontal Merger Guidelines, *supra* note 25, § 1 (explaining that merger analysis is a “fact-specific process”).

40. See *Heinz*, 246 F.3d at 715 (citing *United States v. Baker Hughes Inc.*, 908 F.2d 981, 982 (D.C. Cir. 1990)).

41. See *St. Luke’s*, 778 F.3d at 783.

42. *Gen. Dynamics*, 415 U.S. at 498; *Brown Shoe*, 370 U.S. at 322 n.38 (“[O]nly a further examination of the particular market—its structure, history and probable future—can provide the appropriate setting for judging the probable anticompetitive effect of the merger.”).

43. See, e.g., *St. Luke’s*, 778 F.3d at 791–92; *Heinz*, 246 F.3d at 720–22. Alternatively, defendants may produce evidence to show that the market-share statistics are an inaccurate account of the merger’s probable effects on competition. *United States v. Citizens & S. Nat’l Bank*, 422 U.S. 86, 120 (1975).

44. See *infra* section I.B.

A. *Norms of Antitrust*

Maurice E. Stucke explains that the “battle over antitrust begins with its goals.”⁴⁵ This is because the objectives of American antitrust law are not statutorily established.⁴⁶ Operative terms in Section 7 like “substantially to lessen competition” are not self-defining⁴⁷ and are continually debated in response to evolving economic theories.⁴⁸ This theoretical development sheds light on how the current understanding of competition within healthcare is subject to change. This change is driven by new understandings of the industry, the economic forces influencing the field, and even recognition of new goals of antitrust—goals which could include the pursuit of greater public health.

Through the 1960s, antitrust theory revolved around economic structuralism, the concern that concentrated market structures fostered anticompetitive forms of conduct.⁴⁹ Then in the 1970s, the Chicago School established a rival “price theory,” in which consumer prices were the “dominant metric for assessing competition.”⁵⁰ Proponents of this view emphasize the efficiency of markets as propelled by profit-maximizing actors.⁵¹ Robert Bork later advocated instead that the sole normative goal of antitrust should be the maximization of consumer welfare through the promotion of “economic efficiency.”⁵²

45. Maurice E. Stucke, *Reconsidering Antitrust’s Goals*, 53 B.C. L. Rev. 551, 558 (2012); see also Robert H. Bork, *The Antitrust Paradox: A Policy at War With Itself* 50 (1978) (explaining that defining the goals of antitrust is paramount, and “[e]verything else follows from the answer we give”).

46. Although the Supreme Court has noted in *Kirtsaeng v. John Wiley & Sons, Inc.* that “the principal objective of antitrust policy is to maximize consumer welfare by encouraging firms to behave competitively,” the concept of competition is not definitively defined. 568 U.S. 519, 539 (2013) (quoting Phillip E. Areeda & Herbert Hovenkamp, 1 *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 100 (3d ed. 2006)). Some countries do establish specific priorities of antitrust enforcement in their statutory provisions. See Stucke, *supra* note 45, at 559 n.60 (pointing to antitrust laws in China and South Africa that explicitly define policy goals).

47. Herbert Hovenkamp, *Appraising Merger Efficiencies*, 24 *Geo. Mason L. Rev.* 703, 706 (2017) [hereinafter Hovenkamp, *Appraising Merger Efficiencies*] (explaining that lessening competition can refer to simple rivalry, general welfare, or output).

48. See Lina M. Khan, Note, *Amazon’s Antitrust Paradox*, 126 *Yale L.J.* 710, 718–22 (2017) (tracing the influence of economic structuralism in the 1960s, through the price theory of antitrust from the 1970s and 1980s, to a modern trend of considering non-price effects); see also Stucke, *supra* note 45, at 559–62 (categorizing four major policy goals: ensuring an effective competitive process, promoting consumer welfare, maximizing efficiency, and protecting economic freedom).

49. Khan, *supra* note 48, at 718.

50. *Id.* at 719; see also Richard A. Posner, *The Chicago School of Antitrust Analysis*, 127 *U. Pa. L. Rev.* 925, 932 (1979).

51. Khan, *supra* note 48, at 718–20.

52. Bork, *supra* note 45, at 7. The Supreme Court embraced this objective when concluding that Congress designed the Sherman Act as a “consumer welfare prescription”

These theories inform the FTC and the DOJ as they publish guidelines that establish how the agencies analyze prospective mergers. For example, the Merger Guidelines of 1968 emphasized the preservation of market structures “conducive to competition,”⁵³ and the later guidelines of 1982 opposed mergers that created or enhanced market power.⁵⁴ The guidance in effect today, the most recent 2010 Horizontal Merger Guidelines, expressly acknowledges that non-price effects, including merger-specific efficiencies, can be considered when balancing the anticompetitive effects of consolidation.⁵⁵ These guidelines instruct that “a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm’s ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products.”⁵⁶

In evaluating this same evolution of antitrust theory, FTC Chairperson Lina M. Khan concluded in her early scholarship that the current state of “antitrust law now assesses competition largely with an eye to the short-term interests of consumers, not producers or the health of the market as a whole; antitrust doctrine views low consumer prices, alone, to be evidence of sound competition.”⁵⁷ Chairperson Khan’s insights are especially relevant as the FTC works to update the Horizontal Merger Guidelines⁵⁸

and signaled its agreement with Bork by citing him directly. See *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979) (citing Bork, *supra* note 45, at 66).

53. DOJ, 1968 Merger Guidelines ¶ 2 (1968), <https://www.justice.gov/sites/default/files/atr/legacy/2007/07/11/11247.pdf> [<https://perma.cc/9QGG-4T35>] (“Market structure is the focus of the Department’s merger policy chiefly because the conduct of the individual firms in a market tends to be controlled by the structure of that market . . .”).

54. DOJ, 1982 Merger Guidelines § 2 (1982), <https://www.justice.gov/sites/default/files/atr/legacy/2007/07/11/11248.pdf> [<https://perma.cc/35JN-UXDE>] (defining market power as the “ability of one or more firms profitably to maintain prices above competitive levels for a significant period of time”).

55. Horizontal Merger Guidelines, *supra* note 25, § 10. The federal antitrust enforcement agencies also published a set of guidelines for vertical merger review that similarly acknowledge merger-specific efficiencies. DOJ & FTC, Vertical Merger Guidelines § 6 (2020), https://www.ftc.gov/system/files/documents/reports/us-department-justice-federal-trade-commission-vertical-merger-guidelines/vertical_merger_guidelines_6-30-20.pdf [<https://perma.cc/A6DZ-W7A3>] (“The Agencies evaluate efficiency claims by the parties using the approach set forth in Section 10 of the Horizontal Merger Guidelines . . . The Agencies do not challenge a merger if cognizable efficiencies are of a character and magnitude such that the merger is unlikely to be anticompetitive . . .”).

56. Horizontal Merger Guidelines, *supra* note 25, § 10.

57. Khan, *supra* note 48, at 716.

58. Chairperson Khan announced in July 2021 her intention to review and update the merger guidelines. Press Release, FTC, Statement of FTC Chair Lina M. Khan and Antitrust Division Acting Assistant Attorney General Richard A. Powers on Competition Executive Order’s Call to Consider Revisions to Merger Guidelines (July 9, 2021), <https://www.ftc.gov/news-events/news/press-releases/2021/07/statement-ftc-chair-lina-m-khan-antitrust-division-acting-assistant-attorney-general-richard-powers> [<https://perma.cc/HQ8Q-G7D8>] [hereinafter FTC Commissioner Statement] (“The current guidelines deserve a hard look to determine whether they are overly permissive.”).

and the Biden Administration continues to signal its dedication to strong antitrust enforcement.⁵⁹

The composition of the Supreme Court further bears on antitrust norms in the United States. Although the Court has not ruled on the specific question of the efficiencies defense, there is some evidence that the Court would recognize it as a matter of law. Chief Justice John Roberts along with Justices Clarence Thomas and Samuel Alito have been characterized by former FTC Commissioner Pamela Jones Harbour as maintaining a pro-business bias and favoring antitrust defendants.⁶⁰ Neither of the two newest Supreme Court Justices, Ketanji Brown Jackson and Amy Coney Barrett, has ever decided an antitrust case on the merits, so few meaningful conclusions can be drawn.⁶¹ Justice Brett Kavanaugh, however, while still on the D.C. Circuit, opposed that court's decision to permanently enjoin the merger of Anthem and Cigna, the second- and third-largest health insurance companies in the country. In dissent, then-Judge Kavanaugh forcefully concluded that:

Under the modern approach reflected in cases such as *General Dynamics*, *Baker Hughes*, and *Heinz*, the fact that a merger such as this one would produce heightened market concentration and increased market shares . . . is not the end of the legal analysis. Under current antitrust law, we must take account of the efficiencies and consumer benefits that would result from this merger. Any suggestion to the contrary is not the law.⁶²

This history shows how antitrust is an evolving study of the intersection of law and economics with the potential to adapt to new policy goals, particularly for healthcare. The government and its regulators choose priorities that are prone to modification depending on certain business and economic realities. Definitions of operative terms like “competition” and “substantially lessen” within Section 7 are subject to

59. Exec. Order No. 14,036, 86 Fed. Reg. 36,987, 36,988 (July 9, 2021) (“This order affirms that it is the policy of my Administration to enforce the antitrust laws to combat the . . . harmful effects of monopoly . . . especially . . . [in] healthcare markets . . .”).

60. Pamela Jones Harbour, Antitrust Source, *The Supreme Court's Antitrust Future: New Directions or Revisiting Old Cases?* 1 (2007), https://www.ftc.gov/sites/default/files/documents/public_statements/supreme-courts-antitrust-future-new-directions-or-revisiting-old-cases/dec07-harbour12-17.pdf [<https://perma.cc/EY96-XLU9>].

61. Am. Antitrust Inst., *The Antitrust Implications of Ketanji Brown Jackson's Supreme Court Appointment* 2 (2022), <https://www.antitrustinstitute.org/wp-content/uploads/2022/04/KBJ-Commentary-FINAL.pdf> [<https://perma.cc/4SQ8-73MQ>]; Am. Antitrust Inst., *Senate Confirmation of Justice Amy Coney Barrett Tightens Conservative Grip on Antitrust Law in the Courts* 1 (2020), <https://www.antitrustinstitute.org/wp-content/uploads/2020/10/AAI-Statement-on-AC-Barrett-10.28-1.pdf> [<https://perma.cc/L6VU-PGS3>].

62. *United States v. Anthem, Inc.*, 855 F.3d 345, 377, 379 (D.C. Cir. 2017) (Kavanaugh, J., dissenting) (concluding that the merger would result in lower provider rates and subsequent savings that would be passed through to employers). Then-Judge Kavanaugh further wrote, “Fortunately, the majority opinion in the end does not actually hold that there is no efficiencies defense available in Section 7 cases.” *Id.* at 379.

interpretation and can be outcome determinative for merger challenges.⁶³ The implicit assumption throughout the Horizontal Merger Guidelines that “all mergers are cut from nearly identical cloth” is “inconsistent with actual business practices”⁶⁴—especially in the provision of health.⁶⁵ And while antitrust enforcement is concerned with the market as a whole, the unique realities of healthcare demonstrate how a universal approach to market regulation may clash with public health goals.

Antitrust law is written to apply equally to all private market behavior.⁶⁶ When ruling on price-fixing among a medical association in violation of the Sherman Act, the Supreme Court ruled that the Act “establishes one uniform rule applicable to all industries alike.”⁶⁷ And yet, although antitrust laws do not establish any industry-specific carveouts, the FTC has granted healthcare providers concessions, and the lower courts have granted them relief.⁶⁸ Relevant case law preserves a history of exceptions, including applying the rule of reason to actions against doctors engaging in group boycotting,⁶⁹ failure of the FTC or the DOJ to prosecute price-fixing among physicians,⁷⁰ and variable outcomes for challenges to hospital consolidation.⁷¹ Even Congress has demonstrated a willingness to create statutory antitrust exemptions for medicine.⁷² Despite certain

63. See Hovenkamp, *Appraising Merger Efficiencies*, supra note 47, at 706.

64. Mark A. Jamison & Janice A. Hauge, *Adding Dimension to Merger Analysis*, 12 J. Comp. L. & Econ. 99, 100 (2016) (critiquing the Horizontal Merger Guidelines for their reliance on market definitions of existing markets and their application to all mergers regardless of the actual nature of each transaction).

65. See *infra* section I.B.

66. Spencer Weber Waller, *How Much of Health Care Antitrust Is Really Antitrust?*, 48 Loy. U. Chi. L.J. 643, 643, 645–46 (2017) (“The antitrust laws are intended as laws of general applicability subject to any legislative exemptions and immunities. They are intended to be transubstantive, applying to all parties, in all disputes, and in all sectors, unless Congress speaks to the contrary.”); see also Hovenkamp, *Looming Crisis*, supra note 34, at 492 (“Antitrust economics should not become an excuse for picking a winning interest group and then manipulating the doctrine to get to that result.”).

67. *Arizona v. Maricopa Cnty. Med. Soc’y*, 457 U.S. 332, 349 (1982) (quoting *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 222 (1940)).

68. See Waller, supra note 66, at 643, 646–60.

69. See, e.g., *Wilk v. Am. Med. Ass’n*, 719 F.2d 207, 226 (7th Cir. 1983), cert. denied, 467 U.S. 1210 (1984) (reversing a per se verdict in a boycott case brought by chiropractors); cf. *Everhart v. Jane C. Stormont Hosp. & Training Sch. for Nurses*, No. 79-4191, 1982 WL 1833, at *2 (D. Kan. Feb. 18, 1982) (holding that an alleged boycott of physicians by two hospitals was inappropriate for review under the per se rule). Black letter law at the time traditionally held that group boycotts were per se unlawful. Waller, supra note 66, at 650.

70. Waller, supra note 66, at 654–68 (categorizing the total number of FTC and DOJ actions as “less than a handful”). These outcomes stem from the holding of *Maricopa Cnty. Med. Soc’y*, 457 U.S. at 342–43 (noting that the factfinder in antitrust cases must decide whether, under all circumstances of a case, the restrictive practice at issue imposes an unreasonable restraint on competition).

71. Waller, supra note 66, at 658–60; see also *infra* sections I.B & II.C.

72. The medical student “match” program was challenged in a private treble damage class action on the theory of unlawful price-fixing and market division. Waller, supra note

exceptions for the healthcare industry, under current law, showing antitrust injury in any industry continues to require proving the risk of harm to consumer welfare. But commensurate increases in procompetitive efficiencies may offset these anticompetitive harms.⁷³

B. *Elements of the Efficiencies Defense*

Hospitals and healthcare entities nominally choose mergers and acquisitions in pursuit of efficiencies.⁷⁴ These may include decreases in price, increases in quality or output, and increases in innovation.⁷⁵ Critics of hospital mergers, however, vigorously argue that such deals do not actually yield the lower prices or improved quality that hospitals claim.⁷⁶ When mergers are challenged, entities can argue that merger-specific efficiencies may sufficiently offset certain anticompetitive harms.⁷⁷ They must therefore sufficiently prove the validity of any merger-related benefits, especially reductions in patient costs, for the deal to move forward.⁷⁸

66, at 658. Before litigation could fully commence, Congress was convinced to include a consequential amendment that immunized the residency match program from antitrust scrutiny in an otherwise unrelated pension bill. *Id.*; see also Pension Funding Equity Act of 2004, Pub. L. No. 108-218, § 207, 118 Stat. 596, 611–14 (codified as amended at 15 U.S.C. § 37(b) (2018)) (“Antitrust lawsuits challenging the matching process, regardless of their merit or lack thereof, have the potential to undermine this highly efficient, procompetitive, and long-standing process.”).

73. Horizontal Merger Guidelines, *supra* note 25, § 10; see also, e.g., Fed. Trade Comm’n v. Thomas Jefferson Univ., 505 F. Supp. 3d 522, 558 (E.D. Pa. 2020), appeal dismissed per stipulation, Fed. Trade Comm’n v. Thomas Jefferson Univ., No. 20-3499, 2021 WL 2349954 (3d Cir. Mar. 4, 2021).

74. Brief for Amici Curiae International Center of Law & Economics and Medicaid Defense Fund in Support of Defendants-Appellants Urging Reversal at 9–11, *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.*, 778 F.3d 775 (9th Cir. 2015) (Nos. 12-cv-00560, 13-cv-00116), 2014 WL 2958116 [hereinafter Brief for International Center of Law & Economics] (“There are increasing demands for investment and capital from hospitals and other provider groups to create appropriate infrastructure and economies of scale. To address these issues, many providers merge to achieve capital and operational efficiencies.”).

75. Howard Shelanski, Efficiency Claims and Antitrust Enforcement, *in* 1 *The Oxford Handbook of International Antitrust Economics* 451, 451 (Roger D. Blair & D. Daniel Sokol eds., 2015).

76. See, e.g., 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> (on file with the *Columbia Law Review*) (“[M]ergers have essentially banished competition and raised prices for hospital admissions in most cases, according to an examination of 25 metropolitan areas . . .”); Elsa Pearson, Hospital Mergers and Acquisitions Are a Bad Deal for Patients. Why Aren’t They Being Stopped?, *STAT* (Sept. 2, 2021), <https://www.statnews.com/2021/09/02/hospital-mergers-more-oversight-federal-state-officials/> [<https://perma.cc/T79C-2RMJ>] (“Mergers rarely lead to better care quality, access, or prices. Proposed mergers must be assessed and approved based on evidence, not industry pressure.”).

77. Horizontal Merger Guidelines, *supra* note 25, § 10.

78. In February 2022, the FTC authorized an administrative complaint and filed suit in federal court to block a merger between Rhode Island’s two largest healthcare providers,

When subjected to scrutiny from regulators, parties continue to proffer these efficiencies as justification for mergers that run the risk of monopolizing the market or harming consumer welfare. Admittedly, this defense does not always prevail, and the Supreme Court has never expressly upheld it.⁷⁹ Nonetheless, the Third, Sixth, Eighth, Ninth, Eleventh, and D.C. Circuits have reasoned that an efficiencies defense could rebut a Section 7 claim.⁸⁰ Courts have recognized that possible efficiencies in the healthcare industry can include annual recurring savings from eliminating redundancies,⁸¹ capital savings resulting in lower prices or improved quality of services,⁸² the ability to attract and recruit physicians and

causing the firms to voluntarily abandon the transaction. The federal complaint argued: “Defendants have not substantiated merger-specific, verifiable, and cognizable efficiencies that likely would be sufficient to reverse the Proposed Transaction’s potential to harm customers” Complaint for Temporary Restraining Order and Preliminary Injunction Pursuant to Section 13(b) of the Federal Trade Commission Act at 23, Fed. Trade Comm’n v. Lifespan Corp., No. 22-cv-00081 (D.R.I. filed Feb. 18, 2022); see also Press Release, FTC, Statement Regarding Termination of Attempted Merger of Rhode Island’s Two Largest Healthcare Providers (Mar. 2, 2022), <https://www.ftc.gov/news-events/news/press-releases/2022/03/statement-regarding-termination-attempted-merger-rhode-islands-two-largest-healthcare-providers> [<https://perma.cc/JTQ2-7HDU>] [hereinafter FTC, Rhode Island Healthcare Providers].

Then, in June 2022, the FTC similarly moved to block the consolidation of two major healthcare systems in New Jersey, arguing the same failure to prove specific, verifiable, and cognizable efficiencies. Complaint for Temporary Restraining Order and Preliminary Injunction Pursuant to Section 13(b) of the Federal Trade Commission Act at 26, Fed. Trade Comm’n v. RWJ Barnabas Health, Inc., No. 22-cv-03416 (D.N.J. filed June 3, 2022).

79. Fed. Trade Comm’n v. Penn State Hershey Med. Ctr., 838 F.3d 327, 348 (3d Cir. 2016) (describing *Heinz* as “acknowledging that the Supreme Court has never ‘sanctioned the use of the efficiencies defense,’ but noting that ‘the trend among lower courts is to recognize the defense’ (quoting Fed. Trade Comm’n v. H.J. Heinz Co., 246 F.3d 708, 720 (D.C. Cir. 2001))”); see also Fed. Trade Comm’n v. Procter & Gamble Co., 386 U.S. 568, 580 (1967) (“Possible economies cannot be used as a defense to illegality. Congress was aware that some mergers which lessen competition may also result in economies but it struck the balance in favor of protecting competition.” (citing *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962))). Former FTC Chairperson Timothy Muris argued that the *Procter & Gamble* holding should be read narrowly because the Court was addressing a case where efficiencies were considered to be “possible” but not probable. Moreover, Muris argued that the ruling did not reject the efficiency defense outright because that issue was not directly before the Court. See Timothy J. Muris, *The Efficiency Defense Under Section 7 of the Clayton Act*, 30 Case W. Rsrv. L. Rev. 381, 412–13, 416 (1980).

80. *Penn State Hershey*, 838 F.3d at 348; *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.*, 778 F.3d 775, 788–92 (9th Cir. 2015) (expressing skepticism that the defense exists but nevertheless addressing it); *ProMedica Health Sys., Inc. v. Fed. Trade Comm’n*, 749 F.3d 559, 571 (6th Cir. 2014); *H.J. Heinz Co.*, 246 F.3d at 720–22; Fed. Trade Comm’n v. Tenet Health Care Corp., 186 F.3d 1045, 1054–55 (8th Cir. 1999); Fed. Trade Comm’n v. Univ. Health, Inc., 938 F.2d 1206, 1222–24 (11th Cir. 1991).

81. Fed. Trade Comm’n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1089–91 (N.D. Ill. 2012) (acknowledging that cost savings could be a sufficient efficiency even though the defendant’s projections were held to be too speculative).

82. *Penn State Hershey*, 838 F.3d at 350 (“[S]o long as the capital savings result in some tangible, verifiable benefit to consumers, capital savings may play a role in our efficiencies analysis.”).

specialists,⁸³ and the capacity to offer integrated and tertiary care.⁸⁴ Even the FTC in the Horizontal Merger Guidelines has recognized the defense and noted that a “primary benefit” of mergers is the potential to generate efficiencies.⁸⁵

Under the current Horizontal Merger Guidelines, a party asserting this defense must be able to prove that the efficiencies are (1) verifiable;⁸⁶ (2) not attributable to reduced output or quality;⁸⁷ (3) merger-specific;⁸⁸ and (4) sufficient to outweigh the transaction’s anticompetitive effects.⁸⁹ To prove that efficiencies are merger-specific, a party must demonstrate that the efficiencies cannot readily be achieved by either company alone.⁹⁰ But courts need to ensure that proposed efficiencies “represent more than mere speculation and promises about post-merger behavior.”⁹¹ There is no comprehensive list of what efficiencies a court may consider, and the range of arguments that litigants present reflect the norms and policy goals of contemporaneous antitrust enforcement.⁹²

The defense ventilated a series of merger-related benefits at the trial level in the case of *St. Luke’s*. In that matter, the defendant argued that efficiencies that would result from a hospital merger included the ability to eliminate the fee-for-service reimbursement system and begin to transition to value-based care.⁹³ Nonetheless, the proposed consolidation was ultimately blocked.⁹⁴ In *St. Luke’s*, the named party was an Idaho-based,

83. *Tenet Health Care*, 186 F.3d at 1054 (reasoning that because a merged entity could provide better care more efficiently, it would “be able to attract more highly qualified physicians and specialists”).

84. *Id.*

85. Horizontal Merger Guidelines, *supra* note 25, § 10.

86. Case law adds judicial interpretations of these guidelines. E.g., *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd.*, 778 F.3d 775, 791 (9th Cir. 2015) (observing that efficiencies must “be verifiable, not merely speculative”); *Fed. Trade Comm’n v. Univ. Health, Inc.*, 938 F.2d 1206, 1223 (11th Cir. 1991) (holding that efficiencies “must be shown in what economists label ‘real’ terms” (internal quotation marks omitted) (quoting *Fed. Trade Comm’n v. Procter & Gamble Co.*, 386 U.S. 568, 604 (1967) (Harlan, J., concurring))).

87. Horizontal Merger Guidelines, *supra* note 25, § 10.

88. *Fed. Trade Comm’n v. H.J. Heinz Co.*, 246 F.3d 708, 721–22 (D.C. Cir. 2001).

89. *Fed. Trade Comm’n v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 348–49 (3d Cir. 2016).

90. *Heinz*, 246 F.3d at 722. The Horizontal Merger Guidelines “credit only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects.” Horizontal Merger Guidelines, *supra* note 25, § 10.

91. *Heinz*, 246 F.3d at 721.

92. This Note advocates for specific efficiencies that ought to be directly recognized in any future horizontal merger guidelines or otherwise explicitly analyzed by the courts when they review Section 7 merger challenges, see *infra* Part III.

93. *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke’s Health Sys., Ltd.*, No. 12-CV-00560, 2014 WL 407446, at *14–18 (D. Idaho Jan. 24, 2014), *aff’d*, 778 F.3d 775 (9th Cir. 2015).

94. *Id.* at *17, *19.

nonprofit healthcare system that planned to acquire a local physician group of forty-one doctors as part of a move toward providing integrated care.⁹⁵ Their merger alarmed two competing local hospitals and drew the attention of the FTC, resulting in a Section 7 suit.⁹⁶ St. Luke's stated that any anticompetitive outcomes were outweighed by three specific efficiencies. First, they argued that the merger would allow them to eliminate the fee-for-service reimbursement system and transition to value-based care.⁹⁷ Second, the hospital system asserted that as a result of the merger they could employ a core group of employed physicians to provide primary health services as part of their goal of establishing integrated care.⁹⁸ And third, St. Luke's proposed that the merged parties could share an electronic health records system that would improve preventative care and advance the transition to value-based care.⁹⁹ Yet, while the district court that ruled to block the merger and the circuit court that affirmed recognized the efficiencies defense,¹⁰⁰ they were not persuaded by it.¹⁰¹

At no point did either court determine that any of these proposed efficiencies were unrealistic or unreasonable. Yet, the Ninth Circuit foreshadowed its decision to block the merger at the start of its opinion, writing, "the job before us is not to determine the optimal future shape of the country's health care system, but instead to determine whether this particular merger violates the Clayton Act."¹⁰² The court further concluded that "[i]t is not enough to show that the merger would allow St. Luke's to better serve patients. The Clayton Act focuses on competition, and the claimed efficiencies therefore must show that the prediction of anticompetitive effects from the prima facie case is inaccurate."¹⁰³ Despite the anticipated improvements for patient health, the court concluded that the efficiencies relating to employed physicians and shared electronic records were not merger-specific, that St. Luke's had not proven that the

95. *Id.* at *3.

96. *Id.* at *1.

97. *Id.* at *13–15.

98. *Id.* at *14.

99. *Id.* at *13–14.

100. *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 790 (9th Cir. 2015) ("[W]e assume, as did the district court, that because . . . the Clayton Act only prohibits those mergers whose effect 'may be substantially to lessen competition,' . . . a defendant can rebut . . . with evidence that the proposed merger will create a more efficient combined entity and thus increase competition." (quoting 15 U.S.C. § 18 (2018)); *St. Luke's*, 2014 WL 407446, at *14–15.

101. *Saint Alphonsus*, 778 F.3d at 792 ("The district court did not clearly err in concluding that whatever else St. Luke's proved, it did not demonstrate that efficiencies resulting from the merger would have a positive effect on competition.").

102. *Id.* at 781.

103. *Id.* at 791 (describing *University Health* as "finding efficiencies relevant to the prediction of 'whether the acquisition would substantially lessen competition'" (quoting *Fed. Trade Comm'n v. Univ. Health, Inc.*, 938 F.2d 1206, 1222 (11th Cir. 1991))).

merger would have positive effects on competition, and ultimately that prices for consumers would likely increase.¹⁰⁴

Yet there is reason to be critical of the Ninth Circuit's decision in *St. Luke's*. Roger D. Blair, Christine Piette Durrance, and D. Daniel Sokol argue that the Ninth Circuit and other courts hearing Clayton Act challenges to healthcare mergers fail to use empirical methods when analyzing purported efficiencies.¹⁰⁵ They believe that the courts are neglecting to factor in important aspects of the industry that might mitigate the anti-competitive concerns.¹⁰⁶ Moreover, when the courts analyze efficiencies, the opinions rarely produce clear guidance for parties contemplating a merger, let alone the future courts reviewing them.¹⁰⁷ Finally, this line of case law does not address the issue of how the analysis ought to balance price increases against any improved quality of care.¹⁰⁸

Although the efficiencies defense faces obstacles, it is not entirely foreclosed, and the Supreme Court has yet to hear such a claim from the healthcare industry.¹⁰⁹ Proponents of the defense must find new strategies moving forward if they have any hope of persuading regulators and the courts. Balancing the pro- and anticompetitive aspects of mergers is a difficult task, as both dimensions are determined largely by economic projections.¹¹⁰ But courts and regulators can reassess certain fault lines in current healthcare antitrust analysis according to the aims of value-based care, especially the patient-as-consumer dynamic, procompetitive quality metrics, and cost changes over long-term care.¹¹¹ Absent a clear doctrine of

104. *Id.* at 791–92.

105. Roger D. Blair, Christine Piette Durrance & D. Daniel Sokol, *Hospital Mergers and Economic Efficiency*, 91 *Wash. L. Rev.* 1, 3 (2016) [hereinafter Blair, *Hospital Mergers*]; see also Jamie L. Bjorklund, Note, *St. Alphonsus Medical Center v. St. Luke's Health System: The Uncertain Application of the Efficiencies Defense Is Leading to Unpredictable Outcomes in Healthcare Mergers*, 53 *Idaho L. Rev.* 577, 587 (2017) (“Where some circuit courts are willing to give weight to the pro-competitive effects of improving healthcare delivery systems by recognizing post-merger efficiencies, other circuit courts are not, and focus solely on cost based projections.”).

106. Blair, *Hospital Mergers*, *supra* note 105, at 5 (“Courts must be more effective and sophisticated in their guidance to better shape the changing health care landscape.”).

107. *Id.* at 3 (“A more rigorous analysis would have provided guidance to improve case law for future courts. It also would bring predictability to merger cases decided in the shadow of the law in terms of merger planning . . . and for negotiations between merging parties and antitrust enforcers more generally.”).

108. *Id.* at 65. This is supported by the general economic presumption that when quality improves, consumers are willing to pay more for the same quantity of the good.

109. See *supra* note 79. The first case in which defendants successfully rebutted the government's *prima facie* market concentration argument using mitigating efficiency factors was *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 510–11 (1974) (holding that uncommitted coal reserve levels rendered current market shares a poor metric of future competitive position).

110. Jamie Henikoff Moffitt, *Merging in the Shadow of the Law: The Case for Consistent Judicial Efficiency Analysis*, 63 *Vand. L. Rev.* 1695, 1707 (2010).

111. See *infra* Part III.

efficiencies, the current state of the law risks discouraging potentially beneficial mergers due to high costs from uncertainty.¹¹² Now more than ever, healthcare providers need clarity to understand the lawful or favorable factors to consider when choosing to consolidate.

II. HEALTHCARE STATUS QUO

Healthcare spending in the United States reached an astounding \$4.1 trillion in 2020.¹¹³ This was an increase of 9.7% in spending from the year before, amounting to 19.7% of the country's gross domestic product.¹¹⁴ Analysts predicted that spending would increase in 2022, especially as a result of worsening population health and deferred care caused by the ongoing COVID-19 pandemic.¹¹⁵ They anticipate that hospitals and healthcare providers will continue to contemplate mergers to provide sufficient care, if not just to survive.¹¹⁶ To understand the current healthcare landscape as well as the commercial and legal implications of mergers, Part II examines the healthcare consumer, the battle of economics that plays out during antitrust merger litigation, and the structural changes to the industry stemming from the passage of the ACA alongside the continuing transition toward value-based care.

A. *The Structural Changes to Healthcare*

The American healthcare system is heavily regulated by the government but continues to function as a mix of public, private, for-

112. Jamison & Hauge, *supra* note 64, at 99 (“[Deficiencies in antitrust case law] matter because they raise firms’ costs of merging, which is likely to diminish the number of beneficial mergers.”).

113. Ctrs. for Medicare & Medicaid Servs., *National Health Expenditures 2020 Highlights 1* (2020), <https://www.cms.gov/files/document/highlights.pdf> [<https://perma.cc/N34Q-592N>].

114. *Id.*

115. PwC Health Rsch. Inst., *Medical Cost Trend: Behind the Numbers 2022*, at 5, <https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html> [<https://perma.cc/L8JT-MU37>] [hereinafter PwC, *Medical Cost Trend*] (last visited July 12, 2022) (“The pandemic’s long tail may increase utilization and healthcare spending in 2022 thanks to the return of some care deferred during the pandemic, the ongoing costs of COVID-19, . . . and worsening population health.”).

116. See Pauline Jakubiec, *Yea or Nay? Hospital Mergers and Acquisitions*, *J. Health Care Fin.*, Fall 2021, at 2 (“[T]he increased regulation and rising costs under the ACA has incited hospitals to unite while motivating interest in the antitrust law arena.”). But see, e.g., Stefano Esposito, *After Seven Years, AMITA Health Partnership Breaking Up*, *Chi. Sun Times* (Oct. 21, 2021), <https://chicago.suntimes.com/2021/10/21/22738895/amita-health-partnership-breaking-up-adventhealth-ascension-hospitals> [<https://perma.cc/V5WU-UWQU>] (reporting that, seven years after merging, one of the larger healthcare systems in Illinois is breaking up to “meet the changing needs and expectations of consumers in the rapidly evolving healthcare environment” (internal quotation marks omitted) (quoting a representative of AMITA Health)).

profit, and nonprofit insurers and healthcare providers.¹¹⁷ It is a dynamic and multifaceted enterprise heavily regulated by the government and subject to incredible partisan divide. In order to understand the healthcare status quo driving hospital consolidation, this section proceeds to review structural changes that are affecting the industry, including the impact of the ACA and value-based care.

1. *The Affordable Care Act.* — As a result of industry trends and legislative reform, America is moving toward more integrated care models that require structural changes. In 2010, Congress passed the landmark healthcare reform bill, the Patient Protection and Affordable Care Act,¹¹⁸ which aimed to improve patient outcomes by tying payment of healthcare services to the quality of outcomes—striving for similar goals as value-based care.¹¹⁹ This was an intentional move away from the conventional fee-for-service model of healthcare payments that incentivizes high volumes of services that may not have similarly high value.¹²⁰

Commentators argue that the ACA reforms place new pressures on healthcare entities that drive them to seek mergers as a way of increasing efficiency and containing costs.¹²¹ Yet the passage of the ACA did not include any relief for healthcare providers from antitrust regulation.¹²² When the *St. Luke's* appeal was first announced, it drew attention from scholars because it advanced an efficiencies argument motivated in part by the post-ACA landscape.¹²³ Amici curiae arguing on behalf of the *St. Luke's* system explained that legislative reform from the ACA resulted in

117. Roosa Tikkanen, Robin Osborn, Elias Mossialos, Ana Djordjevic & George A. Wharton, *International Health Care System Profiles: United States*, Commonwealth Fund (June 5, 2020), <https://www.commonwealthfund.org/international-health-policy-center/countries/united-states> [<https://perma.cc/E992-DBP9>]; see also OECD, *supra* note 2, at 2 (describing the fragmented payor mix in the United States when compared to other OECD countries).

118. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 21, 25, 26, 29, and 42 U.S.C.). The package of reforms changed fee and payment structures and created a series of new regulations affecting electronic health records and reporting requirements. *Id.*

119. Brief for International Center of Law & Economics, *supra* note 74, at 9; Bjorklund, *supra* note 105, at 614.

120. Brief for International Center of Law & Economics, *supra* note 74, at 9.

121. See, e.g., Michael W. King, *Health Care Efficiencies: Consolidation and Alternative Models vs. Health Care and Antitrust Regulation—Irreconcilable Differences?*, 43 *Am. J.L. & Med.* 426, 444 (2017) (“Enactment of the ACA has prompted a well-documented surge in merger activity.”); Waller, *supra* note 66, at 661–62.

122. The ACA explicitly instructs that no part of the law “shall be construed to modify, impair, or supersede the operation of any of the antitrust laws.” 42 U.S.C. § 18118(a) (2018). But see *supra* note 72 and accompanying text describing the statutory immunization of the medical residency match program.

123. See Waller, *supra* note 66, at 661–62; Bjorklund, *supra* note 105, at 583–84; see also Brief for International Center of Law & Economics, *supra* note 74, at 9–11.

a dramatic reduction in profitability as providers “face reductions in reimbursement, changes in incentives, and limited access to capital.”¹²⁴ Although the defense that consolidation is justified or mandated by the ACA is not available statutorily, the healthcare market has fundamentally changed. Consolidation will continue and enforcement agencies and the courts should develop coherent guidelines for efficiencies scrutiny in the post-ACA world.

2. *Value-Based Care.* — One cause of the chilling reports of the failings of the healthcare industry¹²⁵ are the inefficiencies produced by the traditional fee-for-service model.¹²⁶ Despite the incredible amounts of money spent on healthcare in the United States, studies by the Commonwealth Fund continue to reflect disappointing results as measured by access to care, administrative efficiency, equity, and health outcomes.¹²⁷ For reference, in every comparative health report the organization issued since 2004, the United States has consistently ranked last.¹²⁸ And tragically, the most recent report found that “[c]ompared to peer nations, the U.S. has among the highest number of hospitalizations from preventable causes and the highest rate of avoidable deaths.”¹²⁹

The COVID-19 pandemic has, of course, further complicated the healthcare crisis. One physician described the situation succinctly, writing, “The financial distress of hospitals during the lockdown highlights their reliance on a constant flow of patient visits and billable services to stay in business.”¹³⁰ The pandemic severely diminished the demand for elective procedural admissions and procedures that were generally lucrative for

124. Brief for International Center of Law & Economics, *supra* note 74, at 10.

125. See *supra* notes 1–3 and accompanying text.

126. Vivian S. Lee, *Fee for Service Is a Terrible Way to Pay for Health Care. Try a Subscription Model Instead*, STAT (June 12, 2020), <https://www.statnews.com/2020/06/12/fee-for-service-is-a-terrible-way-to-pay-for-health-care-try-a-subscription-model-instead/> [<https://perma.cc/U74L-TDHB>] (“For too long, U.S. health care providers have operated within the grip of a fee-for-service model that incentivizes billable treatments over healthy and efficient outcomes.”).

127. Claire Parker, *U.S. Health-Care System Ranks Last Among 11 High-Income Countries, Researchers Say*, Wash. Post (Aug. 5, 2021), <https://www.washingtonpost.com/world/2021/08/05/global-health-rankings/> (on file with the *Columbia Law Review*); see also Emma Wager, Jared Ortaliza & Cynthia Cox, *How Does Health Spending in the U.S. Compare to Other Countries?*, Health System Tracker (Jan. 21, 2022), <https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries-2/> [<https://perma.cc/MR9N-TXGX>].

128. Parker, *supra* note 127.

129. Tikkanen & Abrams, *supra* note 1.

130. Lee, *supra* note 126. Some hospitals, however, have remained profitable throughout the pandemic. A Nashville-based hospital system, for example, earned \$1.1 billion in profit over the course of the pandemic, up from 38% the year prior. Tara Bannow, *Are Hospitals Making Money Treating COVID-19 Patients?*, Mod. Healthcare (Sept. 12, 2020), <https://www.modernhealthcare.com/providers/are-hospitals-making-money-treating-covid-19-patients> (on file with the *Columbia Law Review*).

hospitals.¹³¹ The income from such services has often recouped the losses from providing nonprocedural admissions and intensive long-term critical care, such as treating vulnerable COVID-19 patients.¹³²

Traditionally, the financial realities of fee-for-service models incentivize hospitals to perform well-reimbursed procedures with marginal benefit and unnecessary risk to patients.¹³³ COVID-19 further caused both healthy and chronically ill patients to skip essential health visits, which may lead to otherwise preventable health crises in the future that will likely be costly for providers and patients alike.¹³⁴ Some reports indicate that organizations that could offer value-based care were better equipped to respond to COVID-19 related obstacles to care by offering coordinated care and telehealth services.¹³⁵ Now more than ever, value-based care offers a meaningful way forward for the industry.

The inefficiencies in the current fee-for-service model are firmly entrenched and policymakers are turning to creative new approaches. These reforms are supported by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)—bipartisan legislation that changes the way providers are reimbursed for publicly insured patients¹³⁶—as well as the ACA.¹³⁷ These laws led the Centers for Medicare & Medicaid Services (CMS) to create a series of value-based-care programs that incentivize providers to transform their reimbursement models, especially through Accountable Care Organizations.¹³⁸ There are five original

131. Sourav Bose & Serena Dasani, Hospital Revenue Loss From Delayed Elective Surgeries, Leonard Davis Inst. of Health Econ., Univ. of Pa. (Mar. 16, 2021), <https://ldi.upenn.edu/our-work/research-updates/hospital-revenue-loss-from-delayed-elective-surgeries/> [<https://perma.cc/5JQZ-6AX7>] (“[H]ospitals lost nearly \$22.3 billion in revenue nationally due to the cancellation of elective surgeries.”).

132. Zahir Kanjee, Ateev Mehrotra & Bruce Landon, Opinion, Hospitals Are Busier Than Ever—And Going Out of Business, STAT (May 26, 2020), <https://www.statnews.com/2020/05/26/hospitals-are-busier-than-ever-and-going-out-of-business/> [<https://perma.cc/VFG6-M47N>] (reporting based on the personal experiences of three physician-professors).

133. *Id.*

134. Kelly E. Anderson, Emma E. McGinty, Rachel Presskreischer & Colleen L. Barry, Reports of Forgone Medical Care Among US Adults During the Initial Phase of the COVID-19 Pandemic, JAMA Network Open, Jan. 2021, at 4, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775366> [<https://perma.cc/Y73R-XG58>].

135. Kevin Wang, Why Value-Based Care Is Needed Now More Than Ever, Vera Whole Health (June 29, 2022), <https://www.verawholehealth.com/blog/why-value-based-care-is-needed-now-more-than-ever> [<https://perma.cc/B3Y7-FF87>].

136. Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87 (codified in scattered sections of 42 U.S.C.).

137. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

138. The ACA authorized the formation of Accountable Care Organizations, where hospitals, doctors, and other providers work as a coordinated team to deliver care at a lower cost. Accountable Care Organizations (ACOs), Ctrs. for Medicare & Medicaid Servs., <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO> [<https://perma.cc/N4KM-H2Y5>] (last updated Dec. 1, 2021).

value-based programs as designed by CMS. These include programs targeting renal disease,¹³⁹ hospital value-based purchasing,¹⁴⁰ hospital readmission reduction,¹⁴¹ modification of value criteria,¹⁴² and hospital-acquired condition reduction.¹⁴³ And the CMS Innovation Center is actively testing and devising new programs.¹⁴⁴

Elizabeth Teisberg, Scott Wallace, and Sarah O'Hara extensively studied successful value-based-care delivery organizations around the world to determine that a strong framework for value-based care builds from integrated teams and therefore consolidation.¹⁴⁵ Their proposed framework starts by first understanding the shared health needs of a patient before a multidisciplinary team cooperates on a comprehensive

139. ESRD Quality Incentive Program, Ctrs. for Medicare & Medicaid Servs., <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP> [<https://perma.cc/W9ZL-GRRP>] (last updated Mar. 3, 2022). This program is designed to promote high-quality services in renal dialysis facilities. CMS pays for treatment based on a facility's performance on quality-of-care measures. CMS publicly reports the quality scores, and each facility is required to display this information. *Id.*

140. The Hospital Value-Based Purchasing (VBP) Program, Ctrs. for Medicare & Medicaid Servs., <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing> [<https://perma.cc/658E-ZBAF>] (last updated Dec. 1, 2021) ("The Hospital VBP Program rewards acute care hospitals with incentive payments for the quality of care provided in the inpatient hospital setting.").

141. Hospital Readmissions Reduction Program (HRRP), Ctrs. for Medicare & Medicaid Servs., <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program> [<https://perma.cc/7V4V-Q23K>] (last updated Dec. 21, 2021). This program "encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions." *Id.*

142. Medicare FFS Physician Feedback Program/Value-Based Payment Modifier, Ctrs. for Medicare & Medicaid Servs., <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram> [<https://perma.cc/EQ2Y-A6WV>] (last updated Dec. 1, 2021) (allowing for differential payment based on care quality and providing comparative performance information to healthcare providers).

143. Hospital-Acquired Condition Reduction Program, Ctrs. for Medicare & Medicaid Servs., <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HAC/Hospital-Acquired-Conditions> [<https://perma.cc/UL8H-JU7X>] (last updated Dec. 1, 2021). This program is designed to "encourage[] hospitals to improve patients' safety and reduce the number of conditions people experience from their time in a hospital, such as pressure sores and hip fractures after surgery." *Id.*

144. The CMS Innovation Center, Ctrs. for Medicare & Medicaid Servs., <https://innovation.cms.gov/> [<https://perma.cc/N9GD-LA4N>] (last visited July 27, 2022). The Innovation Center further exists to meet the requirements of the Social Security Act, ACA, and MACRA. See Innovation Models, Ctrs. for Medicare & Medicaid Servs., <https://innovation.cms.gov/innovation-models#views=models> [<https://perma.cc/Z5PH-XW7V>] (last visited July 27, 2022).

145. See Elizabeth Teisberg, Scott Wallace & Sarah O'Hara, Defining and Implementing Value-Based Health Care: A Strategic Framework, 95 *Acad. Med.* 682, 683 (2020).

solution.¹⁴⁶ They argue that this naturally incentivizes expanded partnerships, driven by the benefits of sharing technology, sharing information with patients, supporting rural clinicians, and offering lifestyle and wellness services in a community.¹⁴⁷

One study funded by the National Institutes of Health tracked the spending, utilization, and quality of a value-based-care program run by Blue Cross Blue Shield in Massachusetts over the course of eight years and found evidence of financial savings. The study estimated that the program led to “11.7% relative savings on [insurance] claims.”¹⁴⁸ The authors report that 71% of the savings resulted from lower utilization of services in the later years like laboratory testing and emergency department visits.¹⁴⁹ Even more promising, the study found a general increase in quality under this model when compared to average regional and national quality measures.¹⁵⁰ If these statistics seem at all marginal, one must remember the long history of spending increases coupled with outcome decreases¹⁵¹—even marginal progress is to be applauded. But these cost reductions and quality improvements are not sufficiently factored into merger analysis as laid out in the existing merger guidelines or case law.¹⁵²

Value-based care has the added potential of addressing racial health disparities as well. Any shift in payment models should take the opportunity to target health disparities across minority and socio-economic class groups¹⁵³—disparities that fuel a reluctance to seek healthcare in some community members.¹⁵⁴ Critics of value-based care note that such programs can exacerbate existing disparities by creating an incentive for providers to seek out healthier and generally less diverse patients to maintain high-quality outcomes.¹⁵⁵ This risk makes it all the more

146. *Id.*

147. *Id.* at 684.

148. Zirui Song, Yunan Ji, Dana G. Safran & Michael E. Chernew, *Health Care Spending, Utilization, and Quality 8 Years Into Global Payment*, 381 *New Eng. J. Med.* 252, 255 (2019).

149. *Id.* at 257.

150. *Id.* at 257–61.

151. See *supra* notes 1–3 and accompanying text.

152. See *supra* section II.C.

153. See, e.g., Shantanu Agrawal & Adaeze Enekwechi, *It’s Time to Address the Role of Implicit Bias Within Health Care Delivery*, *Health Affs.* (Jan. 15, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200108.34515/full/> [<https://perma.cc/VMN5-R8AU>] (“A true and comprehensive approach to health equity requires addressing both the social and delivery system factors driving inequity.”).

154. See, e.g., Stephanie Watson, *Distrust of Medical System and Minority Health Care*, *WebMD* (Oct. 7, 2020), <https://www.webmd.com/diabetes/features/minority-medical-distrust> [<https://perma.cc/N8EQ-7YWK>] (“Studies show many people who are part of racial and ethnic minorities don’t trust their doctors or the medical community as a whole.”).

155. E.g., Sahil Sandhu, Robert S. Saunders, Mark B. McClellan & Charlene A. Wong, *Health Equity Should Be a Key Value in Value-Based Payment and Delivery Reform*, *Health Affs.* (Nov. 25, 2020), <https://www.healthaffairs.org/doi/10.1377/forefront.20201119.836369/full/> [<https://perma.cc/Q23S-L54L>].

important that payors carefully identify appropriate participation criteria and quality metrics.¹⁵⁶

The philosophy behind value-based care is impacting other areas of healthcare regulation as well, including the Stark Law and the Anti-Kickback Statutes. Former Secretaries of the Department of Health and Human Services, Kathleen Sebelius and Tommy Thompson, described both of these laws as “remnant[s] of the fee-for-service world [that] harm[s] the very patients they are supposed to protect by deterring more comprehensive patient-centered, coordinated care.” They go on to argue that “[t]o address these issues, we need new value-based exceptions and safe-harbors to more clearly promote the rapid transition from the fee-for-service environment to a value-based model.”¹⁵⁷ Further, a 2016 white paper from the Senate Finance Committee concluded that regulations rooted in the fee-for-service model are serious obstacles to implementing MACRA and other reforms.¹⁵⁸

Value-based care is here to stay, and further integration is an important tool in the pursuit of improvements in quality of care and long-term reductions of cost. Evidence shows that value-based-care models can work, and CMS is learning to design even better solutions for the future. But this reformulation of healthcare reimbursement is not sufficiently analyzed in healthcare antitrust jurisprudence, leaving parties who want to adopt value-based programs but are too small or specialized to do so independently with insufficient guidance on how to contemplate a potential merger.

B. *Understanding the Healthcare Consumer*

A particular commercial reality of the healthcare industry is the diverse payor mix that many hospitals and providers serve. Proper analysis of a healthcare merger challenge under existing law must accurately capture the relevant market and the impact on consumers.¹⁵⁹ But it is not simple to analogize consumers of conventional commodities to patients

156. See Nat'l Quality F., *A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity* 33–38 (2017), https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities_The_Four_I_s_for_Health_Equity.aspx [<https://perma.cc/NTU3-344D>] (providing recommendations on identifying health outcomes that prioritize health equity).

157. Kathleen Sebelius & Tommy G. Thompson, *Opinion, Overcoming Health-Care Challenges by Moving From Volume to Value*, Hill (July 17, 2018), <https://thehill.com/opinion/healthcare/397433-overcoming-health-care-challenges-by-moving-from-volume-to-value> [<https://perma.cc/N6UZ-D4C6>].

158. Senate Fin. Comm. Majority Staff, *Why Stark, Why Now? Suggestions to Improve the Stark Law to Encourage Innovative Payment Models* 19 (2016), <https://www.finance.senate.gov/imo/media/doc/Stark%20White%20Paper,%20SFC%20Majority%20Staff.pdf> [<https://perma.cc/SEJ5-4VAZ>].

159. See *supra* section I.A.

consuming healthcare.¹⁶⁰ The lower courts recognize that “the vast majority of healthcare consumers are not direct purchasers of healthcare—the consumers purchase health insurance and the insurance companies negotiate directly with the providers.”¹⁶¹

Hospitals and healthcare providers first compete to be included in an insurer’s network before proceeding to negotiate reimbursement rates and included services.¹⁶² Among the factors insurance companies consider when determining whether to include a hospital in a network are the quality and reputation of that hospital, its willingness to meet certain price points, and its geographic coverage.¹⁶³ Patient choice of hospitals and physicians, on the other hand, is generally determined by trust in or loyalty to a physician, perceptions of quality, geographic proximity and, of course, whether the hospital accepts their insurance.¹⁶⁴ As the Third Circuit explained in 2016, this naturally results in a “difference between analyzing the likely response of consumers through the patient or payor perspective.”¹⁶⁵ Although it is certainly possible that patient and payor behavior align, courts have not allowed parties to automatically assume that there is “correlated behavior” between patients and payors without specific evidence.¹⁶⁶

A district court recently engaged with this exact issue when considering an FTC action to block a proposed hospital merger. The FTC sought to enjoin the consolidation of Thomas Jefferson University and the Albert Einstein Healthcare Network but was denied a preliminary injunction.¹⁶⁷ This was especially notable since the FTC’s burden when seeking a preliminary injunction is not to *prove* a Section 7 violation but only “a proper showing that, weighing the equities and considering the Commission’s likelihood of ultimate success, such action would be in the

160. See Nat’l Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross of Kan. City, 452 U.S. 378, 387 n.10, 392 (1981) (highlighting Congress’s view in 1974 that the “health care industry does not respond to classic marketplace forces” due to the highly technical nature of medicine and the growth of third-party payors) (quoting S. Rep. No. 93-1285, at 39 (1974)).

161. E.g., Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke’s Health Sys., Ltd., 778 F.3d 775, 784 (9th Cir. 2015).

162. Fed. Trade Comm’n v. Advoc. Health Care, No. 15 C 11473, 2017 WL 1022015, at *2 (N.D. Ill. Mar. 16, 2017).

163. Id. at *1.

164. Fed. Trade Comm’n v. Tenet Health Care Corp., 186 F.3d 1045, 1049 (8th Cir. 1999).

165. Fed. Trade Comm’n v. Penn State Hershey Med. Ctr., 838 F.3d 327, 342–43 (3d Cir. 2016) (“[The District Court] completely neglected any mention of the insurers in the healthcare market. This incorrect focus reflects a misunderstanding of the ‘commercial realities’ of the healthcare market.” (quoting Brown Shoe Co. v. United States, 370 U.S. 294, 336 (1962))).

166. See id.

167. Fed. Trade Comm’n v. Thomas Jefferson Univ., No. 20-3499, 2020 WL 8455862, at *1 (3d Cir. Dec. 21, 2020), appeal dismissed per stipulation, Fed. Trade Comm’n v. Thomas Jefferson Univ., No. 20-3499, 2021 WL 2349954 (3d Cir. Mar. 4, 2021).

public interest.¹⁶⁸ And at this stage, the equities are presumptively tipped in the FTC's favor.¹⁶⁹

The court emphasized the commercial realities of the healthcare industry by positioning the consumer in a market influenced by third-party insurance companies and was particularly critical of testimony from such payors. The decision posited that the testimony of insurers should not be taken at face value and must be considered in light of the insurers' possible bias or motive.¹⁷⁰

Because the anticompetitive impact on consumers in this action was to be measured by the impact on the commercial payors, the credibility of the testimony from private insurance companies was foundational to the outcome.¹⁷¹ The court found that the insurers' testimony was prone to bias because of their dominant position in the market and the perceived threat of the proposed merger.¹⁷² Thus, the court was not convinced that the merger would force private insurance companies to "roll over and pay higher prices" as they had initially asserted.¹⁷³ This critique of payor testimony contributed to the decision not to enjoin the proposed merger because the government did not show "that there [was] a credible threat of harm to competition."¹⁷⁴ After such a decisive outcome, it may come as no surprise that the FTC subsequently voted to voluntarily dismiss its appeal to the Third Circuit.¹⁷⁵

168. Fed. Trade Comm'n v. Thomas Jefferson Univ., 505 F. Supp. 3d 522, 538 (E.D. Pa. 2020) (citing 15 U.S.C. § 53(b) (2018)), appeal dismissed per stipulation, *Thomas Jefferson Univ.*, 2021 WL 2349954.

169. Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1094 (N.D. Ill. 2012) (citing Fed. Trade Comm'n v. Whole Foods Mkt., Inc., 548 F.3d 1028, 1035 (D.C. Cir. 2008)).

170. *Thomas Jefferson Univ.*, 505 F. Supp. 3d at 547. The court later emphasized that testimony from one of the payors exemplified why insurer testimony deserved scrutiny, because the witness believed that "all hospital mergers are bad for consumers." *Id.* at 548.

171. See *id.* at 528.

172. *Id.* at 548 (suggesting that the insurer's true goal of taking part in the litigation was to avoid losing market dominance to a competitor).

173. *Id.* at 551; see also Fed. Trade Comm'n v. Tenet Health Care Corp., 186 F.3d 1045, 1054 (8th Cir. 1999) (questioning testimony from insurers that "entities would unhesitatingly accept a price increase rather than steer their subscribers to [substitute] hospitals").

174. *Thomas Jefferson Univ.*, 505 F. Supp. 3d at 558 (quoting Fed. Trade Comm'n v. Freeman Hosp., 911 F. Supp. 1213, 1227 (W.D. Mo.), *aff'd*, 69 F.3d 260 (8th Cir. 1995)). Because the court determined that the initial burden of proving anticompetitive effects had not been met, there was no discussion of an efficiencies defense. The decision does acknowledge, however, that if the FTC had established a likelihood of success on the merits, defendants could then rebut by showing that the anticompetitive effects would be offset by efficiencies from the merger. *Id.* at 538.

175. In the Matter of Thomas Jefferson University and Albert Einstein Healthcare Network, FTC, <https://www.ftc.gov/enforcement/cases-proceedings/181-0128/thomas-jefferson-university-matter> [<https://perma.cc/6QPM-4SPN>] (last updated Mar. 15, 2021) ("The Commission vote to voluntarily dismiss its appeal to the Third Circuit of the district

Although the crux of the court's decision turned on the impact of the merger on the insurers, the opinion discusses the unique payor mix that reimburses the hospitals and healthcare systems. At the time of litigation, the commercially insured population across the Albert Einstein Healthcare Network was declining, and approximately 70% of the network's revenues came from a single "safety net hospital."¹⁷⁶ The facility was so labeled because it had a significantly high percentage of government-insured inpatients. The court recognized that government insurance does not cover the full cost of patient care because government reimbursement rates do not keep up with the inflationary costs of medical services. This gap ultimately contributes to significant financial losses.¹⁷⁷

The Einstein health system's situation is not unique. In 2014, the Sixth Circuit factored in the commercial reality of Ohio-based hospitals when considering an FTC merger challenge. The court found that two-thirds of the local region's patients were insured by federally funded programs that generally do not cover the actual cost of services received.¹⁷⁸ And almost fifteen years prior, the Eighth Circuit's analysis of a similarly challenged hospital merger found that "[the relevant] patient bases are composed primarily of patients who are covered by Medicare and Medicaid and thus remain largely insensitive to price differentials."¹⁷⁹

The role of government payors complicates the issue of competition in the healthcare industry.¹⁸⁰ The American Hospital Association (AHA), a healthcare industry trade group of nearly 5,000 hospitals and healthcare providers,¹⁸¹ reported data in 2017 that paint a dark picture for healthcare revenues. The AHA reports that Medicare patients make up about 42% of the typical hospital's volume of patients, and Medicaid patients make up another 16%.¹⁸² That means that for 58% of a hospital's patients, the repayment rates for services are set by either federal or state governments.

court decision declining to preliminarily enjoin the merger of Thomas Jefferson University and Albert Einstein Healthcare Network was 4-0.").

176. *Thomas Jefferson Univ.*, 505 F. Supp. 3d at 530.

177. The CEO of the Jefferson network gave sworn testimony about the state of their system's finances, explaining that "we're a safety net hospital and you're so underpaid by the government, you're actually losing money on government sponsored services . . ." *Id.* at 545-46.

178. *ProMedica Health Sys., Inc. v. Fed. Trade Comm'n*, 749 F.3d 559, 561 (6th Cir. 2014).

179. *Fed. Trade Comm'n v. Tenet Health Care Corp.*, 186 F.3d 1045, 1048 (8th Cir. 1999).

180. See Paul Wong & Lawrence Wu, *Health Care Antitrust: Are Courts Adapting to a Complex and Dynamic Industry or Are They Making Exceptions?*, 48 *Loy. U. Chi. L.J.* 667, 672 (2017) ("[T]he many institutional and economic features of health care (i.e., the presence of government payors, uncertainty and risk, asymmetric information, etc.) breeds immense complexity . . .").

181. About the AHA, Am. Hosp. Ass'n, <https://www.aha.org/about> [<https://perma.cc/Z8KF-6F49>] (last visited Aug. 6, 2022).

182. Am. Hosp. Ass'n, *Fact Sheet: Hospital Billing Explained* (2017), <https://www.aha.org/system/files/2018-01/factsheet-hospital-billing-explained-9-2017.pdf> [<https://perma.cc/RL5F-75ZS>] [hereinafter AHA Fact Sheet].

The report goes on to share that Medicare and Medicaid pay less than the actual cost of care for publicly insured patients, estimating a loss of \$57.8 billion to hospitals every year.¹⁸³

The reimbursement rates of government payors undercut the rates of third-party payors as well. Medicare prices are often the start of reimbursement negotiations, so this insulation from price inflation “echo[es]” throughout the market.¹⁸⁴ One study found that a decrease of \$1 in Medicare payments for surgical services causes a reduction of over \$1 in private payments for the same service,¹⁸⁵ and there is reason to believe that changes in Medicaid reimbursement rates have similar spillover effects.¹⁸⁶

These statistics describe a complicated network where some consumers are heavily insulated from price increases, some are free-riders, and few are paying market rates. Insurance of any kind disincentivizes patient-consumers from containing healthcare costs because they bear less financial responsibility.¹⁸⁷ Moreover, a significant portion of healthcare costs may come from emergency services in situations where patients do not have the time or opportunity to compare costs and prices.¹⁸⁸ The combined effect from diverse payor populations of commercially and publicly insured patients is a class of consumers that is not affected by price fluctuations equally nor in the same way as consumers in other industries. Meanwhile, hospitals and providers are suffering significant losses of revenue for incredibly important services.¹⁸⁹ These particularized economic tensions require appropriate examination when antitrust regulators balance the anticompetitive effects of healthcare consolidation against any resulting economic and quality-enhancing efficiencies.

C. *A Battle of Economics*

The state of current healthcare antitrust challenges often amounts to a battle of the experts. A central debate in such cases throughout the 1990s concerned the size of the relevant geographic market, and courts were

183. *Id.*

184. Kanjee et al., *supra* note 132.

185. Jeffrey Clemens & Joshua D. Gottlieb, *In the Shadow of a Giant: Medicare's Influence on Private Physician Payments*, 125 *J. Pol. Econ.* 1, 2 (2017) (“[W]e estimate that a \$1.00 decrease in Medicare’s payment for a surgical service causes a \$1.16 decline in private payments for that service.”).

186. *Id.* at 31–32.

187. Ryan Nunn, Jana Parsons & Jay Shambaugh, *A Dozen Facts About the Economics of the US Health-Care System*, Brookings Inst. (Mar. 10, 2020), <https://www.brookings.edu/research/a-dozen-facts-about-the-economics-of-the-u-s-health-care-system/> [<https://perma.cc/4FEY-FAN3>].

188. *Id.*

189. AHA Fact Sheet, *supra* note 182 (reporting that 63.9% of hospitals were losing money on Medicare and 22.6% were losing money overall as of 2015).

amenable to the larger market estimates provided by private parties.¹⁹⁰ More recently, the FTC and the DOJ have advanced new economic theories and financial models to persuade judges to rule in their favor.¹⁹¹ In the absence of decisive guidance from the agencies, a range of outcomes emerge from the lower courts.

In *ProMedica*, the Sixth Circuit attempted to parse through competing arguments concerning the product market, particularly which products were reasonably interchangeable.¹⁹² Arguably, each and every individual medical procedure could result in a unique market, but to limit such an insurmountable analysis, the parties sought to “cluster” the markets. The court made clear that the parties could not agree on which services were to be clustered and which were not. To advance their case, the government argued an “administrative-convenience” theory for clustering while the defendant-appellant argued a “transactional-complements” theory.¹⁹³

In *Advocate Health Care*, the Seventh Circuit heard testimony regarding two different economic tests, and the court had to balance their credibility.¹⁹⁴ One expert testified to the “hypothetical monopolist test,” which asks whether a single firm controlling all output of a product within a given region would could raise prices profitably a bit above competitive levels.¹⁹⁵ Any price increase is referred to as an “SSNIP,” a “small but significant and non-transitory increase in price.”¹⁹⁶ The court also heard from experts about the Elzinga–Hogarty test, in which the number of people who leave an area to get services is measured against how many people come into an area to get services and care.¹⁹⁷ The Seventh Circuit concluded that the district court misunderstood the relevant economic test

190. See, e.g., *Fed. Trade Comm’n v. Tenet Health Care Corp.*, 186 F.3d 1045, 1055 (8th Cir. 1999); Wong & Wu, *supra* note 180, at 681.

191. Lisa Jose Fales & Paul Feinstein, *How to Turn a Losing Streak Into Wins: The FTC and Hospital Merger Enforcement*, 29 *Antitrust* 31, 31 (2014), http://awa2015.concurrences.com/IMG/pdf/fall14-fales_c_.pdf [<https://perma.cc/F4PP-DFB8>]; Wong & Wu, *supra* note 180, at 681.

192. *ProMedica Health Sys., Inc. v. Fed. Trade Comm’n*, 749 F.3d 559, 565 (6th Cir. 2014) (“The general question is whether two products can be used for the same purpose, and if so, whether and to what extent purchasers are willing to substitute one for the other.” (quoting *Fed. Trade Comm’n v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 119 (D.D.C. 2004))).

193. *Id.* at 566–67.

194. *Fed. Trade Comm’n v. Advoc. Health Care Network*, 841 F.3d 460, 465, 468 (7th Cir. 2016).

195. *Id.* at 465; *Horizontal Merger Guidelines*, *supra* note 25, § 4.1.1.

196. *Horizontal Merger Guidelines*, *supra* note 25, § 4.1.1.

197. *Advoc. Health Care*, 841 F.3d at 469–70; see also *HTI Health Servs. v. Quorum Health Grp.*, 960 F. Supp. 1104, 1121 n.13 (S.D. Miss. 1997) (“In a merger setting, the purpose of the [Elzinga–Hogarty] test is to analyze patterns of consumer origin and destination and then to use that information to identify geographically the relevant competitors of the merging firms.”).

and proceeded with its own subsequent analysis that aimed to rectify that mistake.¹⁹⁸

The relevance of either of these cases does not lie in the accuracy of the outcomes but rather in the breadth of economic testimony and theory that was ventilated before the court. In *Advocate Health Care*, the circuit court concluded from a cold record that the district court had reached the incorrect conclusions based primarily on their economic misunderstandings.¹⁹⁹ When government data and experts seek to prove that a proposed merger will result in harmful market concentration, healthcare providers naturally try to fight off the challenge with competing studies and models of their own. These market studies are not necessarily a part of the pre-merger consideration process for industry leaders. Instead, they are motivated by the sudden and urgent demands of litigation. The validity of various economic measures of market size and concentration are debated during litigation, but the economic gymnastics do not stop there. When a party tries to argue in their defense for procompetitive efficiencies, the economic analysis is equally dense.

Jamie H. Moffitt argues that judicial scrutiny of efficiency claims from any industry is lacking.²⁰⁰ Her account describes a jurisprudence that forecloses the efficiencies defense without fully interrogating the possible benefits that may flow to consumers.²⁰¹ She reviewed twenty-five years of Section 7 cases in which litigants raised efficiency claims and found a pattern of courts claiming to balance merger-generated efficiencies with other negative impacts on competition but concluded that they were not doing so.²⁰² Her research argues that courts do not consider the efficiencies defense fully, but rather they are principally preoccupied by market concentration claims.²⁰³ Moffitt explains that in almost all cases reviewed “courts only recognized significant efficiencies in situations where they had already determined that the merger did not substantially increase market concentration.”²⁰⁴

A central tension in healthcare antitrust stems from competing definitions and measurements of cost, quality, and output of services. In

198. *Advoc. Health Care*, 841 F.3d at 473.

199. *Id.*

200. Moffitt, *supra* note 110, at 1698–99 (“In cases with limited concentration concerns, courts often cite efficiencies as factors contributing to market competitiveness. In cases involving highly concentrated markets, however, courts often discard similar types of efficiencies. No balancing analysis is ever performed.”).

201. *See id.*

202. *Id.*

203. *Id.*

204. *Id.* at 1714–15. Professor Moffitt does include a caveat that hospital mergers do not consistently follow this pattern. But her proposition only cites to one case decided in 1996, and she herself believes the anomaly was explained by the nonprofit nature of the merging organization. *Id.* (citing *Fed. Trade Comm’n v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1302 (W.D. Mich. 1996)).

most industries, lower prices, higher quality, and more output are beneficial for consumers, so these metrics dominate the analysis of proposed mergers and transactions. But in the healthcare industry, providers, administrators, regulators, and policymakers continually debate what amounts to “quality” care. Paul Wong and Lawrence Wu point to a very concrete disconnect by explaining that a common healthcare policy goal is cost containment (to limit the exorbitant amount of money being spent overall in the industry), whereas antitrust law assumes that more output is better than less.²⁰⁵ This standard assumption “creat[es] a false distinction between price and quality efficiencies” that ultimately discounts any quality-of-care increases that result from a merger.²⁰⁶ Yet this commercial reality is not adequately factored into current judicial analysis of proposed efficiencies.²⁰⁷

The problem here is that mergers are not cut from the same cloth, and antitrust challenges are multifaceted and variable as a result. Accordingly, the underlying body of antitrust law addresses multiple diverging issues that require potential merging parties and fact-finders alike to assess dense, competing testimony regarding evolving economic theories. As merging healthcare providers contemplate antitrust considerations, there are few concrete guardrails available to help structure future consolidations. This uncertainty is harmful to commercial parties, risking the possibility that “corporations facing stricter antitrust regimes will abandon important deals that could have contributed to the competitiveness of the U.S. economy.”²⁰⁸

III. A VALUE-BASED DEFENSE

A growing consensus surrounding the provision of healthcare is the pursuit of improvements not just for the health and well-being of individual patients but for communities as a whole.²⁰⁹ Lack of insurance and inability to access or simply afford care continue to be obstacles in providing for a healthy society.²¹⁰ Rising prices are a top concern for

205. Wong & Wu, *supra* note 180, at 670–71 n.4.

206. Roger D. Blair & D. Daniel Sokol, *Quality-Enhancing Merger Efficiencies*, 100 *Iowa L. Rev.* 1969, 1971 (2015).

207. See Moffit, *supra* note 110, at 1708.

208. *Id.* at 1699.

209. See, e.g., Triple Aims for Population: Overview, Inst. for Healthcare Improvement, <https://www.ihl.org/Topics/TripleAim/Pages/Overview.aspx#:~:text=It%20is%20IHI's%20belief%20that,capita%20cost%20of%20health%20care> [https://perma.cc/Y4NV-YR9W] (last visited Aug. 11, 2022) (popularizing the concept of the “Triple Aims” of healthcare: improving the experience of care, improving the health of populations, and reducing per capita costs of healthcare); see also What Is Population Health?, CDC, <https://www.cdc.gov/pophealthtraining/whatis.html> [https://perma.cc/UJ2J-HWQS] (last visited July 27, 2022).

210. Sara R. Collins, Munira Z. Gunja & Gabriella N. Aboulafia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability*, Commonwealth Fund (Aug. 19, 2020),

patients, policymakers, and this author alike. Current antitrust laws and enforcers actively seek to counteract mergers that risk driving up costs for patients, and this enforcement ultimately should continue. The goal of this Note is to highlight legal uncertainties in merger analysis and advocate for more guidance on the efficiencies defense. Clearer guardrails may facilitate the transition to value-based-care reimbursement models, which are an important tool in combating the rise of healthcare costs and inequality.

Ultimately, the laws promulgated by Congress and the initiatives of federal agencies like CMS are further driving industry forces toward re-orientation around value-based care.²¹¹ In this process, providers are likely to consolidate to integrate care and will undoubtedly come into contact with antitrust regulators. The promising movement to value-based care may be obstructed by the enforcement of antitrust laws that continue to analyze the industry according to models of fee-for-service healthcare provision. While this Note does not argue for the deregulation of healthcare mergers, it anticipates that mergers will continue to increase in number and scale, and clearer guidance will promote efficient enforcement. Even if the FTC's and the DOJ's antitrust enforcement continues at the same rate of success and intensity moving forward,²¹² there is still a need for a clear analytical framework to review mergers and efficiencies, especially those that center on value-based care. Such a framework is necessary for both courts and private actors when evaluating healthcare consolidations.²¹³

<https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial> [<https://perma.cc/UW55-QQWD>] (finding that insurance status is the most important determinant of whether a person has access to healthcare and that one-third of adults reported a cost-related problem getting needed healthcare in the last year).

211. See *supra* section II.A.

212. In February 2022, the FTC authorized an administrative complaint and filed suit in federal court to block a merger between Rhode Island's two largest healthcare providers, causing the firms to voluntarily abandon the transaction. FTC Bureau of Competition Director Holly Vedova publicly stated: "This enforcement action should serve as notice that the FTC remains vigilant in enforcing the antitrust laws and will stop at nothing to protect healthcare consumers who are faced with unlawful hospital consolidation." FTC, Rhode Island Healthcare Providers, *supra* note 78.

213. This Note does not argue for legislative change because the political will opposes statutory modifications to existing antitrust law that would expressly lower scrutiny. See *supra* notes 58–59 and accompanying text. Moreover, statutory change may exacerbate uncertainty in the healthcare industry. As Alden Abbott, formerly with the FTC and the DOJ investigating healthcare antitrust concerns, persuasively testified before a Congressional committee: "Antitrust statutory amendments affecting such areas as burdens of proof, presumptions, merger and monopolization standards, and blanket limits on mergers applicable to certain categories of firms (among other possible changes being advanced) would transform enforcement norms and judicial analysis, generating enormous private-sector uncertainty." Alden Abbott, Testimony, Lack of Resources and Lack of Authority Over Nonprofit Organizations Are the Biggest Hindrances to Antitrust Enforcement in Healthcare (Apr. 29, 2021), <https://docs.house.gov/meetings/JU/JU05/20210429/>

Absent a clear doctrine or definition of efficiencies, the current state of the law risks discouraging potentially beneficial mergers due to high costs related to uncertainty.²¹⁴ Although the efficiencies defense is viable,²¹⁵ neither the courts nor the enforcement agencies are explicit or consistent about their approach to balancing anticompetitive harms and procompetitive efficiencies.²¹⁶ Healthcare providers need clarity to understand the lawful or favorable factors to consider when choosing to consolidate.

In January 2022, the FTC and the DOJ launched their review of the existing 2010 Horizontal Merger Guidelines with the goal of reflecting the new realities of major industries and the global economy.²¹⁷ Chairperson Khan, in a statement, identified three key questions that the antitrust enforcers hope to address in any new guidance. First, “are the guidelines adequately attentive to the range of business strategies and incentives that might drive acquisitions?” Second, “[a]re there factors beyond wages, salaries, and financial compensation that the guidelines should consider when determining anticompetitive effects?” And finally, “[a]re there certain markets where the guidelines should provide a framework to assess direct evidence of market power?”²¹⁸ This Note offers several proposals that seek to answer those questions. These include concessions when evaluating impacts on consumers who are insured from price changes, prioritizing quality as a procompetitive dimension, and clarifying the time frame for analyzing post-merger outcomes.

A. *Rethinking the Consumer*

The FTC and the courts should clarify that, within the scope of a valid efficiencies defense, insurance can insulate consumers from increased costs. They should recognize this insulation as a mitigating factor when balancing procompetitive efficiencies against negative price effects. This approach is not a blanket sanction of all hospital mergers simply because insurance offers some financial protection for patients. Indeed, unrestrained price increases for any consumers, privately insured or otherwise,

112518/HHRG-117-JU05-Wstate-Abbot [<https://perma.cc/FHW4-WWHK>]. The goal of this Note is to advocate for greater clarity in this area of law, not less.

214. Jamison & Hauge, *supra* note 64, at 99, 107–08.

215. See *supra* notes 79–92 and accompanying text.

216. Moffitt, *supra* note 110, at 1701 n.15 (“[N]either the courts nor the agencies have developed standards for determining, first, what mitigating factors should be deemed particularly relevant, and second, the priority or weight that should be afforded such factors.” (internal quotation marks omitted) (quoting Thomas A. Piraino, *A New Approach to the Antitrust Analysis of Mergers*, 83 B.U. L. Rev. 785, 791–92 (2003))).

217. Lina M. Khan, Chair, FTC, Remarks of Chair Lina M. Khan Regarding the Request for Information on Merger Enforcement 1 (Jan. 18, 2022), https://www.ftc.gov/system/files/documents/public_statements/1599783/statement_of_chair_lina_m_khan_regarding_the_request_for_information_on_merger_enforcement_final.pdf [<https://perma.cc/67SH-YAYQ>].

218. *Id.* at 3.

should be outcome determinative for any merger proposal. Rather, this solution is a deliberate analytical step that would provide clarity to merging parties around exactly how and to what extent the FTC or the courts give weight to this mitigating factor.

Conventional antitrust analysis emphasizes the direct impact on consumers in the form of cost increases.²¹⁹ But in the healthcare context, the consumers of services—the patients—are often insulated from the price changes that result from mergers.²²⁰ Courts have demonstrated an awareness of the complex payor mix facing the healthcare industry.²²¹ And it is a “consumer” population that is distinct from the customers of conventional commodities or fungible goods. Therefore, the continued adherence to the assumption that all mergers are cut from the same cloth is “inconsistent with actual business practice.”²²² Future healthcare antitrust analysis should engage at length with the payor mix and balance the price impacts on commercially insured patients against the quality improvements that will ideally flow to the entire patient population.

In practice, any updates to the horizontal merger guidelines ought to expressly clarify that while consumer protection is an overarching priority, the unique composition of a consumer class can influence the impact that price effects have on individuals. To be more specific, the FTC should recognize that insurance—especially in the healthcare industry, in which government insurance is particularly prominent—does insulate consumers from price effects. By acknowledging this reality, the FTC should establish that balancing is appropriate to determine whether verifiable, merger-specific efficiencies for the entire consumer class (as in the goals of value-based health to target population health) can offset harms for a smaller consumer class.

The courts should analytically adopt this approach as well, regardless of whether the FTC updates its guidelines. The realities of the industry stand in contrast to the norms of antitrust theory that have been adopted and applied pro forma across all enterprises.²²³ Yet these norms are the manifestation of a set of chosen priorities and economic models that have

219. See *supra* section I.A. But see Christine S. Wilson, Comm’r, FTC, Keynote Address at the *George Mason Law Review* Antitrust Symposium: Welfare Standards Underlying Antitrust Enforcement: What You Measure Is What You Get 5–6 (Feb. 15, 2019), https://www.ftc.gov/system/files/documents/public_statements/1455663/welfare_standard_speech_-_cmr-wilson.pdf [<https://perma.cc/L2MM-DU23>] (explaining that while the language of the Horizontal Merger Guidelines focuses on price, non-price terms such as reduced quality and diminished innovation are considered as indicia of enhanced market power).

220. See *supra* section II.B (describing the breakdown of payor mix in which a significant percentage of the hospital patient population is publicly insured and therefore less affected by price increases).

221. See *supra* note 176 and accompanying text.

222. See Jamison & Hauge, *supra* note 64, at 100.

223. See *supra* section I.A.

been renegotiated over time.²²⁴ Even without adopting a new legal paradigm of “healthcare antitrust,” there is leeway for the judiciary to factor in the unique business realities of the healthcare consumer within the existing efficiencies defense.

B. *Reemphasizing Quality Measurements*

Similarly, both the FTC and the courts should explicitly embrace procompetitive quality outcomes as mitigating factors. Improvements in quality of care are often presented in the arsenal of efficiencies that will follow from proposed mergers.²²⁵ Unfortunately, a trend among the courts is to gloss over these efficiencies.²²⁶ To be clear, a commercial party must sufficiently establish that any efficiencies are merger-specific and not merely speculative.²²⁷ The proposed merger should be blocked for any defendant that fails to meet either of these elements. But for those healthcare mergers for which efficiencies are verifiably merger-specific, courts should more thoroughly assess potential improvements in product quality to consumers. Blair, Durrance, and Sokol join Moffitt in arguing that courts are more comfortable or better equipped to consider price outcomes alone because of how variable efficiencies arguments can be.²²⁸ This is not a sufficient reason to discount quality as a procompetitive dimension capable of offsetting price increases.²²⁹

Although value and quality are malleable concepts, the government already has proven adept at defining quality sufficiently for the purposes of the CMS’s Medicare Hospital Value-Based Purchasing Program.²³⁰ These include measures of mortality and complications, healthcare-

224. See *supra* notes 47–56 and accompanying text.

225. See *supra* section I.B.

226. Blair, *Hospital Mergers*, *supra* note 105, at 63 (“Overall, the hospital merger cases show that courts rarely spend much focus on their analysis of efficiencies. Often the efficiencies analysis is a throw-away section of a decision—merely a summary, rather than an in-depth analysis of issues that is customary in other areas of the analysis . . .”).

227. See *supra* notes 86–90 and accompanying text.

228. Blair, *Hospital Mergers*, *supra* note 105, at 58 (“[T]he overly light (and often simplistic) treatment of efficiencies by the courts suggests that unlike an issue like market definition, courts feel uncomfortable in analyzing the efficiencies of a particular hospital merger. The lack of comfort with a serious efficiencies analysis condemns potentially procompetitive mergers.”); Moffitt, *supra* note 110, at 1709–10, 1718–23 & n.63 (identifying courts’ frequent failure to truly balance efficiencies against anticompetitive factors).

229. Specific healthcare efficiencies are difficult to identify in this Note because of a lack of data on how mergers affect what are ultimately very variable and marginal medical costs. But some other industries have identified efficiencies sufficient to offset price increases that result from a merger. See, e.g., Orley C. Ashenfelter, Daniel S. Hosken & Matthew C. Weinberg, *Efficiencies Brewed: Pricing and Consolidation in the US Beer Industry*, 46 *RAND J. Econ.* 328, 329–30 (2015) (discussing merger efficiencies in the brewery industry); Dario Focarelli & Fabio Panetta, *Are Mergers Beneficial to Consumers? Evidence From the Market for Bank Deposits*, 93 *Am. Econ. Rev.* 1152, 1170 (2003) (discussing efficiencies in banking mergers).

230. See *Ctrs. for Medicare & Medicaid Servs.*, *supra* note 140.

associated infections, patient safety, patient experience, efficiency, and cost reduction.²³¹ These quality measurements still factor in cost but mitigate the outcome-determinative aspect of price alone.

In the value-based-care landscape, “merger-specific” should instead be analyzed by the FTC and the courts as an inquiry into whether either party alone can accomplish the increased quality of care or if a value-based care program would even be possible independent of consolidation. Mergers that seek to provide value-based care are generally restricted to potential partners that are geographically close enough to be feasible for patients to travel between the combined entities.²³² Analysis of future value-based-care consolidations should further consider the lack of alternatives for stand-alone or smaller systems. For these healthcare providers, improving quality may not be as simple as hiring more physicians and starting new service competencies given that there is a growing shortage of doctors and qualified medical professionals to fill these roles.²³³

The FTC should delineate carefully considered dimensions that are specific to the consumption of the product of healthcare. Adopting these or similar quality measurements has the further benefit of synergizing healthcare antitrust analysis with the goals of the government’s own reimbursement programs run by CMS. By clarifying its policy goals for quality as a procompetitive factor, the FTC will instruct merging parties on how to structure their consolidation and inform them of what specific economic studies are necessary to verify that a merger can accomplish such improvements.

C. *Reimagining the Horizon*

Lastly, negative price effects from hospital mergers that pursue value-based-care models should be analyzed over a longer term of patient care. One obstacle with existing antitrust scrutiny is the great emphasis placed on short-term cost fluctuations that exacerbates the entrenchment of the fee-for-service status quo. Twenty years ago, the Eighth Circuit reasoned that in view of “the significant changes experienced by the hospital industry in the recent past and the profound changes likely facing the industry in the near future, . . . a merger, deemed anticompetitive today, could be considered procompetitive tomorrow.”²³⁴ Nonetheless, the federal

231. *Id.*

232. See, e.g., Kathryn Han, Medicare Announces Geographic-Based Approach to Value-Based Care, *JD Supra* (Dec. 16, 2020), <https://www.jdsupra.com/legalnews/medicare-announces-geographic-based-83513/> [<https://perma.cc/4SV3-8SB8>].

233. The Association of American Medical Colleges reported that the U.S. healthcare system would face a shortage of between 37,800 and 124,000 physicians in primary and specialty care by 2034. IHS Markit Ltd., *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034*, Ass’n Am. Med. Colls., at viii (2021), <https://www.aamc.org/media/54681/download?attachment> [<https://perma.cc/V49N-PU3D>].

234. *Fed. Trade Comm’n v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054–55 (8th Cir. 1999) (quoting *United States v. Mercy Health Servs.*, 107 F.3d 632, 637 (8th Cir. 1997)).

enforcement agencies adopt an exacting standard that functions to preempt healthcare mergers that risk short-term increases in price—in spite of goals to improve patient care and efficiency.²³⁵ The Horizontal Merger Guidelines currently establish that while the agencies “normally give the most weight to the results of [price effects] analysis over the short term,” delayed benefits from efficiencies are considered.²³⁶ Yet, as it stands, the guidelines go on to explain that delayed benefits “will be given less weight because they are less proximate and more difficult to predict.”²³⁷

Value-based-care and fee-for-service models employ two fundamentally different lenses for understanding value.²³⁸ The former prioritizes the service that patients value most. Naturally, in an ideal world, value-based care would be priced at fair market value and affordable. The priority in this model, however, is to treat the specific needs of the patient comprehensively and successfully over the long term. After all, healthcare is not a fungible commodity. Fee-for-service models and most attempts to contain rising costs are focused on cost-cutting alone—seeking the cheapest way of serving an immediate need, with less concern for long-term health outcomes.²³⁹ Federico Esposti and Giuseppe Banfi are two researchers who argue that a great benefit of value-based medicine is that it reduces the risk of false economics linked with these cost-cutting measures that are centered on the wrong objectives.²⁴⁰

The current antitrust landscape explicitly emphasizes the status quo of current markets.²⁴¹ Of course, the impacts of mergers are felt in the short term, and where short-term price increases are unreasonable, any consolidation should not be realized. But mergers in any industry, especially for healthcare consolidation in the pursuit of value-based reimbursement systems, produce efficiencies in the long-term and have the potential to generate markets that exist only in the future.²⁴² By its inherent design, the goal of value-based care is to treat healthcare needs comprehensively at the onset so that fewer services are needed over time and cost is contained on the long-term horizon. And the standard metrics for healthcare evaluation are changing as a result. Treatment costs and

235. See *supra* section I.A.

236. Horizontal Merger Guidelines, *supra* note 25, § 10, at 31 n.15.

237. *Id.*

238. Arguably, the two could be considered different products or even markets for purposes of antitrust analysis.

239. Lee, *supra* note 126.

240. Federico Esposti & Giuseppe Banfi, BMC Health Servs. Rsch., Fighting Healthcare Rocketing Costs With Value-Based Medicine: The Case of Stroke Management 1–2 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6995121/pdf/12913_2020_Article_4925.pdf [<https://perma.cc/C9B7-8E6W>] (“In other words, value-based medicine, VBM, is a redefinition of patient-centred targets for healthcare strategic interventions and optimization policies, reducing the risk of false economies linked with cost-reductions designed on poorly defined objectives.”).

241. See *supra* section I.A.

242. Jamison & Hauge, *supra* note 64, at 101.

outcomes should be analyzed differently when focusing on the long-term horizon of value-based care.

The courts should embrace a reframing of efficiencies for this kind of hospital merger—those seeking to change the reimbursement model—in terms of how value-based care impacts consumer costs over time. This is undoubtedly a highly fact-specific exercise in which parties could most likely only produce projections of how their specific merged enterprise would ultimately lower costs. Not to mention that if the merger goes forward, there are limited options to ensure that the merger party fully realizes the transition to value-based care.²⁴³ So, it would not be practical for the FTC to attempt to carve out a value-based exception in any new horizontal merger guidelines. Nonetheless, courts should weigh the importance of adjusting for a longer horizon of cost for such a specific type of merger as a factor when balancing price effects against the promise of improved quality through value-based care.

CONCLUSION

We live in a world where the healthcare industry incentivizes cost decreases at the expense of quality of care.²⁴⁴ Prices continue to skyrocket without commensurate returns on health outcomes.²⁴⁵ The need to reform the system is clear, and we need creative solutions now more than ever. Value-based care is one model that could pave a new way forward, but the current antitrust framework may impede vital progress. The FTC has the great responsibility to “weed out those mergers whose effect ‘may be substantially to lessen competition’ from those that enhance competition.”²⁴⁶ Under such a mandate, the FTC should seek to provide as many guardrails as possible to assist industry leaders and courts alike in their effort to find solutions to the rampant inefficiencies in the American healthcare industry. Given that healthcare mergers face heightened scrutiny under the Biden Administration,²⁴⁷ potential partners need substantive guidance on how to lawfully prepare for consolidation.²⁴⁸ Although relatively few mergers face legal challenges that result in public

243. One option could be for the merging parties to reach a contractual agreement with the enforcement agencies that outlines their transition plan and timeline. As an example, an agreement with a state antitrust enforcement agency in which the defendant contractually agreed to pass savings from the mergers on to consumers persuaded a district court to allow the merger to proceed. *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 149 (E.D.N.Y. 1997).

244. Lee, *supra* note 126.

245. See *supra* notes 1–3.

246. *Fed. Trade Comm’n v. H.J. Heinz Co.*, 246 F.3d 708, 713 (D.C. Cir. 2001).

247. See *supra* note 59 and accompanying text.

248. Jamison & Hauge, *supra* note 64, at 99.

litigation,²⁴⁹ those that do will send signals to hospitals and providers that are considering how to best make their case to antitrust enforcers.²⁵⁰

The law as it stands results in variable and unpredictable outcomes that turn on battles between experts of economics that the courts are not necessarily well-suited to adjudicate effectively. More clarity is needed to promote procompetitive hospital mergers that foster value-based-care services. As part of an efficiencies defense for such a merger, courts and regulators ought to evaluate proposed benefits to consumers through the same lens that informs value-based-care programs authorized by CMS. Moving forward, the FTC and the courts should explicitly analyze certain value-based-care factors including impacts on consumers who are insulated from price changes, quality as a procompetitive dimension, and an appropriate time frame for analyzing post-merger cost and quality outcomes.

249. See Waller, *supra* note 66, at 657.

250. See Jamison & Hauge, *supra* note 64, at 99. It is possible that the reason why we do not see efficiencies realized in decided court cases is that the cases that go to trial are not the ones with the strongest efficiencies. See Blair, *Hospital Mergers*, *supra* note 105, at 58. Or it could be that the efficiencies are real, but judges simply discount them. *Id.* at 63. But there is reason to believe that efficiencies can persuade regulators if the data is strong. Former FTC Chairperson Edith Ramirez has explained that efficiencies have convinced regulators not to block proposed mergers before ever reaching litigation. Edith Ramirez, Chair, FTC, Remarks at the Ninth Annual Global Antitrust Enforcement Symposium, Georgetown University Law Center: The Horizontal Merger Guidelines Five Years Later 11 (Sept. 29, 2015), https://www.ftc.gov/system/files/documents/public_statements/805441/ramirez_-_georgetown_antitrust_enforcement_symposium_9-29-15_0.pdf [<https://perma.cc/PN63-CLVY>]. The details of those efficiencies are generally not made publicly available to inform future parties.

