Disclaimer

The views expressed are those of the presenter and do not necessarily reflect the views of the Federal Trade Commission or its Commissioners.
Healthcare Costs are a Big Deal

• 17.2% of Gross Domestic Product of U.S.

• In English, this is $2.8 trillion dollars per year

• This is $8,915 per person
  – Cal. Healthcare Foundation, Health Care Costs 101
Recognition of high utilizers ("hot spotters") is not new......

Table 1: Distribution of Health Expenditures for the U.S. Non-Institutionalized Population, By Magnitude of Expenditures as a % of U.S. Population

<table>
<thead>
<tr>
<th>Year</th>
<th>1%</th>
<th>5%</th>
<th>10%</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>26%</td>
<td>50</td>
<td>66</td>
<td>96</td>
</tr>
<tr>
<td>1977</td>
<td>27%</td>
<td>55</td>
<td>70</td>
<td>97</td>
</tr>
<tr>
<td>1980</td>
<td>29%</td>
<td>55</td>
<td>70</td>
<td>96</td>
</tr>
<tr>
<td>1987</td>
<td>28%</td>
<td>56</td>
<td>70</td>
<td>97</td>
</tr>
<tr>
<td>1996</td>
<td>27%</td>
<td>55</td>
<td>69</td>
<td>97</td>
</tr>
</tbody>
</table>

Source: Derived from Berc & Monheit Health Care Trends
Key Strategy: Identify and Treat Most Expensive Patients

• HiTech Act
  – Over $20 billion in federal dollars to create electronic medical records to share information

• Accountable Care Organizations (ACO’s)
  – Create shared-savings incentives to treat most expensive patients efficiently
Success Story at Boeing: Coordinate Care & Manage Hand-Offs

Discussion

Employers such as Boeing typically lack a sufficient population with severe chronic illness in any one location to power a statistically robust analysis of change in total per capita health care spending. However, the 20% magnitude of spending reduction, net of the supplemental fees paid to participating physician groups, aligns with peer-reviewed findings recently reported for similar care clinical leadership described in the “Home Runs” article. These three organizationally diverse physician groups, including an IPA composed of many small physician practices, successfully replicated an innovative primary care model by adapting it to their unique environments.

An initial 3-6% net reduction in population-wide per capita total spending while improving quality and patient experience of care is likely attainable by judiciously intensifying care for the sickest chronically ill Americans under age 65 participating in employer-sponsored plans. As described in the “Home Runs” article, the percent savings opportunity is likely 2–3 times greater in the population over age 65.

This initial sizable spending reduction does not require large delivery system scale, delivery system integration, costly IT, many years of waiting for results, reduction in provider fees, eliminating “McAllen-style” baseline overutilization of services – or the type of exceptional clinical leadership described in the “Home Runs” article. These three organizationally diverse physician groups, including an IPA composed of many small physician practices, successfully replicated an innovative primary care model by adapting it to their unique environments.

It does require the leadership of at least one large payer. In most communities, this would need to be Medicare and/or a consortium of large private payers that fund technical assistance and incentivize the implementation of new care models expressly designed to both lower per capita spending and improve quality of care. These incentives will likely need to be robust, via

URL to article: http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/

URLs in this post:
1. Bending The Cost Curve: http://content.healthaffairs.org/content/vol28/issue5/
2. Overhauling The Delivery System: http://content.healthaffairs.org/content/vol27/issue5/
3. American Medical Home Runs: http://content.healthaffairs.org/cgi/content/abstract
   /28/5/1317

Milstein & Kothari, Are Higher-Value Care Models Replicable, Health Affairs (October 20, 2009)
Mixed Record of Government Enforcement Actions

- Rockford (1990)
- University Health (1991)
- Freeman (1995)
- Butterworth (1997)
- LIJMC (1997)
- Tenet (1999)
- Sutter Health (2001)

- Years in the Desert
- Evanston (2008)
- Inova (2008)
- OSF (2012)
- Reading (2012)
- Phoebe Putney (2013)
- St. Luke’s (2014)
- ProMedica (2014)
Geographic Market Determination is Critical

• The relevant market is a construct of:
  – the geographic market (where do parties compete) and
  – product market (what are the competing products or services).

• No major dispute in St. Luke’s that Primary Care Physician (PCP) Services was a proper product market.
Healthcare Markets are Local: Nampa and the Treasure Valley
Healthcare Markets are Local: ProMedica
Uncompetitive Local Healthcare Markets Hurt Even Big Companies

Employers, who provide almost 50 percent of the U.S. population with health care benefits, are struggling to manage healthcare costs, the rise of which results in higher premiums, lower benefits, and lower wages for employees. Concerned about providing affordable benefits to their employees over time, employers see the maintenance of competition in health care markets as critical to quality improvement and cost reduction. Moreover, given the local nature of health care delivery, even national employers still only represent a small portion of any given local market and typically lack adequate leverage to impact the price of care. Therefore, ensuring competition among providers is critical to all employers’ quality improvement and cost reduction.


Amicus brief by Center for Payment Reform for large employers, including Boeing, Walmart and Wells Fargo, in support of Plaintiffs
The “Buyers” in St. Luke’s were Health Insurance Companies

• The standard for geographic market is “…where buyers can turn for alternate sources of supply.” (Morgan, Strand v. Radiology, Ltd., 924 F.2d 1484, 1490 (9th Cir. 1991).)

• …the vast majority of health care consumers are not direct purchasers of health care—the consumers purchase health insurance and the insurance companies negotiate directly with providers.” (Findings, ¶ 53 (emphasis added).)
Bargaining leverage depends on substitute physician groups in the market

- **Before the Acquisition:** Saltzer PCPs offer an attractive substitute for St. Luke’s PCPs, and vice versa
  - The health plan thus has a credible “outside option” when it negotiates with each provider
Bargaining leverage depends on substitute physician groups in the market

- **After the Acquisition**: the health plan loses a credible outside option, and the provider gains negotiating leverage

St. Luke’s & Saltzer

Health Plan

Saint Al’s

Others

Entrants?

Trial Slide (Dr. Dranove)
St. Luke’s and Saltzer Account for Nearly 80% of PCP services in Nampa
Opportunities for improved managed care negotiations exist based on a higher number of physicians. Moreover, aligning with one of the two hospital systems is essential to assure access to the private payers (though Saltzer would still have some influences as a private entity).
Burden Shifts to Defendants

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Syllabus.

UNITED STATES v. PHILADELPHIA NATIONAL BANK ET AL.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA.


behavior, or probable anticompetitive effects. Specifically, we think that a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects. See United States v. Koppers Co., 202 F.Supp. 437 (D.C.W.D. Pa. 1962).
Defendants’ Claimed Efficiencies Must Be Merger Specific

“[E]fficiencies must be ‘merger-specific’ to be cognizable as a defense.”

Defendants Could Not Demonstrate “Substantial,” “Merger-Specific” Benefits

• Luke’s failed to show necessity of employing physicians:
  – “...while employing physicians is one way to put together a unified and committed team of physicians, it is not the only way. The same efficiencies have been demonstrated with other groups of physicians.” (Conclusions, ¶ 46.)

  – “the efficiencies resulting from Epic and White Cloud [a St.Luke’s-sponsored analytics system] are not merger-specific. “ (Findings, ¶ 206.)
9th Circuit Affirms with a Twist

• 9th Circuit Agrees that Efficiency Claims were not Merger Specific but Continued:

  “But even if we assume that the claimed efficiencies were merger-specific, the defense would nonetheless fail...[St Luke’s] did not demonstrate that efficiencies resulting from the merger would have a positive effect on competition.” St. Luke’s, 778 F.3d 775,792 (9th Cir. 2015)
Cost and Quality Claims Made in the 1990’s Did Not Pan Out

Hospitals gained approval of these mergers by claiming that they would bring about economies of scale, but the promised economies have yet to appear as reduced prices to insurers or patients. To the contrary, consolidation has led to price increases of at least 40 percent and reduced quality. Thus, hospital mergers increased the 

Hospitals assured the public that the mergers had only the purest of motives: economies of scale would lower costs and enable the hospitals to provide more community benefits. Many local judges and juries bought the argument and permitted the mergers. Virtually overnight, in some parts of the country, the mergers almost eliminated any competition among hospitals.

But, far from providing more community benefits, the mergers created massive increases in prices and probable diminution in quality. One study showed that severely ill Medicare heart attack 

Both nonprofit and for-profit hospitals acted alike in raising prices: one analysis revealed no difference between the willingness of nonprofit and for-profit hospitals to “exploit merger-related market power.” Nonprofits set lower prices but had higher markups.
New Studies Find that Hospital Purchases of Doctors Do Not Lower Costs or Improve Quality


Affordable Care Act Did Not Overturn the Antitrust Laws

• Nothing in this Act “shall be construed to modify, impair or supersede the operation of any of the antitrust laws.” 42 U.S.C. § 18118(a).
The “Healthcare Reform” Defense Is Contradicted by Federal ACO Regulations

Furthermore, competition benefits the Shared Savings Program by allowing the opportunity for the formation of two or more ACOs in an area. Competition among ACOs can accelerate advancements in quality and efficiency. All of these benefits to Medicare patients would be reduced or eliminated if we were to allow ACOs to participate in the Shared Savings Program when their formation and participation would create market power.”
St. Luke’s: Current Status

• Defendants’ motion for reconsideration and hearing *en banc* denied by the 9th Circuit.

• Idaho and FTC actively monitoring divestiture process

• Motion to compel expedited discovery pending.
Conclusion

• Competitive healthcare markets are critical to the economic health of local and national employers

• Since these markets are extremely local, healthcare is a natural for state/federal cooperation.
References/Readings

- Promedica Health Sys. Inc. v. FTC, 749 F.3d 559 (6th Cir. 2014)
