ACOs through the Eyes of Evanston: Comparing Competitive Efficiencies and Harms of Hospital Mergers and ACO Formation

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Jacob Harper*

I. INTRODUCTION

The controversial Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act (collectively referred to as the Affordable Care Act ("ACA") and colloquially as "healthcare reform") are now infamous for the "individual mandate."1 While much of the public focus rests on this hotly contested provision, the ACA also changes the nation's health care delivery systems in a number of fundamental ways.2 Foremost, this legislation strongly encourages the implementation of Accountable Care Organizations ("ACOs") through the Medicare Shared Savings Program.4

ACOs represent the newest iteration of the federal government's solution to the long-standing problem of increasing health care costs.5 To incentivize the creation of these organizations, however, the government had to bend, and in some cases, break a number of laws affecting health care providers.6 Among these laws are the Sherman, Clayton, and Federal Trade Commission ("FTC") Acts, collectively known as antitrust law, which seek to foster the healthy functioning of markets by protecting competition and deterring monopolization by a single firm.7 To effectuate compliance with these laws, the FTC and the United States Department of Justice ("DOJ") jointly investigate and prosecute violations of antitrust law.8

When conducting such investigations, the FTC and DOJ are often required to weigh the pro-competitive benefits against the anti-competitive harms of the firm or merger they are analyzing.9 This type of analysis generally requires an associated complex economic analysis and is intensely fact-driven.10 In particular, because its members must often share information about their customers with rivals, the health care industry has faced long-standing antitrust scrutiny from the FTC and DOJ over concerns of coordinated economic activity.11 Such scrutiny is only furthered by government mandates for health care entities to ensure continuity of care for their patients.12 As rivals work ever more closely together, the opportunity for and likelihood of collusion rises.13

In evaluating pro-competitive efficiencies, the FTC may come to a sharp divide between the creation of ACOs and more traditional hospital mergers.14 ACOs, in part because of their strictly regulated structure and less formal integration in business operations of their member organizations (i.e. each provider retains their separate legal identity in the ACO structure), will likely have striking pro-competitive benefits with only limited risks.15 Conversely, hospital mergers, as the FTC has borne witness, often lead to higher prices with few lasting increases in efficiency.16 As a result, mergers among hospitals have often been rejected or modified by the FTC to address these concerns.17

This comment will critically examine the various analyses used by the FTC and DOJ in assessing coordinated efforts by health care entities, and compare the pro-competitive efficiencies and anti-competitive harms of hospital mergers with those of ACOs. Part II discusses the history and structure of ACOs, as well as the laws, regulations, and guidelines that the FTC and DOJ may use in conducting antitrust analysis. Part III explores both the merit and the weight of harms and efficiencies present in hospital merger and ACO antitrust analysis. Part IV recommends possible solutions health care entities may consider to reduce exposure to antitrust suit while still maintaining a competitive business model.

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Finally, Part V finds that ACOs, while certainly not perfect, may be an effective organizational structure from an antitrust perspective.

II. HISTORY OF THE ACO PROGRAM AND RELEVANT LAWS AND GUIDANCE AFFECTING ACOs

A. Organizational Differences Between Hospitals and ACOs

Technically, an ACO is a “meta-organization” comprised of multiple hospitals and health care providers. However, it could be set up without a hospital, but because of the massive upfront capital required, few providers have sufficient reserves to finance the start-up costs. Some analysts predict that a single hospital or health system could create an ACO, and either contract with or directly employ the physicians and other providers needed to make the entity function.

In terms of size, hospitals are for the most part unrestricted and can vary greatly. ACOs, on the other hand, must agree to provide comprehensive health services to at least 5,000 beneficiaries for at least three years. Thus, a small practice group or a small specialty hospital may be unable to meet the requirements for the provision of a full range of service, or may not be able to treat that number of individuals. Therefore, physicians and hospitals are forced to work together to meet the ACO conditions of participation.

As ACO health care providers begin to coordinate care and other practice operations, such as billing, administration and compliance, more fully, the ACO is anticipated to achieve an unheralded level of vertical integration. In an ACO, primary care physicians, specialists, hospitalists, therapists, and home health providers would all function together to enhance continuity of care to beneficiaries. Vertically integrated ACOs would likely have hospitals that could offer a full range of care — primary, secondary, and tertiary services.

However, by themselves, hospitals only achieve modest vertical integration, because they are restricted through antitrust laws from achieving full integration. Hospitals can contract with and employ physicians and practice groups, employ hospital staff, and purchase supplies and equipment. There are limits on physician involvement, joint purchasing of supplies, and joint ventures on expensive equipment. Moreover, the exchange of patient data, pricing, and cost report information among a hospital or hospitals and providers is challenging. An ACO, conversely, must share cost, pricing, and patient information, among its member providers and hospitals.

Hospitals generally obtain revenue from three sources: Medicare and Medicaid payments; private insurance payments; and, to a lesser degree, copayments and deductibles received from individual patients. Hospitals cannot easily negotiate with Medicare and Medicaid for changes in payment rates, and any desired changes must be completed through roundabout lobbying efforts, not standard buyer-seller negotiations. As such, a hospital's main buyer is private insurers, usually managed care organizations (“MCOs”), and hospitals negotiate with these private insurers. Through negotiations with MCOs, hospitals receive either a per diem rate or a fee for each service performed (“fee-for-service” or “FFS”), which hospitals generally prefer. Health care providers, as well, are almost always paid under an FFS system.

As part of an ACO, hospitals and health care providers still receive FFS payments, but can also receive payments under the Medicare Shared Savings program. While these entities are new, MCOs are also looking to contract with ACOs under terms similar to those set out under the Medicare program.

Hospital mergers consist of identification of a potential acquisition, a series of negotiations with the target regarding price and other factors (i.e. religious directives, indemnities, medical staff relations) and due diligence reviews. of the risks and rewards a merger could bring. In addition, any substantial mergers must be reviewed pursuant to the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (“HSR”) by the FTC and DOJ. Even so, most mergers reported pursuant to HSR do not undergo serious investigation. Overall, while a merger could cost millions depending on whether the government challenges, this process is generally less expensive than the formation of an ACO.
Providers must consider several cost factors when forming an ACO, including administrative, actuarial, compliance and legal costs, and time spent interacting with and submitting an application to the government (which must be approved by the FTC). Moreover, ACOs must also ensure participating providers perform their respective duties to the ACO and to the assigned beneficiaries, and consider the resultant risks, both financial and reputational, associated with the factors laid out above. While the Centers for Medicare & Medicaid Services ("CMS") has estimated start-up costs for an ACO to be $1.8 million, the American Hospital Association, in an independent study, estimated that “the costs of the necessary elements to successfully manage the care of a defined population is considerably higher – $11.6 to $26.1 million . . .”

B. Relevant Laws Affecting ACOs
To understand the current antitrust issues surrounding ACOs, it is necessary to examine the intersection of health care and antitrust law in the United States.

1. Health Care Laws and Guidance
   a. The Social Security Act
      The period of heavy governmental regulation of the health care industry began in the mid-1960's with the passage of the Social Security Amendments of 1965 (“SSA”) during the Lyndon Johnson administration. In expanding programs for Social Security, the SSA created the Medicare and Medicaid programs. These programs were intended to subsidize most, if not all, healthcare costs of the elderly (65 and older), disabled, and poor.
      Medicare was initially divided into two parts: Part A, which covered inpatient and hospital procedures and treatment; and Part B which covered outpatient and physician services, but required a premium and deductible. While the Medicare program was considered a success in terms of its benefit to society, appropriations for the law quickly accelerated to meet increasing demand for government-subsidized health services.

b. Health Maintenance Organization Act
   By the mid-1970's, the federal government, recognizing the costs associated with federal health care programs, passed the Health Maintenance Organization Act of 1973 ("HMOA") as a cost-containment measure. In seeking to provide better integration of health care services and avoid duplication of effort by encouraging health care entities to provide most of a patient's care for a flat fee, paved the way for managed care organizations ("MCOs"). In return, insurers incentivized patients to remain in the care of one or a few predetermined providers through lower “in-network” costs. Unfortunately, this legislation could not stem the tide of growth in health care spending.

c. The Affordable Care Act
   Witnessing these rising costs and other problems in the health care industry, legislators and the Obama administration passed health care reform in 2010, which set the stage for the rise of ACOs. These laws represented the most sweeping changes to Medicare and Medicaid since the creation of these programs in 1965. ACA established the Medicare Shared Savings Program, which mandated the establishment of a methodology and controlling rules for the formation, payment, and regulation of ACOs. Importantly, the Medicare Shared Savings Program called for the suspension of enforcement or limitation on enforcement of a number of laws affecting health care providers. These laws include the Stark law, Anti-Kickback Statute, and the Sherman and Clayton Acts. These laws generally prohibit improper financial relationships and coordination between health care providers, prohibitions which the federal government believes may limit over-utilization of services, medically unnecessary services and ultimately harm to patients.

Designers of the program anticipate that ACOs will increase vertical integration in patient care, creating better coordination and efficiency among providers, while simultaneously disincentivizing over-utilization. By forcing providers to reduce redundancy in medical tests and procedures, the government hopes to gain substantial savings in the Medicare program. As part of the ACO design,
participating providers will receive a portion of those savings (assuming they meet a host of quality benchmark requirements).61

2. Antitrust Laws and Guidance

a. The Sherman Act
In the late 19th century, several industries in the United States, such as oil and steel production, became heavily concentrated, allowing dominant operators to exercise considerable monopolistic powers, including decreasing output of goods and increasing prices to socially undesirable levels.62 Moreover, industries were forming trusts, whereby executives of industry-leading firms would coordinate their activities and compel shareholders to put their shares in a large industry trust.63 Once there, the leadership was able to coordinate all industry activity through operation of the trust, leading to significant anti-competitive effects.64

At this point, the federal government stepped in, enacting the Sherman Antitrust Act (“Sherman Act”) in 1890.65 Recognizing the negative impact that trusts and monopolies were having on consumers, the federal government, through the Sherman Act, outlawed “every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce . . .”66 Moreover, it declared that “every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of . . . the trade or commerce” would be guilty of a felony.67 But because this language is overly broad and could be interpreted as restricting nearly every contract in existence, significant judicial interpretation of the law was required.68

b. Clayton Act
Despite the broad provisions of the Sherman Act,69 it had difficulty rooting out anti-competitive activity of a single firm, since the law generally required an agreement or coordination of activity.70 Moreover, sophisticated business executives could get around the laws through tacit agreements and other activities that the Sherman Act could not legally reach.71 To overcome these situations, the federal legislature enacted the Clayton Antitrust Act in 1914.72 This Act made substantive additions to and revisions of the Sherman Act.73 Not only did this Act seek to ban certain unilateral activities, it also extended the competition laws to potentially anti-competitive actions before they could influence price or output.74 As the Act sets out, mergers may be illegal if “in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition [or merger] may be substantially to lessen competition, or to tend to create a monopoly.”75

Importantly, the Clayton Act identified and made illegal activities such as price discrimination between different purchasers, tying arrangements, exclusive dealing arrangements, and mergers and acquisitions that may significantly reduce competition.76 With the passage of the Clayton Act, anti-competitive outcomes did not need to be shown - instead, the federal government could point to factors such as market concentration to infer that anti-competitive effects existed or were likely to exist.77 The Clayton Act significantly broadened the scope of antitrust enforcement authority.78

c. Federal Trade Commission Act
Simultaneous to the passage of the Clayton Act, the Wilson administration created the Federal Trade Commission Act (“FTC Act”).79 The FTC Act established the FTC as the authoritative body on assessing business and competition practices of corporations and other entities.80 Tasked with enforcing the competition laws of the United States, the FTC was granted authority to investigate trade practices and act on its findings in order to preserve competition.81

d. FTC/DOJ Merger Guidelines
Recognizing that health care is a complex and unique area of commerce, the FTC and DOJ have jointly issued various statements and guidelines on their antitrust enforcement policies.82 Moreover, these statements have been widely adopted and cited by the judiciary.83 For over forty-four years, DOJ has published a set of merger guidelines and enforcement policies.84 First issued in 1968, these guidelines were significantly revised in 1982 and 1984.85 Currently, however, only the 1984 amendments regarding vertical mergers
are still in effect. The FTC and DOJ jointly issued a comprehensive set of merger guidelines in 1992 ("Merger Guidelines") heavily focused on horizontal integration. The Merger Guidelines outlined the FTC's enforcement policy and analytical techniques used when evaluating potentially anti-competitive mergers and acquisitions. The Merger Guidelines were revised in 1997 and reworked again in 2010.

e. Commentary to the Merger Guidelines
In addition to the guidance set out in the Merger Guidelines, commentary to the Merger Guidelines was issued in 2006. This document was based on the ongoing experiential learning by the FTC and DOJ, as well as the changes occurring in the United States business climate throughout the past few decades. While these Merger Guidelines do not apply to vertical mergers, an aspect of ACO integration which will not be explored in this comment, they do apply to horizontal agreements concerning rivals or potential rivals, which, in the case of ACOs, would be providers to providers or hospitals.

f. Statement on ACO Antitrust Enforcement
In 2011, the FTC and DOJ issued a Statement ("Statement") on the anticipated methodology for evaluating the propriety of a proposed or existing ACO, and whether the ACO could cause anti-competitive harms. The Statement first sets out a safety zone in which the FTC and DOJ would likely not pursue enforcement against an ACO and a methodology for calculating such zone. It further identified two exceptions for ACOs that fall outside of the safety zone, but may otherwise be sheltered from antitrust enforcement by the federal government. Finally, the Statement details how ACOs that fall outside of the safety zone and do not qualify for an exception will be subject to a "rule of reason" analysis.

C. In the Matter of Evanston Northwestern Healthcare Corp. – An Instructive Case in Hospital Merger Analysis
While the FTC and DOJ have long scrutinized mergers among hospitals, these organizations have expressly condoned the formation of ACOs and have issued specific guidance on how their antitrust analyses concerning these entities will be conducted. To illustrate the potential benefits and harms that each type of entity could cause to competition, this comment examines the case of In the Matter of Evanston Northwestern Healthcare Corp. This case was an administrative matter based on an FTC complaint against a Chicago-area hospital chain which had merged with a local rival. The comment first analyzes the outcome of Evanston based on the five-part test set out by the FTC in the decision, noting elements and factors important to the Agency. Then, the comment uses these factors as a basis for analyzing ACOs under the FTC's rule of reason analysis.

1. Relevant Facts of Evanston
In Evanston, a small hospital chain merged with a local rival hospital and prices at these hospitals soon rose. As a result of this and a recent additional acquisition, Evanston Northwestern Healthcare Corporation ("ENH") currently exists as a three-hospital chain in the suburbs of northern Chicago. As of the Evanston case, the chain was composed of three hospitals: Evanston Hospital (400 beds), Glenbrook Hospital (125 beds) and Highland Park Hospital (200 beds). These hospitals all provide varying levels of care, but all offer secondary care, and in some cases tertiary care. In addition, there are at least one hundred hospitals serving the Chicago area, with nine hospitals located within fifteen miles of the ENH hospitals in question. Nevertheless, the geographic triangle made up by these three hospitals did not contain any other hospitals.

In 1999 and 2000, Highland Park executives agreed to merge Highland Park Hospital with ENH. As a result of the merger, ENH was almost immediately able to leverage its regional market power to raise prices paid by private insurers, MCOs. When patients are treated by a health care entity that contracts with an MCO, the MCO generally pays the majority of the charges incurred. The patient and other insured individuals in the patient's pool, through insurance policy premiums, fund the payor to make such payments. In addition, a patient generally pays a deductible and copayment or coinsurance directly to the hospital. Nevertheless, the majority of payment received by the hospital treating such a patient is determined through negotiated contracting.
between the MCO and the hospital. As a hospital’s market share rises, an MCO servicing patients in that hospital’s area may more likely need the hospital’s services to meet its customer demands, and the payors are thus forced to agree to higher charges.

In Evanston, Evanston and Glenbrook Hospitals had directly competed pre-merger against Highland Park Hospital for contracts with private, using separate negotiating teams and unaware of bids, discounts and pricing information that the other was offering. Post-merger, the informational and negotiating objectives of the combined entity aligned, and ENH used this enhance leverage to command higher prices from MCOs.

In 1998, Evanston and Glenbrook collectively brought in $441 million, fifty one percent of which was from private payors. Similarly, Highland Park generated $101 million in 1998. Of this, forty five percent came from private MCOs.

In 2004, the FTC brought a complaint against the merged entity, alleging that the merger had violated Section 7 of the Clayton Act, which prohibits mergers and acquisitions that tend to substantially lessen competition. Due to provisions of HSR, proposed mergers of any substantial weight must be evaluated prospectively by the FTC or DOJ before consummation of the merger. While Evanston was considered long after a merger had already taken place, the analysis involved is consistent with the framework outlined above, and in fact can be more elucidating, since the results of the merger are evident.

1. Defining a Market
Perhaps the most critical step in conducting antitrust review of a merger is in defining the relevant market for which market power will then be calculated. In turn, market definition is divided into a two-pronged analysis: identifying the relevant geographic market and determining the appropriate product market.

To arrive at a legitimate geographic market, the FTC’s Merger Guidelines analyze whether a hypothetical monopolist could “profitably impose at least a ‘small but significant and nontransitory’ increase in price (‘SSNIP’), holding constant the terms of sale for all products produced elsewhere,” in a given geographical region.
This analytical framework, however, leaves much to be litigated, and reasonable experts can disagree on just how such an area may be defined.\textsuperscript{127} In Evanston, the FTC asserted that the relevant market consisted of the triangle formed by the three hospitals in question.\textsuperscript{128} Conversely, ENH stated that the market consisted of these three hospitals and several additional hospitals contained in a north-south axis of thirty-six miles.\textsuperscript{129}

While the ALJ essentially split the parties’ disagreement and defined the market as the ENH hospitals and several other hospitals within a close vicinity, the FTC rejected the ALJ’s holding.\textsuperscript{130} Instead, because this case was decided post-merger, the FTC had actual evidence of a price increase within the geographic area made up by the ENH hospitals.\textsuperscript{131} Circularly, the relevant market was defined by where price increases occurred in that location.\textsuperscript{132} Nevertheless, the FTC identified three factors that could be used to assist in defining a geographic market, to wit: population density, traffic patterns, and socio-economic factors.\textsuperscript{133}

Product market definition is similarly based on the SSNIP of a hypothetical monopolist, but is chiefly concerned with what substitutes exist for a product that the merged firms are selling.\textsuperscript{134} The FTC generally considers an SSNIP of five percent to demonstrate harm to competition, but is quick to acknowledge that this number may be higher or lower depending on the facts of each matter.\textsuperscript{135}

In Evanston, the parties debated whether the product market should consist of only acute inpatient care or include outpatient procedures as well.\textsuperscript{136} The FTC agreed with the ALJ that the relevant market was solely for inpatient care, and established a number of factors used to resolve the argument.\textsuperscript{137} For instance, ENH executives testifying to the fact that the pricing for outpatient services was made independent of pricing for inpatient services, and without regard for whether consumers “would switch to outpatient services.”\textsuperscript{138} This lack of a corollary demand implied a low cross-elasticity.\textsuperscript{139}

Other issues, too, were damning to ENH’s position. The hospital’s buyers, MCOs, testified that they could not substitute inpatient services and outpatient services.\textsuperscript{140} Furthermore, multiple courts had long held that inpatient services constituted a definitive product market, such that the FTC would have had to severely upset precedent to include outpatient services.\textsuperscript{141} Finally, the facts show that even the inclusion of outpatient services in the economic analysis “would not alter the outcome of this case.”\textsuperscript{142} With the relevant markets defined specifically along the lines the FTC had first envisioned, the analysis moved to the second step in the merger framework.\textsuperscript{143}

2. Anti-competitive Effects

The step of identifying anti-competitive effects is perhaps the easiest, particularly when evaluating already-consummated mergers.\textsuperscript{144} In Evanston, the FTC and the ALJ readily concluded that the price of inpatient services at ENH had gone up substantially.\textsuperscript{145} The theory behind this price increase was one of unilateral effects.\textsuperscript{146}

In a perfectly competitive scenario, two competing firms do not have access to the exact same resources or information necessary to leverage themselves in the marketplace, since each firm acts as a check on the monopolistic tendencies of the other.\textsuperscript{147} Moreover, buyers can substitute the goods of these two firms based on need and preference if one is engaging in anti-competitive practices, assuming the other can sufficiently increase output to meet market demand.\textsuperscript{148} As a result, the firms tend to remain at competitive levels of price and output.\textsuperscript{149}

However, when these firms merge, buyers are left with no other option or, if there are other firms in the market, less attractive options in terms of the products they seek.\textsuperscript{150} The merged firm has two methods to control price.\textsuperscript{151} First, it may leverage its dominant position against buyers to create a “take-it-or-leave-it” situation, where consumers’ only option is to pay higher prices for products.\textsuperscript{152} While other firms may counteract this effect, they may not be a first or second preference for consumers because of higher costs or lower quality.\textsuperscript{153} As a result, buyers are harmed.\textsuperscript{154}

Second, through merger, the firms at issue align both their goals and their informational resources.\textsuperscript{155} This coordinated alignment adds to their leverage against buyers because they now know the prices that each other’s former buyers were previously willing to
pay. Moreover, the goals of the prior firms were each to make profit for themselves to the detriment of the competing firm. Now, these united firms seek to make profit for the same set of owners, and therefore coordinate their marketing and negotiating strategies to achieve this goal. 

Evanston defendants, likewise, coordinated their negotiation efforts with private payors, and actively forced higher prices to be paid by MCOs for the health services at issue. As their representatives testified, the MCOs had no other available options than to provide coverage from one of these hospitals for their policyholders in the region.

3. Ease of Entry
The Merger Guidelines call for an assessment of whether potential rivals could enter into a market if the merged firms engaged in anti-competitive practices. Under the Merger Guidelines at the time of the case, entry by potential rivals must be likely enough in a two-year period to conclude that a merger's anti-competitive effects may be counteracted.

In pre-merger analysis, the FTC examines the applicable barriers to entry, which may include: regulations and zoning, the possibility of predatory pricing, licensure and certification requirements, time, start-up capital, sophistication, intellectual property, and sunk costs. Both the FTC and the ALJ in Evanston found that new entry would be unlikely to offset the harms caused by the ENH merger. This determination was based primarily on the fact that no new hospitals had been built in the area, and that entry took a substantial amount of time and start-up capital, thereby making entry into this market substantially unlikely.

4. Pro-competitive Efficiencies
Alternatively, pro-competitive effects may be used to balance out the anti-competitive harms of a merger. These effects may consist of a variety of justifications, including enhanced administrative efficiencies, economies of scale, quality improvements, the ability to provide new product lines, other innovations, and increased financial strength in one or both of the merged firms. Nevertheless, these efficiencies must be demonstrably strong in order to rebut the presumption of anti-competitive effects from an increase in price or showing of significant market power.

Nearly every defendant argues that a merger will create significant administrative efficiencies and can cut costs. Because the firms no longer need to duplicate their efforts in terms of administrative functions, human resources oversight and marketing efforts, the firms can function with essentially a single set of these professionals. Still, it was difficult for ENH to tie the cost-cutting efficiencies to a restraint in price increases or other competitive benefit. But in simply making itself stronger, ENH ignored that antitrust law is, at its heart, intended to protect competition, not the competitors.

Economies of scale may demonstrate a rational basis for approving an otherwise anti-competitive merger. These economies of scale efficiencies are achieved by stronger purchasing abilities, financial benefits, such as obtaining lower interest rates, and technological advantages of increasing returns to scale, whereby a firm's infrastructure and production investments lower the cost of each unit produced. For instance, a hospital may invest, as ENH did here, in an electronic medical records system that seamlessly interacts with all departments of the hospital (or hospitals), allowing patients to be treated more thoroughly, precisely and quickly. These economies of scale, however, have high upfront costs, and cannot usually be achieved by smaller firms with less capital.

Economies of scale tend to be a compelling pro-competitive rationale, as they are typically related to quality improvements and innovation. Although antitrust law views an increase in price with significant scrutiny, it is cognizant of the fact that many products are only developed through the efforts of major firms or through coordination among lesser firms. Therefore, although dense market concentration is considered problematic, firms that can significantly increase the quality of an existing product or innovate to create new products may be able to point to these countervailing efficiencies when accused of a violation.

Nevertheless, the “least restrictive alternative” rule tends to weaken the pro-competitive power of
innovation and quality improvements. This theory holds that antitrust violations will only be excused when there is no less restrictive alternative available to achieve the efficiencies claimed. In other words, if two entities could have formed a joint venture or other semi-coordinated entity to develop or enhance the goods offered instead of merging, the FTC and courts may still find a violation of antitrust law.

In Evanston, for instance, ENH claimed that it significantly improved the quality of care at the Highland Park location, proffering a $120 million investment and expansion over sixteen service areas. The FTC, conversely, set out a three-pronged test to determine whether such quality improvements should be considered. This test requires that the efficiencies claimed be verifiable, merger-specific, and greater than the merger's anti-competitive effects. Initially, the FTC noted that although ENH had invested funds towards quality improvements, there were no facts demonstrating that actual quality had been improved.

Next, the FTC determined that the claimed benefits were not merger-specific, and could have been achieved by less restrictive means. In fact, the agency found that Highland Park Hospital already had devoted $100 million to improve quality at the hospital before the merger, covering most of the same areas claimed by ENH, and had a plan in place to effectively finance these improvements. While ENH argued that these improvements specifically required ENH management's skill, the FTC was unpersuaded that Highland Park could not have reasonably made the improvements on its own. As a result, the merger efficiencies failed to meet the "least restrictive alternative" theory and failed to meet the second prong of the test set out above. Notwithstanding the fact that these efficiencies were neither verified nor merger-specific, the FTC also held that ENH did not produce substantial evidence that these alleged benefits outweighed the concrete anti-competitive harms.

5. Failing Firms
The Merger Guidelines do allow for an otherwise illegal merger to be approved if one firm is acquiring a firm that is imminently failing. The Guidelines, nevertheless, require three specific criteria for this defense to be established. These are:

1. the failing firm must be unable to meet its financial obligations in the short term;
2. this firm must not be able to reorganize and survive under Chapter 11 bankruptcy protection; and
3. the firm must have failed in making good-faith efforts to obtain an offer of acquisition that would allow its assets to remain in the relevant market.

While Highland Park was considered a "weak" hospital in Evanston, it did not come close to meeting the applicable criteria, and such criteria can only be met in the most limited of instances. As a result, the FTC flatly rejected this argument.

B. ACO Antitrust Framework
The FTC has not yet demonstrated exactly how ACO antitrust analysis will commence, but has noted that any evaluations will be conducted under the rule of reason. The rule of reason takes into consideration all of the relevant pro-competitive and anti-competitive effects when assessing the propriety of a proposed ACO formation.

Considering the case of Evanston as if the hospitals had merely set up an ACO rather than engaged in a full merger, many aspects of the analysis remain the same. For instance, the product market and geographical market determination would be the same or similar. The "failing firms" issue would be unlikely to arise, since the ACO does not necessarily have any "assets" other than skill of administrative personnel, which would not be lost to the market if the ACO exited.

Assessing the ease of entry does not yield a clear result. Although an ACO does not need to build an extensive physical plant and instead uses hospitals and providers already in a market, ACO formation requires time and significant capital investments. Further, considering the limited supply of doctors and hospitals interested in joining an ACO, entry into the relevant market may be as difficult as creating another hospital.
Conversely, it may be harder for the FTC to establish a compelling theory of competitive harms when assessing a potential ACO. Due to the lack of full integration among ACO member-hospitals, such as coordinated negotiating teams, ACOs will probably not be able to exert the same degree of competitive pressure as merged hospitals. Nevertheless, the same anti-competitive risks exist, particularly with regard to price fixing, since all participants in the ACO will generally know the fees and costs of their rivals and can therefore more easily collude. However, while informational effects could arise, the collusion of ACO member-hospitals in private payor negotiation is mitigated by their inability to fully leverage their position against MCOs, though such effect could exist if the ACO contracted universally with MCOs on behalf of its members.

The most important differences in ACO formation analysis are in the pro-competitive efficiencies an ACO may realize. These include significant cost-cutting and the implementation of quality metrics. Moreover, many believe that the ACO, if it functions correctly, serves as an innovative new product in and of itself. By providing an unprecedented continuum of care, increasingly positive health outcomes may be realized. Patients are given preventative care, seen by hospitalists for emergencies and followed up by home health agencies that already know and understand each patient's unique medical history and care requirements. Because of such coordination, fewer services, such as diagnostic tests or hospital readmissions, need to be performed, saving substantial amounts of federal Medicare money.

Furthermore, because of compliance and quality requirements, each ACO member will likely become a stronger, more viable competitor in its respective market. Such positive effects will likely outweigh any associated rises in costs to private payors.

IV. WHAT SHOULD HOSPITAL ADMINISTRATORS DO TO AVOID OR LIMIT POSSIBLE ANTITRUST ALLEGATIONS

In general, antitrust analysis is a complex, fact-intensive undertaking and can have significant ramifications for hospitals and health care entities of any size. Indeed, ENH, similarly sized to many nearby hospitals, unsuccessfully argued that these hospitals were competitors. As a result, hospital administrators should consider a variety of options when identifying potential growth and business opportunities. While ACOs may be arduous to set up, they represent a striking option from an antitrust perspective.

Importantly, ACOs do not have the same type of integration as a traditional hospital merger. Unlike merged hospitals, one hospital under an ACO umbrella does not own or otherwise control the activities of another hospital in the ACO. Moreover, cost-containment measures such as reduction in administrative staff cannot be readily achieved. Finally, participation in the Shared Saving Program places a number of compliance burdens on ACO members they would not otherwise have to face.

Nevertheless, ACOs tend to allow two important coordinated activities: first, knowledge and possible sharing of each member's private payor rates and negotiating postures, and second, the potential leverage of private payors through unilateral "take-it-or-leave-it" effects. In essence, ACOs may be able to achieve many of the same bargaining outcomes as member hospitals if they simply merged, particularly if the ACO negotiates with MCOs on behalf of all members. While the legality of these coordinated efforts may be debatable, the FTC and DOJ analysis is anticipated to be far more favorable to ACOs than to traditional hospital mergers. Moreover, ACOs have been expressly encouraged by lawmakers and administrative agencies alike, suggesting that the FTC and DOJ may be more receptive to arguments about efficiencies, cost-containment and other pro-competitive effects.

In addition, ACOs may also receive the benefit of involvement in the Medicare Shared Savings Program. For instance, Highland Park Hospital generated $101 million in 1998, of which forty three percent ($43.43 million) was derived from Medicare and Medicaid programs. Assuming that an ACO participated in the two-sided risk-sharing model, the ACO would be eligible to receive up to sixty percent of the savings realized. While actual revenue amounts would drop to achieve such savings, associated costs incurred to generate those additional revenues would also disappear. As a
result, it is likely that significant cost cutting could result in profits for the ACO. This, of course, is in addition to the possible rise in private payor rates as a result of greater information flows between ACO member entities.

ACO formation, however, may not be well-suited for every hospital wishing to expand its business operations. First and foremost, nothing truly takes the place of a traditional merger or acquisition in terms of an administrator's ability to operate multiple facilities and expand its practices. Furthermore, ACOs as a health care delivery model are untested and represent significant upfront costs that many hospitals, particularly more rural hospitals, may be unable or unwilling to pay. Finally, participation in the ACO program requires a health care entity to meet significant quality benchmarks and reporting requirements. In other words, ACOs act as a guarantor of the health of the beneficiaries they are assigned, but their patients, conversely, are free to go elsewhere to receive treatment. Any negative health outcomes, however, may affect the ACO's payment or participation status. For these reasons, a hospital administrator considering merger or ACO formation must think critically about the issues involved and weigh the corresponding risks and rewards for each option.

V. CONCLUSION

Antitrust analysis by the FTC, DOJ and federal courts will differ between hospital mergers and ACO formation. While merging hospitals may be unable to offer substantial pro-competitive justifications for a rise in private payor costs, ACOs receive both a more favorable analytical framework and by their nature have significant efficiencies, effects which have been both recognized and developed by the federal government. This beneficial analysis, almost a "benefit-of-the-doubt", given to ACOs should serve as an additional incentive for hospital organizations to consider formation of this type of entity.

Admittedly, a host of criticism and functional difficulties still surround ACOs, but as improvements are made to the regulatory framework and experiential knowledge about ACO operation is gathered, these types of entities will become more viable. Hospital and health system executives should keep these entities in mind when determining business strategy and future organizational opportunities.

1 See Patient Protection and Affordable Care Act of 2010 § 1501 (codified at 42 U.S.C.A. § 18091 and 26 U.S.C.A. § 5000A (2010)) [hereinafter ACA] (requiring that individuals who file tax returns after 2013 to continuously maintain health insurance coverage for themselves and their dependents); see also Florida ex. rel. Bondi v United States Dep't of Health & Human Servs., 780 F. Supp. 2d 1256, 1298–99, 1304 (N.D. Fla. 2011) (holding section 18091 unconstitutional and the entire act void because this section was inseverable).

2 See Delaware Healthcare Assoc. Glossary of Health Care Terms and Abbreviations, http://www.deha.org/Glossary/GlossaryH.htm (last visited Mar. 18, 2013) (defining health care delivery system as "that combination of insurance companies, employer groups, providers of care and government agencies that work together to provide health care to a population").


6 See Medicare Program: Final Waivers in Connection With the Shared Savings Program, 76 Fed. Reg. 67992, 67992 (Nov. 2, 2011) [hereinafter Final Waivers Statement] (discussing the authority of the Secretary of HHS to waive certain laws "as necessary to carry out the provisions" of the Shared Savings Program); see also Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations, 76 Fed. Reg. 67026, 67026 (Oct. 28, 2011) [hereinafter ACO Statement] (acknowledging that while the Federal Trade Commission ("FTC") and the Department of Justice ("DOJ") will "vigorously monitor" competitive effects of ACOs, they "recognize that ACOS may generate opportunities" for innovation and achieving better health outcomes).


8 FED. TRADE COMM'N, AN FTC GUIDE TO THE ANTITRUST LAWS: THE ENFORCERS (last updated July 8, 2008), available at http://www.ftc.gov/bc/antitrust/enforcers.shtm (describing the joint role played by the FTC and the DOJ).

9 FED. TRADE COMM'N, AN FTC GUIDE TO THE ANTITRUST LAWS: Mergers: Introduction (last updated May 26, 2011), available at http://www.ftc.gov/bc/antitrust/mergers.shtm (noting efficiencies which may include more efficient operation of a firm, but also harms such as higher consumer
prices, fewer goods, lower quality goods, and stunted innovation).


See, e.g., FED. TRADE COMM’N, BUREAU OF COMPETITION, HEALTH CARE DIV., OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, 1 (Mar. 2013) [hereinafter FTC Overview of Antitrust Actions] available at http://www.ftc.gov/bc/healthcare/antitrust/htcupdate.pdf (noting that since the mid 1970’s, the FTC has had a division devoted solely to health care antitrust concerns).

See, e.g., Coordination and Continuity of Care, 42 C.F.R. § 438.208 (2012) (requiring entities that provide managed care to coordinate the delivery of health care services to enrollees).

See Haley Paint Co. v. E.I. Du Pont De Nemours and Co., 804 F. Supp. 2d 419, 426 (D. Md. 2011) (holding that defendant’s attendance at trade association meetings followed by consistent and predictable industry-wide price increases was strong evidence of price fixing); see also In re Text Messaging Antitrust Litig., 630 F.3d 622, 627–28 (7th Cir. 2010) (finding that parallel pricing by rivals may be, but is not necessarily, proof of an antitrust violation).

See Julie Brill, Comm’r, Fed. Trade Comm’n, Remarks before the North Carolina Bar Association’s Antitrust and Trade Regulation Section (Feb. 9, 2012) (discussing the different approaches and attitudes the federal government has regarding hospital mergers and ACOs).


Andrew I. Gavel, William E. Kovacic & Jonathan B. Baker, ANTITRUST LAW IN PERSPECTIVE: CASES, CONCEPTS AND PROBLEMS IN COMPETITION POLICY 477 (2nd ed. 2008) (explaining that most concerns over mergers are not resolved through litigation, but through firm restructuring of transactions or agreements or divestiture of certain assets).

See Ctrs. for Medicare & Medicaid Servs., Accountable Care Organizations, CMS.GOV, https://www.cms.gov/ACO/ (last visited Mar. 18, 2013) [hereinafter CMS ACO Overview] (explaining that ACOs may consist of “doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care”).


See, e.g., Leigh Page, HHS Releases Proposed Rules on ACOs; Antitrust Agencies Issue Enforcement Policy, BECKER’S HOSPITAL REVIEW (Mar. 31, 2011), http://www.beckershospitalreview.com/hospital-physician-relationships/10-key-points-in-newly-released-proposed-rules-on-acos.html (explaining that so long as the proper number of primary care physicians was involved, a single hospital could become an ACO).

See Jaimie Oh, 50 Largest Hospitals in America, BECKER’S HOSPITAL REVIEW (Oct. 26, 2010), http://www.beckershospitalreview.com/lists/50-largest-hospitals-in-america.html (listing the largest U.S. facilities, such as the massive, 2,236-bed New York-Presbyterian Hospital in Manhattan).


See, e.g., Page, supra note 20, (detailing that, according to CMS officials, specialists would not be able to create an ACO).

See CMS ACO Overview, supra note 18 (explaining that ACOs may consist of “doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care”).

See James J. Pizzo & Mark E. Grubs, Getting to There from Here: Evolving to ACOs Through Clinical Integration Programs KAUFMAN, HALL & ASSOCIATES, INC. 3 (2011), available at http://www.advocatehealth.com/documents/app/ci_to_aco.pdf (explaining that ACOs will have significant clinical integration and defining both horizontal integration and vertical integration).


See generally FTC Overview of Antitrust Actions, supra note 11 (identifying a variety of concerns about hospital business interactions and relationships).

See generally Robert Kocher & Mikhil Sahni, Hospitals’ Race to Employ Physicians — The Logic Behind a Money-Losing Proposition, 364 NEW ENGL. J. MED. 1790 (2011) (considering a full range of hospital-physician
relationships).


33 See In the Matter of Evanston Northwestern Healthcare Corp., 2007 WL 2286195 at *5 (F.T.C. 2007) (finding that the hospitals in question received revenues from Medicare, Medicaid and private insurers).


35 See generally Matthew S. Lewis & Kevin E. Pflum, Diagnosing Hospital System Bargaining Power in Managed Care Networks 1 (Sept. 30, 2011) (unpublished manuscript) (on file with author) (recognizing that MCOs are the “primary purchasers of hospital services”).

36 See Evanston, 2007 WL 2286195 at *6 (discussing fee-for-service arrangements and “per diem” payment systems).

37 See Centers for Medicaid & Medicare Services, Fee Schedule – General Information, CMS.gov (Mar. 14, 2012 4:09 PM), https://www.cms.gov/FeeScheduleGenInfo/ (stating that CMS’s list of fee maximums is used to reimburse providers on a fee-for-service basis).

38 See Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67802, 67804 (Nov. 2, 2011) (codified at 42 C.F.R. pt. 425) [hereinafter Shared Savings Program] (explaining that because providers now have a financial benefit for not ordering excessive services, the program will reduce overall costs).

39 See David Newman, Cong. Research Serv., R44174, ACCOUNTABLE CARE ORGANIZATIONS AND THE MEDICARE SHARED SAVINGS PROGRAM 2 (2010), available at http://www.hospitalmedicine.org/AM/Template.cfm?Section=Advocacy_Policy&Template=/CM/ContentDisplay.cfm&ContentID=28506 (explaining that “ACOs may contract with any payer (Medicare, Medicaid, or private insurer) to provide services and share in any resulting savings”).


41 See Hart-Scott-Rodino Antitrust Improvements Act of 1976, Pub. L. No. 94-435 (codified at 15 U.S.C. § 18a) (1976) (requiring merging or acquiring/acquired businesses to submit information to the FTC and DOJ in most instances at least 30 days before the transaction can be completed).


44 Id. at 67802.

45 See AHA Press Release, supra note 43.


47 See id.

48 See id.


52 See Paul Saucer, et. al., The Past, Present and Future of Managed Long-Term Care, Off. of Disability, Aging & Long-Term Care Pol’y, Off. of the Assistant Sec. for Planning & Evaluation, Dep’t of Health & Human Servs. 10 (2005), http://aspe.hhs.gov/daltcp/reports/mltc.pdf (explaining that HMOs and MCOs bear a financial risk in delivering health care services to their enrollees).
54 Def't of Health and Human Servs., Off. of Inspector Gen., OEI-02-99-00030, Medicare + Choice HMO Extra Benefits: Beneficiary Perspectives 6 (2000) (explaining how HMOs utilize a primary-care physician as a gatekeeper to higher-priced specialist services).

55 See Christopher Chantrell, US Health Care Spending History from 1900, USGOVERNMENTSPENDING.com http://usgovernmentspending.com/healthcare_spending (last visited Mar. 6, 2013) (graphically showing the increase in spending and stated that “Medicare and Medicaid have made health care into the biggest government program in the United States”).


57 See 42 C.F.R. § 425.10(a)(2011) (signaling a change in health care by establishing the individual mandate, insurance exchanges and the Shared Savings Program).

58 See id. at § 425.10(b) (noting such rules as quality metrics and compliance plans).

59 Final Waivers Statement, supra note 6, at 67993.

60 See Shared Savings Program, supra note 38, at 67822 (explaining that because providers now have a financial benefit for not ordering excessive services, the program will reduce overall costs).

61 Id. at 67814–15. (setting out both the quality metrics and compliance activities ACOs must meet to receive such savings).

62 See, e.g., Standard Oil Co. of New Jersey v. United States, 221 U.S. 1, 77 (1911) (holding that a firm’s price fixing and limitation on production were anti-competitive and violated the law).


64 See id. (describing the anti-competitive schemes of trusts in the late 19th century).


67 See id. at § 2.


69 Id.

70 See FTC Fact Sheet supra note 63, at 1 (noting that the Clayton Act was necessary to preempt anti-competitive actions).

71 See id. (describing the ways in which businesses avoided Sherman Act violations).


73 See id. (imposing new penalties in areas where the Sherman Act had failed to correct identified problems).

74 See FTC Fact Sheet, supra note 63, at 1.


77 Horizontal Merger Guidelines supra note 10, at 25.


80 See id.


85 Id. at 14, 17.

86 Id. at 24.

87 See Horizontal Merger Guidelines, supra note 10, at 1, n. 1. (setting forth the notion that the publication of such information would allow courts, legal practitioners and businesses to gain a better understanding of the Agencies’ enforcement decisions).

88 Kolasky, supra note 84, at 25; Horizontal Merger Guidelines, supra note 10.

89 See generally Commentary on Merger Guidelines, supra note 42, at 2 (setting out the five-part analytical framework for mergers).

90 Id. at 5.

91 Id. at v (explaining that horizontal mergers are “a significant dynamic force” and that the “vast majority” of these mergers are harmless and in fact beneficial).

92 See generally ACO Antitrust Statement, supra note 6.

93 Id. at 67028 (laying out a calculus for determining market share and determining that a market share greater than thirty percent would disqualify an ACO participant from the safety zone).

94 Id. at 67029 (such as an ACO set up in a rural area).

95 Id. at 67027 (“A rule of reason analysis evaluates whether the collaboration is likely to have anticompetitive
effects and, if so, whether the collaboration’s potential pro-competitive efficiencies are likely to outweigh those effects.”). 96 Id. at 67028-29 (establishing a “safety zone” for ACOs in more competitive areas and stating that ACOs falling out of this zone would still undergo review under the “rule of reason”). 97 2007 WL 2286195 at *1 (F.T.C. 2007). 98 See Erica L. Rice, Evanston’s Legacy: A Prescription for Addressing Two-Stage Competition in Hospital Merger Antitrust Analysis, 90 B.U. L. Rev. 431, 443-52 (2010) (describing the background of the Evanston case). 99 In the Matter of Evanston Northwestern Healthcare Corp., 2007 WL 2286195 at *2 (F.T.C. 2007) (stating, “there is no dispute that ENH substantially raised its prices shortly after the merg[er]”). 100 Id. at *9 (identifying the triangle these three hospitals currently form); see also Rush North Shore Medical Center Merger Into NorthShore University HealthSystem Final, NorthShore University HealthSystem, (Jan. 1, 2009), http://www.northshore.org/about-us/press/press-releases/rush-north-shore-medical-center-merger-into-northshore-university-healthsystem-final/ (discussed the completed acquisition of Rush, now known as Skokie hospital, by ENH). 101 Evanston, 2007 WL 2286195 at *8-10. 102 Id. at *9 (discussing the Kellogg Cancer Care Center, various trauma centers, psychiatric care, neurosurgery and other secondary and tertiary services). 103 Id. at *9-10 104 Id. 105 Id. at *10 (discussing the goals of management, particularly the goal of reducing competition among Evanston and Highland Park); see also Rice, supra note 98, at 449 (listing the two goals of the merger as reducing competition and increasing negotiating clout with private payors). 106 Evanston, 2007 WL 2286195 at *12 (detailing the price increase and subsequent negotiating tactics of ENH). 107 Id. at *5-6 (discussing payment mechanisms for managed care organizations such as HMOs and PPOs). 108 Id. at *5. 109 Id. (describing the practical functioning of copays and their purpose); see also What is Copay, Coincurrence and Deductible?, MEDICAL-BILLING-CODING.ORG, http://www.medical-billing-coding.org/Content246.htm (last visited Mar. 18, 2013) (defining copay as “a flat dollar amount paid for a medical service by an insured”). 110 Evanston, 2007 WL 2286195 at *6-7 (describing competition among hospitals for managed care contracts). 111 Id. at *14 (assessing the testimony of Jane Ballengee and noting that the insurer was forced into accepting greatly increased prices because without the hospital chain there would be insufficient coverage). 112 See id. at *14 (noting that the MCOs could work each entity against the other to reduce prices); see also Rice, supra note 98, at 455-56 (commenting that courts should recognize the MCO as the true buyer of hospital services because of the significant role it plays in commanding prices).

113 But see Rice, supra note 98, at 449 (noting that while rising prices were “clearly established and undisputed,” the activity “was only illegally if [the increase] was a direct result of [ENH’s] increased market power.”). 114 Evanston, 2007 WL 2286195 at *8. 115 Id. at *9. 116 Id. at *3 (referencing the FTC’s three-count complaint alleging violations of the Clayton Act through price-fixing, attempting to monopolize and raising prices above competitive levels). 117 Id. at *4 (reporting that while the administrative law judge had dismissed the second count, he still found that ENH had violated the Clayton Act). 118 Id. at *3 (ruling that divestiture of Highland Park Hospital was not appropriate given the substantial costs involved and the long history of existing as a merged entity). 119 Id. at *79 (rejecting divestiture and requiring establishment of two negotiating teams). 120 See Commentary on Merger Guidelines, supra note 42, at 2 (discussing the framework used by the FTC and DOJ in analyzing both pre- and post-merger antitrust investigations). 121 Id. at 2. 122 Hart-Scott-Rodino Antitrust Improvements Act of 1976, Pub. L. No. 94-435 (codified at 15 U.S.C. §18a) (requiring merging or acquiring/acquired businesses to submit information to the FTC and DOJ in most instances at least thirty days before the transaction can be completed). 123 Commentary on Merger Guidelines, supra note 42, at 2; see also Rice, supra note 98, at 432 (“[T]he [post-acquisition FTC complaint] is notable because although not unheard of, post-merger challenges are generally rare, particularly with regard to hospital mergers.”). 124 See Evanston, 2007 WL 2286195 at *49-50 (“There are substantial factual and analytical overlaps between the market definition process and competitive effects analysis in unilateral effects cases.”). 125 See id. at *45-49 (analyzing the FTC’s specific tests in defining the relevant markets, that of the “hypothetical monopolist”); see also In the Matter of DaVita Inc., F.T.C. Docket No. C-4152 (F.T.C. 2005) (ordering divestiture for a dialysis corporation after an extensive review of the geographic product markets of the company and its acquired competitor). 126 Evanston, 2007 WL 2286195 at *48; see also Horizontal Merger Guidelines, supra note 10, at 13 (further discussing and revising this test). 127 See, e.g., Evanston, 2007 WL 2286195 at *45-49 (weighing valid points made by each party’s economic experts). 128 Id. at *48 (circularly positing that, because of actual evidence obtained, the FTC could specifically delineate these three hospitals as a relevant market). 129 Id. (arguing that MCOs and other payers had a bevy of contracting options throughout northern Chicago). 130 See Rice, supra note 98, at 446 (analyzing the ALJ’s “payor problem” and “silent majority” problem as well as the ALJ’s unique calculus for determining the geographic market). 131 See Evanston, 2007 WL 2286195 at *53 (“Higher-than-
predicted post-merger price increases resulted from market power gained through the merger.”).  
132 See Evans, supra  note 10, at 20-22 (observing that the “extent of direct competition” between two products is important to the unilateral effects theory).

See id. at 22 (commenting that buyers may negotiate with several sellers to reduce price, but when these sellers merge, the buyer is prevented from engaging in this practice).


See id. (introducing how unilateral effects actually result in anti-competitive harms).

See id. (explaining the effect of a merger of the most attractive firms on market prices).

See id. (stating that all sellers can price equivalent products to a buyer at the cost of the most expensive producer the buyer must buy from).

See id. (suggesting either through paying higher prices to the merged firms, paying higher prices to less efficient firms, or by receiving lower quality products altogether).


See id. at *31 (discussing “Learning-About-Demand” whereby the merged firms increase their knowledge of the market through review of each other’s closely-kept bidding data).

See, e.g., J. Scott Armstrong, The “Myth of Market Share”: Can Focusing Too Much on the Competition Harm Profitability?, KNOWLEDGE@WHARTON (Jan. 24, 2007), http://knowledge.wharton.upenn.edu/article.cfm?articleid=1645 (“[I]t is a common practice of many companies to focus their attention on grabbing market share from their competitors.”).

Id. (describing a study testing cooperation to achieve profit maximization).

See Evans, 2007 WL 2286195 at *10–11, *13 (describing the various ways by which Evanston coordinated their efforts and secured substantially better contracts from MCOs).

See id. at *14 (noting that an MCO’s clientele had stated that it could not effectively market without ENH in its network).

See, e.g., id. at *63 (describing ENH’s argument about possible influx of new competitors into the relevant market).

See Commentary on Merger Guidelines, supra note 42, at 46–47 (acknowledging a two year limit but further noting that the FTC would readily challenge whether additional entrants were likely to establish themselves during that window).

See Horizontal Merger Guidelines, supra note 10, at 15–16 (describing who is and is not considered a market participant for purposes of antitrust review).

See Evans, 2007 WL 2286195 at *63 (identifying elements that made it unlikely for new market participants to enter within two years, such as actual construction times and regulatory delays).
specifically for technological and knowledge improvement).  

See Commentary on Merger Guidelines, supra note 42, at 49 (setting forth these and other efficiencies, such as the ability to provide new product lines and other innovations and increased financial strength in one or both of the merged firms).

See id. at 49 (requiring that any claimed efficiencies be "cognizable" and "merger-specific").

See id. at 49 (finding that, while ENH put forth a variety of precompetitive benefits, these claims were not sufficiently substantiated or merger-specific).

Id. at *12 (discussing a consultant's estimation that, through the merger, Evanston could cut costs through economies of scale and elimination of duplicative functions).

Id. at *70 (stating that, regardless of the claimed improvements and cost-savings, these factors had no verifiable effect of countering the anti-competitive harms).

See Brunswick Corp. v. Pueblo Bowl-o-mat, Inc., 429 U.S. 477, 488 (1977) (citing Brown Shoe Co. v. United States, 370 U.S. 294, 320 (1962)) ("The antitrust laws, however, were enacted for 'the protection of competition not competitors.'").


See Evanston, 2007 WL 2286195 at *71 (identifying that installation of an electronic medical records system and integration of the teaching hospital were the only two that installation of an electronic medical records system expands).

See Henry Chesbrough, Open Innovation: A Key to Achieving Socioeconomic Evolution, JAPAN ECONOMIC FOUNDATION (2010), available at http://openinnovation.berkeley.edu/papers/How_Smaller_Companies_Can_Benefit.pdf (explaining that small and medium enterprises usually do not have enough resources to dedicate personnel specifically for technological and knowledge improvement).

See Evanston, 2007 WL 2286195 at *44.


See Commentary on Merger Guidelines, supra note 42, at v (clarifying that many mergers produce efficiencies that pose no harm to consumers).

See generally Gabriel Feldman, Misuse of the Less Restrictive Alternative Inquiry in Rule of Reason Analysis,
See ACO Antitrust Statement, supra note 6, at 67030.

See Evanston, 2007 WL 2286195 at *45–49 (outlining the specific considerations the FTC gives to market definition).

See AHA Press Release, supra note 43 (describing the unforeseen costs in CMS' initial estimate).

See generally ACO Antitrust Statement, supra note 6 (describing the proposed enforcement scheme).

See Evanston, 2007 WL 2286195 at *74 (demonstrating that the FTC recognizes the serious upward pricing effects of collusive negotiations).


Id. (describing the current confusion regarding how private payors will interact with ACOs, but noting that a number of MCOs are engaging with hospitals and health systems about ACO strategy).

See generally Shared Savings Program, supra note 38, at 67870 (laying out the number quality reporting requirements an ACO must meet to receive a portion of savings).


See Shared Savings Program, supra note 38, at 67952 (setting out the final rule regarding mandatory compliance plans in ACOs; in requiring such reporting of quality, providers are forced to become more efficient in their provision of services while maintaining a high quality of care).

See Horizontal Merger Guidelines, supra note 10, at 1 (describing the investigative processes of the FTC and DOJ).

See ACO Antitrust Statement, supra note 6, at 67030 (noting the use of rule of reason analysis for this review).

See Shared Savings Program, supra note 38, at 67952 (discussing mandatory compliance initiatives); cf. ACA §§ 6102, 6401 (mandating that all health care providers have a compliance plan).


See Shared Savings Program, supra note 38, at 67930 (discussing the proposed and final sharing methodology).

See, e.g., Rice, supra note 98, at 445 (explaining that while ENH maintained separate facilities for its post-merger chain, all corporate functions were combined, and an integrated billing system was established. Furthermore, the three hospitals all used a single Medicare identification number and granted medical privileges to physicians on a universal basis).

See Shared Savings Program, supra note 38, at 67871 (setting out that if the federal government determines the ACO had too many negative health outcomes, it may withhold the shared savings, and that such decision is not appealable).

See generally Horizontal Merger Guidelines, supra note 10; cf. ACO Antitrust Statement, supra note 6 (because of the unique nature and structure of ACOs, the FTC cannot approach them the same way).