2013 MacEachern Symposium:
On a Collision Course? Healthcare Integration and Antitrust

Northwestern University, James L. Allen Center
June 5, 2013

SPEAKER: DAVID MARX, JR.
Partner, McDermott Will & Emery LLP

"How Is Hospital Integration Possible, Outside of the Largest Cities, Without Running Afoul of the Antitrust Laws?"

Allen — It's time to hear our next speaker, who is David Marx. David is a partner in the law firm of McDermott Will & Emery, based in the Chicago office where he serves as the head of the firm's Chicago antitrust and competition practice group.

David has served as lead counsel of some of the most celebrated hospital merger cases in the United States. And I think today you will hear about his defense of those cases, and you will hear a striking contrast, I think, from the earlier presentation you heard from Jeff Goldsmith with respect to efficiencies that can be achieved in hospital mergers.

So David is also a former senior trial lawyer in the Antitrust Division of the Department of Justice and Federal Trade Commission. He has written several articles and three books on antitrust in the health care field. And he is a frequent speaker before the American Health Lawyers Association and other industry groups. David was also the former chair of the Antitrust Law committee of the American Health Lawyers Association.

He earned his JD degree at Syracuse University and is an honor graduate of Amherst College. David is a lawyer's lawyer on hospital mergers, and we're very, very pleased to introduce David Marx.

Marx — Thank you very much. [Audience applause.] Well, thank you very much for the invitation. I'm delighted to be here today. Henry is right. My perspective will be a tad different than the perspectives that you've heard so far, and I'll be happy to answer any questions about that a little later.

I'm flattered really to be here with such a distinguished array of speakers, some of my old friends and colleagues in the government in my past life where, as Henry pointed out, I served at the Antitrust Division and the Federal Trade Commission. Most of my friends, and I still have a few at the

Federal Trade Commission and the Antitrust Division, are pretty certain that I've forgotten everything that I learned when I was there. But you can be the judge of that.

Let me start at the outset by saying I am an antitrust lawyer, and I am a firm believer in competition. I believe in the applicability of the antitrust laws to health care markets, and I support government and private enforcement efforts with respect to the antitrust laws when it is justified. Which leads me to a serious concern. And that is that based on recent enforcement actions, the government's enforcement of the antitrust laws will prevent hospital consolidation from occurring where it's needed the most, in non-urban areas – the 225 MSAs where there are five or fewer independent hospitals. And future demand, if health care is delivered the way that I think we all want it to be delivered, which is less, will not support the continued existence of all present providers.

Those 225 MSAs that have five or fewer independent, competing hospitals generally have populations of less than one million people. For the most part they have populations of 200,000 to 700,000 people. For example, Toledo – and I will talk a little bit about Toledo because I did represent ProMedica Health System – has a population in its metropolitan area of about 650,000 people. The simple truth is while the FTC has disagreed with me – we'll see what the 6th Circuit has to say – I don't think 650,000 people can support four independent hospital systems, when two of them have three hospitals and one of them is an academic medical center with 300-and-some-odd beds.

So what leads me to that conclusion? Well, I'll try and explain it to you. I'll be talking about five or six different topics here this morning: the state of competition in health care markets today; the analysis of hospital or health care system mergers under the Horizontal Merger Guidelines; recent FTC enforcement actions against mergers involving health care providers – Josh mentioned a few of them, I'll talk about a couple of others; the FTC's application of those traditional merger guidelines analysis to hospital mergers; the flaws – what I perceive to be the flaws – in the FTC's analytic framework; and where it is that I think we should go from here.

Let's start with the state of competition in health care markets today. Health care markets are extensively regulated. They are not competitive in the traditional sense. Hospitals, physicians, they don't sell widgets; they don't manufacture commodity products. I think everybody would agree that hospitals, and frankly physicians, offer differentiated services.

There's an alphabet soup of laws and accompanying regulations that govern health care delivery. I'm not a health care lawyer, thank goodness. You know, I have an easy job as an antitrust lawyer. I think the health care lawyers have it much harder. They have to keep track of things like the Accountable Care

Act. They have to keep track of things like Stark. They have to keep track of anti-kickback laws and all the regulations that apply in that setting. I don't have to worry about any of those things. I just to worry about Sherman Act Section 1, Clayton Act Section 7, and every once in a while Sherman Act Section 2, which prohibits monopolies that are unlawfully achieved or maintained.

But think about the regulations that health care providers face. You've got Medicare and Medicaid payment policies. I have no idea how they do what they do. I just know that my friends on the provider side tell me that Medicare doesn't pay what it costs to deliver services to them; Medicaid pays even less, but they pay it even slower, which is a really bad combination as best I can tell.

There are substantive restrictions and requirements imposed by federal and state governments on health care providers. The state Certificate-of-Need laws shaped the hospital landscape that we have today. And while it is true that most of those Certificate-of-Need laws no longer exist – although I think they still exist in some places, maybe even Illinois – they've had a lasting effect, and that has been, I think, largely anti-competitive. It's protected the existing competitors and prevented, in some instances, competition that should have taken place.

And, of course, hospital relationships with physicians are guided by regulation. Hospitals can't pay for referrals by physicians. Physicians can't refer to places where they have a financial interest. I'm not sure this necessarily makes a lot of sense. I understand the actual and potential risk of fraud and abuse, but I'm not sure that those laws are necessarily in the public interest.

From 60 to 70 percent of patients treated at hospitals are "insured" – and I use that term in quotes – by Medicare and Medicaid and represent charity care. As I said, Medicare reimburses hospitals at less than their cost of providing inpatient care; Medicaid pays even less.

The commercial health insurance markets in most states are dominated by a few of what I would call power buyers; think Blue Cross Blue Shield licensees, Wellpoint, Aetna, United, and Humana. They're not small players. The commercial insurance markets that are the focus of FTC hospital merger enforcement actions are rarely unconcentrated. And even then, the commercial health insurance companies really are purchasing intermediaries. I think they're agents. They're not the actual consumers of health care. They bear, for the most part, very little risk.

Most hospital markets outside the major metropolitan areas are highly concentrated. That is they have fewer than five equally sized competitors.

Cities like Syracuse, New York – 663,000 people in the metropolitan area. Syracuse doesn't have five or more hospitals, independent competitors there. Rochester, New York, which has about one million people, I think, in or around the MSA only has really three competing systems. Rockford, I've forgotten what – I should remember because I represented them, too, but I think that the population in Rockford is less than a million; there are only three competing systems in Rockford today. Toledo, as I said, 650,000 people. San Antonio is a little bigger, 2.2 million, but there are really only three major hospital systems competing in San Antonio today.

Even in some of the major metropolitan areas we are seeing increasing consolidation that is reducing the number of independent competitors. We've seen consolidation here in Chicago. The Chicago metropolitan area, there's room for more consolidation, but we're rapidly getting to where there's really only going to be five or six independent competitors in the major metropolitan area. New York is consolidating as well. So are hospitals in other big cities.

Most hospital transactions from 2007 to 2012 did not, did not involve competing hospitals. So when the FTC and the Department of Justice say, well, most transactions don't raise antitrust issues, they're right. You know, there isn't enforcement in most of the cases because they don't involve competing hospitals. I think about 52 percent of the transactions over the past five years involved competing hospitals. The AHA just released a report, I think, yesterday or Monday that contains some of this data.

Of the 361 transactions that occurred over the past five or six years, only 153 involved an overlap in the metropolitan service area. And of those 153 transactions involving competitors in the metropolitan service area, over 91 percent were in MSAs with more than four competitors, and almost 90 percent were in MSAs with more than five competitors. So they really weren't in the concentrated markets.

Of the 20 transactions that did involve competitors in MSAs with fewer than five competitors, which would be a concentrated market under the FTC and Department of Justice Horizontal Merger Guidelines, 16 had populations of less than 200,000 people, and nine of those 20 transactions involved small hospitals with fewer than 50 beds.

Hospital markets are not configured to and do not operate efficiently. Hospitals have excess capacity to treat patients. Capacity utilization is down. Average length of stay is down. Patient days are not increasing; Jeff Goldsmith provided some of the data that supports that. Most cities are over-bedded, but in most of those cities the competitors are reluctant to take beds out of service. Hospitals hate to cut services. They're afraid that if they eliminate services they will be perceived as failing, and that employers and

payers will shift their business to those facilities that provide full service as opposed to something less than full service. Demand for inpatient services is or should be declining, particularly since more diagnostic services and more care is being delivered on an out-patient service basis.

Hospitals and physicians need to more closely integrate their patient information systems and services, but that's expensive and it requires their mutual financial, practical, and intellectual commitment to common objectives. True clinical integration, true clinical integration between hospitals and physicians is difficult, time consuming – it can take from one to three years to implement, even when it's done quickly – and expensive, especially for physicians who may not have the resources to commit to both the infrastructure required and the administrative or committee responsibilities that they need, typically, to undertake, to achieve true hospital/physician and physician/physician coordination of care.

Where's the evidence? Where is the evidence that the current state of competition, which the FTC and the Department of Justice want to preserve, is actually working? The cost of delivering health care services is increasing faster than most other sectors of the economy. The sheer volume of dollars paid to health care providers is increasing at a rate, as best I can tell, that's well above the rate of inflation. There's no evidence, there's no evidence though that hospital or even health care system operating margins are consistently high or suggestive of monopoly rents.

Evidence of higher and enhanced quality of services is mixed at best, I would say. So the effect of the regulatory environment and current care delivery models is to disaggregate hospital care into the smallest possible units of services – somebody said it's really just aggregated it to the point where they're charging individually for sponges. The regulatory environment and current care delivery models have promoted the rapid adoption of new technologies – think about the Da Vinci robots that are now what, 10 or 11 or 12, 13 years old that everybody wants to have – and encouraged hospitals to freeze their prices at high initial levels, incur reportable and therefore reimbursable costs, and create an equally stylized set of charges of uncertain relationships to costs.

So against that background and state of competition, where does antitrust enforcement fit? How are hospital mergers analyzed by the government and by the courts? They're analyzed under the Horizontal Merger Guidelines that were issued in 2010. The unifying theme of the Merger Guidelines is that mergers should not be permitted to create, enhance, or entrench market power, or to facilitate its exercise. Market power, of course, is the ability to raise prices above competitive levels for a prolonged period of time.

The focus of the Merger Guidelines is on both price and non-price effects. Non-price effects are reduced product quality or variety, reduced service, with diminished innovation. A reduction of either price or non-price competition is anti-competitive.

There are two kinds of anti-competitive effects that the Merger Guidelines talk about – what we call unilateral effects and coordinated effects. Unilateral effects have been a focal point of FTC merger enforcement since 2007, since the Evanston Northwestern Healthcare case. And that's really been the fundamental underpinning of the five cases that the FTC has brought since then. Unilateral effects can result simply from the elimination of competition between the two merging firms. Unilateral price effects are greater, the Merger Guidelines tell us, the more buyers of services sold by one of the merging firms consider the services sold by the other merging firm to be their next best substitute. That's when unilateral effects should be at their greatest.

Coordinated effects are an economist's way of saying price fixing or market allocation, and you should bear in mind if you should happen to be unfortunate enough to have to read the Horizontal Merger Guidelines, that they were written by economists for economists. So most of it really is in a language that's not all that easy, I think, to understand.

Coordinated effects, which were the focal point for merger analysis in most of the cases that the FTC and Department of Justice brought back in the 1990s, have been deemphasized as the basis for enforcement following those losses in the 1990s, though coordinated effects were cited, however, in the Rockford OSF Healthcare case involving Rockford Health System, as a possible, possible anti-competitive result of that proposed merger.

So what is the traditional analytic framework under the Horizontal Merger Guidelines? Well, first you start with market definition – product and geographic. The Guidelines use what they call the hypothetical monopolist test to evaluate whether groups of products in candidate markets are sufficiently broad to equal a relevant market.

The government would say that traditionally in hospital mergers the product market is the cluster of services offered by general acute care, inpatient hospitals: primary, secondary, tertiary, and quaternary care services, as distinguished from outpatient services. In other words, the FTC distinguishes between inpatient and outpatient services and says when we analyze the hospital merger we're going to focus primarily on a cluster of services that hospitals offer on an inpatient basis.

Market definition is done to evaluate whether groups of products in candidate markets are sufficiently broad to equal a relevant market, and is

supposed to focus on the demand substitution factor. In other words, looking at a market from the consumer's perspective, the purchaser's perspective, the question is to what extent do the customers have the ability and the willingness to substitute away from one product to another, or one supplier to another, if the price of that product increases? That's product market definition and geographic market definition.

Once the market's been defined, the government looks to identify – or the Guidelines look to identify – the competitors, calculate their market shares, and compute the market concentration, typically the Herfindahl-Hirschman Index. The Guidelines provide that a market is unconcentrated if the HHI, which is calculated by summing the squares of each competitor's market share, is less than 1,000. So in a market that has 10 equally-sized competitors, 10 percent, the HHI would be 1,000 – 100 added up 10 times.

The definition of an unconcentrated market remarkably changed in 2010, when the new Merger Guidelines came out from the prior merger guidelines. It changed from 1,000 to 1,500 – so an unconcentrated market is now a market that has an HHI of less than 1,500. A moderately concentrated market is one with an HHI of 1,500 to 2,500, and a highly concentrated market is one that has an HHI of greater than 2,500, which is the functional equivalent of four equally sized firms. I won't do the math for you, but trust me, that's what they mean.

There is a presumptive Merger Guidelines violation if the transaction involves a merger where the post-acquisition HHI exceeds 2,500 and, as a result of that transaction, the change was more than 200 points. If there is a presumptive Merger Guidelines violation, under the Merger Guidelines the burden shifts to the parties to demonstrate that the transaction will not be anti-competitive.

Once the HHI has been computed, the Guidelines talk about looking at barriers to entry – Certificate-of-Needs laws represent probably the single greatest barrier to entry – and the ability of the merging hospitals' competitors to reposition in response to a transaction. The Guidelines require consideration of merger-specific, cognizable efficiencies that have been verified and do not arise from anti-competitive reductions in service or output. Think, for example, elimination of duplicative or underutilized resources; if the merger will result in the elimination of those things and the more efficient utilization of resources, that would be a pro-competitive efficiency. Consolidation of services is frequently an efficiency that can be generated through a transaction involving competitors. The ability to offer new services and better-utilize capital – those could all be pro-competitive benefits that result from a merger of competing hospitals. And then, of course, if there are financial difficulties or a failing firm, the Guidelines require evaluation of that.

Let's talk for a few minutes about the recent enforcement actions that create the concern that I have about the future of enforcement. Evanston Northwestern Healthcare and FTC v. Inova were in 2008. ProMedica was 2012. OSF Health Care, that's Rockford, was 2012. Phoebe Putney was 2011; it's a little bit different but still important. Reading Health System, 2012. And then there are two transactions that don't involve hospitals – Lab Corp of America and Carilion Clinic – but do involve healthcare providers in the sense that Lab Corporation of America involves lab services, and Carilion Clinic involved a merger of competitors providing out-patient services.

I think most people are probably familiar, particularly here, if you live around here with the Evanston Northwestern Healthcare case. The FTC challenged the consummated merger of Evanston Northwestern Healthcare and Highland Park Hospital. ENH, at the time, consisted of two hospitals: Evanston Hospital, a 400-bed primary, secondary, and tertiary services hospital, and Glenbrook North Hospital, a 125-bed community hospital offering primary and secondary services. Highland Park Hospital was about a 125- or 150- to 200-bed community hospital offering, at that time, primarily primary and secondary service.

The geographic market that the FTC alleged, but frankly didn't really matter very much to their analysis, was defined to be the geographic triangle surrounding the three merged hospitals. The notion of that geographic triangle around the three hospitals being a relevant geographic market strikes me as a little odd, particularly in this community, but that's what it was, and ultimately it didn't matter to the outcome.

Evanston Northwestern had a pre-merger share of 35 percent, and the post-merger HHI was about 2739, increased by 384; that made it, although it pre-dated the most recent Merger Guidelines, presumptively unlawful under even the 2010 Guidelines.

But that really wasn't the basis for the enforcement. The FTC concluded that the merger of Evanston Northwestern Healthcare and Highland Park Hospital violated Clayton Act Section 7 as it related to a product market of acute-care inpatient hospital services because there was econometric, anecdotal, and documentary evidence that after the transaction ENH was able to raise prices at both its hospital and Highland Park Hospital to significantly above competitive levels. And the only explanation for that price increase was the merger. There were damning documents. There was damaging testimony that suggested that the transaction was undertaken specifically with the intent to raise prices and that it was successful.

That transaction led, a couple of years later, to the FTC's challenge to Inova Health System's acquisition, proposed acquisition of Prince William Health

System in northern Virginia. Basic facts surrounding this case: Inova owned five hospitals with 1,900 beds in northern Virginia. Prince William Health System had a 180-bed hospital, also located in northern Virginia, pre-merger. Post-merger Inova would have controlled about 73 percent of the licensed beds in northern Virginia and six hospitals, leaving only four independent hospitals as competitors.

Again, the product market was general acute care, inpatient services. And this is a unilateral effects case. The merger, the government said, would have resulted in a significant increase in prices at Prince William Health System, and incremental increases at Inova. The government presumably used some econometric techniques, although they were never publicly disclosed, to reach those conclusions. Again, this was a unilateral effects case. This was a case where the government said, after the transaction, Inova Health System all by itself, irrespective of the other four competitors who would still remain, will be able to increase prices simply by virtue of the fact that it acquired Prince William.

ProMedica was a post-consummation challenge to ProMedica Health System's acquisition of St. Luke's Hospital in Toledo, Ohio. St. Luke's is a 178-bed community hospital offering primary and secondary services. For the most part not tertiary services, although open-heart surgery is arguably a tertiary service. The FTC didn't really consider it important enough to be able to characterize it that way. ProMedica, on the other hand, offers primary, secondary, and tertiary care services through its three hospitals in Toledo that had about 1,100 beds. Two other competitors in the Toledo market at the time of transaction: University of Toledo Medical Center, which is an academic medical center. It didn't offer OB services. It had about 225 to 300 beds. And then there was Mercy Health Partners. It had a three-system hospital like ProMedica that had about 1,000 beds, and each Mercy Hospital is located proximately to – probably across the street from – each of the three ProMedica Hospitals in Toledo.

The complaint challenged the transaction with respect to two separate product markets, a little bit different than what the FTC had done before – general acute care, inpatient services, excluding tertiary services, and inpatient OB services, which were carved out of the general acute care, inpatient services market. Following an administrative trial, a 30-day administrative trial before an ALJ, the administrative law judge found that the transaction violated Clayton Act, Section 7, in the market for general acute care, inpatient services, but he declined to carve out inpatient OB services as a separate market, and rejected the argument that St. Luke's financial condition jeopardized its future competitive viability.

For frame of reference, this was a 4-to-3 deal; 3-to-2 as it related to OB services because UTMC did not provide them. Post-acquisition ProMedica's

share would have been about 58 percent; post-acquisition HHI would have been about 4,400, up by over 1,000.

An important factoid to bear in mind here: St. Luke's admitted only ten commercially insured patients a day. The market in this case was general acute care, inpatient services sold to commercial insurers. So we're talking about a transaction that was going to impact at most ten patients a day, and for general acute care services. And two of those ten, but only two of those ten, were moms delivering babies, and those were low-risk deliveries. St. Luke's did not do high-risk deliveries.

On appeal, the FTC affirmed the ALJ's conclusion as to liability but defined the markets differently than the ALJ did. As to in-patient OB services, the FTC, of course, characterized the merger as a "merger to duopoly" from the beginning even though as it related to high-risk deliveries the market was always a duopoly.

The FTC rejected the argument that St. Luke's market share overstated its competitive significance because it was a financially weakened competitor, notwithstanding the fact that St. Luke's cost coverage ratio was less than 1.0 for all payers, including its largest commercial health insurance plan. St. Luke's had posted operating losses from 2007 until the time of the merger. It dipped into its reserve fund to fund its operating losses and capital improvements, reducing it by about 50 percent, and its two largest commercial health insurance payors refused to renegotiate their rates to higher levels. ProMedica's appeal is presently pending before the 6th Circuit.

OSF was a 3-to-2 transaction. Two markets: general acute care inpatient services; separate market for physician services. In the primary care physician services market the transaction was going to result in the merged firm having a share of about 35 percent. The judge in that case basically said he didn't think there was likely to be a problem there, but it didn't matter because there was a problem as it related to general acute care, in-patient services.

The merging hospitals argued that Rockford simply couldn't support three independent systems any more. Indeed the Department of Justice had approved the transaction involving the second- and third-largest hospital providers five years earlier, and this deal also involved the second- and third-largest providers, but the FTC wouldn't approve it.

The largest competitor there, SwedishAmerican, was gaining share in all respects. And the merging hospitals' argument was that SwedishAmerican would be able to compete effectively with the merged OSF Rockford system. There were efficiencies that the parties thought they would be able to generate that the court rejected. The federal court judge granted a

preliminary injunction prohibiting the parties from pursuing the deal while the FTC's administrative proceedings were ongoing. Following that ruling, the parties abandoned the transaction.

Phoebe-Putney was a merger to monopoly in Albany, Georgia. The FTC challenged the deal. The federal district court and Court of Appeals said state action immunity applied. The Supreme Court said otherwise. That deal is now back in administrative litigation before the FTC.

Reading Health System is an interesting case. The FTC challenged the acquisition by Reading Health System, a 737-bed facility, of the Surgical Institute of Reading, a physician-owned surgical specialty hospital with 15 licensed beds – 15 licensed beds – and they challenged this deal alleging violations in four narrow, very narrow product lines: inpatient orthopedic spine surgical services; outpatient orthopedic spine services; outpatient ENT surgical services; and outpatient general surgical services.

Again, the parties abandoned the transaction in the face of the government's challenge of what should arguably have been a deal that they wouldn't challenge based on the antitrust safety-zone articulated in the 1996 Statements of Antitrust Enforcement Policy in Health Care, Policy Enforcement Statement 1, since the Surgical Institute of Reading only had 15 beds.

I'll leave it to you to follow up for yourself the Lab Corp of America, in the interest of time, and Carilion Clinic cases. Suffice it to say it that, again, they reflect, I think, the government's enforcement philosophy. Carilion Clinic, the interesting thing about it is that it involved only outpatient services.

What have we learned from these enforcement actions? The FTC uses traditional Merger Guidelines analysis to create a presumption of illegality based on the market structure in prospective transactions. The focus is on services purchased by commercial health plans. The market is generally defined, based on a cluster of services offered by hospitals and purchased by commercial health plans. But sometimes the FTC does carve out individual services from general acute care, inpatient services based upon what they call different competitive conditions, which are supply-side based. How many competitors are there offering that particular service? OB services was carved out in ProMedica because UTMC didn't provide it. That is a supply-side based argument.

The FTC defines the geographic market, but it focuses on the transaction's effect on one of the merging hospital's core service areas, which is the way that they focused in ProMedica. They really focused on – they talked about how the transaction was going to affect consumers right around St. Luke's Hospital, in what they called St. Luke's core service area. The problem with

that, of course, is that once you define your relevant geographic market, from an antitrust perspective, economic and employer perspective, what you're saying is all the competitors in that geographic market, are reasonable alternatives for the purchaser. So if St. Luke's prices were to go up, then people who lived around St. Luke's could go to any of the other hospitals competing in that relative geographic market. So any discussion about the transaction's effect on that core service area seems to me to conflict with the notion of how it is that you define geographic markets, which I'll talk about in just a second.

Once the FTC defines a market, we've got market share and concentration calculation, again, focusing on unilateral effects. The FTC, I think, has demonstrated a healthy skepticism of the defenses that hospitals argue in support of their transaction.

What's wrong with the FTC's analysis? Well, competition isn't working very well right now, I don't think. I don't think there's anybody who would say that it is. The FTC's enforcement of the antitrust laws with respect to hospital mergers ignores competitive reality on both the supply and the demand side. Commercial health plans, I would suggest, focus on total health care cost. They focus on the total health care cost comprised of inpatient, outpatient, physician, and ancillary services for their insured patient base. They only care what the total cost is that they're going to have to pay. I don't think they really care about what it costs separately on an in-patient basis or an out-patient basis, as long as they arrive at a total healthcare cost number that is acceptable.

Hospitals and health care systems price their services to payers based on their estimated total health care cost to treat that insured patient base. The issue for the future, I think, is how to compensate health care providers for providing care that results in their not having to provide services. The objective is for patients not to have to go into the hospitals, not to have to go to outpatient facilities, but how do you compensate the providers for not providing those services, but being able to do it in the event that people need it?

The FTC's product market definition is analytically flawed. It's based on the supply side, not the demand side. If you focus on general acute care, inpatient service by itself, nobody contracts just for that. They contract for the full range of services today. But that's not where the FTC's enforcement is based.

Additionally, the FTC's focus on only commercial patients ignores the elephant in the room: the 70 percent of the patients that hospitals have to treat, for which they don't get adequately compensated. You can't ignore the effect of Medicare and Medicaid not covering the cost of delivering care by focusing just on commercially insured patients. The FTC's market share

computation also ignores ease of service expansion and the ability of hospitals to reposition quickly. The FTC's focus on the subset of patients within a relevant geographic and a core service area of patients located immediately around one of the merging hospitals is inconsistent with geographic market definition principles.

The FTC made it pretty clear in the ProMedica case, with respect to St. Luke's, that St. Luke's was going to be required to spend down its resources, to spend down its balance sheet, before it would be allowed to consolidate to achieve efficiencies or effectively re-position its services.

And I think the FTC has to recognize, which it hasn't so far, that hospitals have to align with their medical staff to compete successfully in the future, and those who don't will not be able to compete with those who do.

So where should health care provider merger analysis go from here? I think the relevant product market needs to be redefined to more accurately reflect the services that payers, government and commercial, are purchasing and providers are selling: total health care. Providers need to be able to demonstrate, better than they've been able to do it so far, measurable quality improvements that result from scale or mergers. I don't disagree with the notion that there isn't good evidence that scale results in lower costs or better outcomes. It's incumbent upon the providers to develop the evidence of that.

Payers – Joe can talk about this in a few minutes – need to begin to offer more alternatives to the all-inclusive networks they presently favor. Payers need to offer, as an alternative, a narrow or single-provider network that can be offered at a lower price to employers than the all-inclusive network that employers presently prefer.

Payers need to be offering tiered plans so that if you go to a higher-cost provider, you pay more. Put the decision making in the hands of the consumers. These things aren't being done enough now. They have to be done in the future.

And finally, merger analysis has to be dynamic, not static. It has to reflect where the delivery of services is going, not where it's been.

And a few final points in response, I think, to Jeff's earlier presentation. First, as for the notion of physicians taking on financial risk, I think that ship has sailed. No physician who I know, no physician who I talk to today, is prepared to take on the kind of financial risk that Jeff is talking about. And that makes sense. Because in large part I don't think that the problem that hospitals, that health care providers confront today can be solved by hospitals by themselves; they only deliver part of the service. It can't be

solved by physicians by themselves because they only deliver part of the service. They have to integrate, I believe, to be able to find a way to solve the problem, to deliver that total healthcare cost together. Neither one is responsible by themselves; neither one can solve the problem by itself.

And frankly I think that in the future we need to see more consolidation among all of the providers in order to be able to address the issue. But given the current enforcement environment, the reality is in those communities that have less than five hospitals, in non-urban areas, if the providers there try to consolidate, I think the FTC is most likely to challenge it, and the consolidation that I think needs to take place to begin to address the issues likely won't occur. I know I've probably run over my time, but I'll take questions if anybody has them.

Allen Time for questions.

Man Yes. Jeff Goldsmith showed a couple of slides that show evidence that there's a lot of market power out there in the concentrated markets, and that results in higher payment rates for commercial carriers to those providers. If you want an industry to transform, they're not going to do it as long as they have a comfortable margin to work with. It takes a lot of effort to transform an organization, so don't you have to do something about the market power that's out there now if you want these organizations to actually change?

Marx Well, I think, you know, the question is whether or not the health systems are exercising what people perceive to be their market power. Again, I haven't seen much evidence that the health care systems, even the not-for-profit health care systems, some of which Jeff identified, are necessarily generating what I would consider to be anti-competitive or monopoly rents.

But I think the other side of this is that you've got the government on the one hand is the major – two governments, federal and state – are major payers. They represent 70 percent of the population that providers are seeing. They are power buyers, so they can exercise some control. But similarly in most markets the commercial health insurance companies are power buyers, too. They don't have as much financial risk because they pass it on to the employers, and there it gets disaggregated.

But it seems to me that between the government on the one hand, and the commercial insurers on the other hand, they're in a position to be able to offset whatever market power people perceive the hospitals have. How is it that they can do that? Again, single provider networks – offer alternative provider networks at different rates to employers and see what happens. If employers really want to pay less for health care, then they're going to have to offer less choice. Consumers pay for more choice. If you want to be able to pick where you're going to go, which doctor you're going to see, you're going

to pay more for that. If you want to have less choice, then economics tells you that you're going to pay less for that. The payers need to offer that full range of options, respectfully – and Joe will disagree, I'm sure – I think payers have a responsibility to try and help put those options in front of employers. And then maybe we'll see a change.

Allen Maybe just one more question.

Woman Earlier in your presentation, you had a slide up there that one of the red flags was a reduction in the types of services, the variety of services offered, right? I'm wondering what the FTC's response is to the fact that the government's out there saying that to stabilize your finances, by definition you have to reduce the services offered?

Marx Well, they have not taken seriously yet the suggestion that hospitals that are operating inefficiently will reduce services. And most hospitals have been reluctant to do that because they're afraid that if they do, they'll be perceived as something less than a real hospital and patients won't come to them for the services they're still offering.

In ProMedica there was evidence that St. Luke's had considered eliminating services in an effort to try to address their financial concerns. The government said, well, St. Luke's didn't consider that seriously enough; there wasn't a real risk that that would happen. And in order to be able to credit that possibility, the reduction in services would have to be such that it would eliminate any anti-competitive effect. That is, their share would be reduced so there wouldn't be any anti-competitive effects from the merger, which is frankly an impossible burden, I think, for a hospital that hasn't taken that action, to be able to meet.

If the hospital gets to that point, the concern is that they're going to disappear. I mean, by then it's really too late. Again the question becomes should hospitals be required to dissipate their resources before they can consolidate with a competitor – and particularly if you talk about not-for-profit hospitals, which, of course, St. Luke's was. You know, its reserve fund had been reduced by over 50 percent in the three years that preceded the transaction with ProMedica. But again, the government, the FTC's response was, yes, it's true they hadn't made any money for the past three years, but they were trending up; they hadn't lost as much in 2010 as they lost in 2009, 2008, 2007. It's hard to respond to that.

[Audience applause.]

Allen Thank you, David, for your spirited defense of hospital consolidation.