

# ANTITRUST & HEALTHCARE CONSOLIDATION: *ST. LUKE'S* AND THE FAILURE OF THE EFFICIENCIES DEFENSE

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## I. INTRODUCTION

The changes brought about by the Patient Protection and Affordable Care Act (“ACA”) have prompted several scholars to call for a reconsideration of the efficiencies defense in healthcare mergers under Section 7 of the Clayton Act. The ACA implemented several changes to increase quality of care that inherently incentivized entities to integrate. This integration, in theory, increases efficiencies and lowers costs. After the ACA was passed, there was an upsurge of healthcare mergers. Recently, the Federal Trade Commission (“FTC”) and Department of Justice (“DOJ”) (collectively, the “Agencies”) have successfully challenged healthcare mergers for violating antitrust laws.<sup>1</sup> These cases show a tension between antitrust law and ACA objectives. One such case is *St. Alphonsus Medical Center – Nampa, Inc. v. St. Luke’s Health Systems* (“*St. Luke’s*”),<sup>2</sup> in which the defendant unsuccessfully argued that merger efficiencies would overcome the potential for the merger’s anticompetitive consequences. The treatment of efficiencies in *St. Luke’s* has provoked a call to action from scholars, who argue for a reconsideration of the defense.

Although some scholars argue for more expansive treatment of the efficiencies defense, this Article argues that courts are properly

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<sup>1</sup> In 2017, the U.S. District Court for the District of Columbia enjoined Aetna’s proposed acquisition of Humana and Anthem’s acquisition of Cigna. *See also* Fed. Trade Comm’n v. Penn State Hershey Med. Ctr., 838 F.3d 327 (2016).

<sup>2</sup> 778 F.3d 775 (9th Cir. 2014).

evaluating efficiencies in light of empirical data, the Agencies' preliminary review of proposed mergers, and the existing burden-shifting framework that courts employ under the Clayton Act. Section II of this Article provides an overview of the current state of healthcare consolidation. Section III explains how the courts currently apply Section 7 of the Clayton Act to antitrust matters involving healthcare mergers. Section IV provides an overview of the *St. Luke's* decision, which is critical to understanding the arguments for and against changing the courts' treatment of efficiencies. Section V presents scholarly arguments in favor of expanding the efficiencies defense in the analysis of healthcare mergers. Section VI counters that the efficiencies defense is properly limited by the courts. Finally, Section VII of this Article concludes that the courts' current standard is necessary to protect both competition and quality of health services.

## II. THE ACA, CONSOLIDATION & ANTITRUST ENFORCEMENT

In 2010, Congress passed the ACA,<sup>3</sup> vastly changing the landscape of the healthcare industry. Although the ACA had several objectives, its overarching goal was to improve quality and efficiency of healthcare services.<sup>4</sup> One way to achieve this goal was to transition from a fee-for-service payment structure to value-based reimbursement.<sup>5</sup> Pre-ACA, health systems predominantly operated under a fee-for-service structure, under which each service was reimbursed separately.<sup>6</sup> This structure

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<sup>3</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>4</sup> See 124 Stat. 119, §§ 2717, 2718; Cory H. Howard, *The Federal Trade Commission and Federal Courts' Scrutiny of Healthcare Mergers: Do Inflexible Standards and Increased Scrutiny Stifle the Legislative Intent of the Patient Protection and Affordable Care Act?*, 18 QUINNIPIAC HEALTH L.J. 67, 69–70 (2015).

<sup>5</sup> 124 Stat. 119, §§ 3001, 3006, 3007. For a broad overview of value-based purchasing programs, see Bruce Fried & Jeremy Sherer, *ValueBased Reimbursement: The Rock Thrown Into The Health Care Pond*, HEALTH AFFAIRS BLOG (Jul. 8, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160708.055764/full/>.

<sup>6</sup> 124 Stat. 119, § 1115A(a)(2)(B); Fried & Sherer, *supra* note 5.

inherently incentivizes physicians to provide excessive care.<sup>7</sup> In an effort to combat unnecessary care and expenditures, the ACA created value-based payment systems, in which reimbursement depends on weighing health outcomes against overall costs.<sup>8</sup> The transition to value-based purchasing “require[s] sophisticated management expertise and significant capital investments.”<sup>9</sup> The push towards quality-based reimbursement thus encouraged entities to consolidate to provide more complete care.

As part of the move towards value-based purchasing, the ACA created accountable care organizations (“ACOs”), networks of providers that work together to service 5,000 patients or more.<sup>10</sup> ACOs are accountable for providing quality services to the population, and when they achieve their quality goals, they share in the savings they obtain through the ACA’s Medicare Shared Savings Program (“MSSP”).<sup>11</sup> Because ACOs provided strong payment incentives for providers to create integrated, efficient networks, ACOs enhanced vertical consolidation, i.e. hospitals acquiring physician groups.<sup>12</sup> After the ACA went into effect, market pressure to

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<sup>7</sup> Fried & Sherer, *supra* note 5.

<sup>8</sup> 124 Stat. 119, §§ 3001, 3006. *See also* Thomas L. Greaney, *The Tangled Web: Integration, Exclusivity, and Market Power in Provider Contracting*, 14 HOUS. J. HEALTH L. & POL’Y 59, 60 (2014).

<sup>9</sup> 3 HEALTH CARE 2020: CONSOLIDATION, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION 2 (2016).

<sup>10</sup> 124 Stat. 119, § 1899.

<sup>11</sup> *Accountable Care Organizations*, CENTERS FOR MEDICARE & MEDICAID SERVICES (May 5, 2017), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/>. *See also* 124 Stat. 119, § 3022.

<sup>12</sup> Greaney, *supra* note 8, at 60. While this article focuses on consolidation generally, it is important to note that ACOs pose special antitrust problems and have separate guidance from the Agencies. The Agencies issued a policy statement creating safety zones for ACOs that meet safe harbors. *See* Fed. Trade Comm’n & Dep’t of Justice, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011). ACOs with a common service and a market share of 30% of each common service are inside the safety zone and do not risk antitrust violations. *Id.* at 67,028.

cut expenses and improve quality further escalated the existing volume of mergers and acquisitions.<sup>13</sup> This escalation continues as smaller entities merge with larger systems in an effort to maintain financial stability.<sup>14</sup>

Before the ACA, there were roughly 1,113 hospital mergers between 1998 and 2012, averaging 74 per year.<sup>15</sup> After the ACA passed, there was an uptick in consolidation within the industry. In 2016, alone, 102 hospital merger and purchase transactions were announced, an increase of 55% since 2010.<sup>16</sup> The Agencies responded to this increase by bringing more enforcement actions. In the wake of this “merger mania,” FTC Commissioner Brill clarified that “the ACA is not a free pass to avoid FTC regulation” and pointed out that antitrust enforcement is as crucial now as ever in facilitating healthcare markets.<sup>17</sup> In reviewing antitrust actions concerning mergers under Section 7 of the Clayton Act, courts apply a burden-shifting framework.<sup>18</sup> Several scholars argue that the courts’ treatment of efficiencies within this framework is at odds with ACA intent. The interplay of antitrust and healthcare laws creates several

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<sup>13</sup> Molly Ebraheim, *Antitrust and Hospital Mergers: Uniqueness and Consistency in Market Definition Analysis*, 48 U. TOL. L. REV. 337, 337 (2017).

<sup>14</sup> Deloitte predicts that only 50% of the health systems operating in 2014 will be independent by 2024. *The great consolidation: The potential for rapid consolidation of health systems*, DELOITTE (2014), <https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/great-consolidation-health-systems.html>.

<sup>15</sup> *Trendwatch Chartbook 2016: Trends Affecting Hospitals and Health Systems*, AMERICAN HOSPITAL ASSOCIATION (2016), <http://www.aha.org/research/reports/tw/chartbook/index.shtml>.

<sup>16</sup> *Hospital Merger and Acquisition Activity Continues Upward Trend, According to Kaufman Hall Analysis*, HEALTH SYSTEM MANAGEMENT (Jan. 24, 2017), <http://health-system-management.advanceweb.com/hospital-merger-and-acquisition-activity-continues-upward-trend-according-to-kaufman-hall-analysis/>.

<sup>17</sup> Lori Lustrin, *Antitrust’s Attempt at Healthy Competition in Health Care*, LAW360 (Mar. 23, 2015), <https://www.bilzin.com/we-think-big/insights/publications/2015/03/antitrusts-attempt-at-healthy-competition-in-health>.

<sup>18</sup> *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 982 (D.C. Cir. 1990).

questions about whether to change the courts' analysis of efficiencies under Section 7.

### III. APPLICATION OF SECTION 7 OF THE CLAYTON ACT TO MERGERS

Before discussing the relevant arguments for change, it is first necessary to provide an overview of the standard courts use when assessing potential Clayton Act violations of merging entities. Section 7 of the Clayton Act prohibits a merger where the effect *may* be to substantially lessen competition or tend to create a monopoly.<sup>19</sup> It is important to note that the plaintiff does not have to prove anticompetitive effects with certainty but rather that the merger has an appreciable danger of anticompetitive consequences.<sup>20</sup> Presently, courts analyze mergers under a burden-shifting framework, in which the plaintiff has the initial burden to establish that the merger will produce “undue concentration in the market for a particular product in a particular geographic area.”<sup>21</sup>

To satisfy this burden, the plaintiff must first define the relevant market, consisting of both the product market and geographic market.<sup>22</sup> Absent direct evidence of market power, market definition is important to the court's analysis because it determines the defendant's market share, thus aiding in the court's assessment of an entity's post-merger power.<sup>23</sup> To determine the product market, the plaintiff implements a hypothetical monopolist test to find reasonably interchangeable substitute products, if

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<sup>19</sup> 15 U.S.C. § 18 (2018). *See also* 2-9 Treatise on Health Care Law, § 9.04 (2017).

<sup>20</sup> *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 355 (1963).

<sup>21</sup> *Baker Hughes, Inc.*, 908 F.2d at 982; *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 715 (D.C. Cir. 2001) (quoting *Phila. Nat'l Bank*, 374 U.S. at 363) (“[T]he government must show that the merger would produce ‘a firm controlling an undue percentage share of the relevant market, and [would] result[ ] in a significant increase in the concentration of firms in that market’”).

<sup>22</sup> *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 618 (1974).

<sup>23</sup> *Phila Nat'l Bank*, 374 U.S. at 363.

any, that limit the hypothetical monopolist's ability to implement a small but significant non-transitory increase in price.<sup>24</sup> To determine the relevant geographic market, the plaintiff employs a similar test, looking to geographic alternatives where consumers may reasonably turn for the same products or services.<sup>25</sup>

After defining the relevant market, the plaintiff determines the defendant's market share along with the market share of other industry actors to show the potential power of the post-merger entity.<sup>26</sup> A plaintiff can sometimes establish a prima facie case by relying solely on the defendant's market share.<sup>27</sup> The plaintiff determines industry concentration using the Herfindahl-Hirschman Index ("HHI") Test, which is "calculated by summing the squares of the individual firms' market shares," thus giving proportional weight to larger market shares.<sup>28</sup> Mergers resulting in un-concentrated markets are unlikely to have adverse competitive effects.<sup>29</sup> Under the Agencies' 2010 Horizontal Merger Guidelines (the "Guidelines"), mergers resulting in highly concentrated markets involving an HHI increase by 100 to 200 points raise concerns, and HHI increases beyond 200 points are presumed to enhance market power.<sup>30</sup> The plaintiff may also look to unilateral or coordinated effects of the firms.<sup>31</sup> Unilateral effects arise where a merger diminishes competition, and the merged entity can unilaterally exercise market power

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<sup>24</sup> *St. Luke's*, 778 F.3d at 784 (citing *Theme Promotions, Inc. v. News Am. Mktg. FSI*, 546 F.3d 991, 1002 (9th Cir. 2008)).

<sup>25</sup> *Id.*

<sup>26</sup> *United States v. Syufy Enters.*, 903 F.2d 659, 664 (9th Cir. 1990).

<sup>27</sup> *FTC v. H.J. Heinz Co.*, 246 F.3d 708 at 716 (D.C. Cir. 2001); *Syufy Enters.*, 903 F.2d at 664.

<sup>28</sup> *St. Luke's*, 778 F.3d at 786.

<sup>29</sup> U.S. DEP'T OF JUSTICE AND THE FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 5.3 (2010) [hereinafter MERGER GUIDELINES].

<sup>30</sup> *Id.*

<sup>31</sup> *Id.* at §§ 6–7.

in a variety of contexts, such as raising prices or suppressing output.<sup>32</sup> Coordinated effects, on the other hand, occur where a merger increases the probability that firms will coordinate their interactions in a way that harms customers.<sup>33</sup>

Finally, the plaintiff may also look to barriers to entry.<sup>34</sup> Ease of entry into a market may lessen some of the concerns that the post-merging entity will reduce competition in a given market.<sup>35</sup> Entry into the market must be timely, likely, and sufficient to counteract the anticompetitive effects of a merger.<sup>36</sup> If, after presentation of its case, the plaintiff satisfies its initial burden, there arises a presumption that the merger is anticompetitive.<sup>37</sup> The burden then shifts to the defendant to rebut such presumption.<sup>38</sup>

Defendants typically rely on a broad defense, using evidence showing that the market share statistics inaccurately account for the merger's likely effects on competition.<sup>39</sup> Defendants also commonly contest market definition, since it is integral in determining the defendant's market share.<sup>40</sup> Finally, defendants can argue that the merger produces

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<sup>32</sup> *Id.* at § 6.

<sup>33</sup> *Id.* at § 7.

<sup>34</sup> *Id.* at § 9.

<sup>35</sup> *Id.*; see also *United States v. Falstaff Brewing Corp.*, 410 U.S. 526, 532–33 (1973); *Baker Hughes, Inc.*, 908 F.2d at 987; Thomas L. Greaney & Douglas Ross, *Navigating through the Fog of Vertical Merger Law: A Guide to Counselling Hospital-Physician Consolidation Under the Clayton Act*, 91 WASH. L. REV. 199, 238–39 (2016).

<sup>36</sup> MERGER GUIDELINES, *supra* note 29, § 9.

<sup>37</sup> *Baker Hughes, Inc.*, 908 F.2d at 983.

<sup>38</sup> *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 631 (1974); *Olin Corp. v. FTC*, 986 F.2d 1295, 1305 (9th Cir. 1993); *California v. Am. Stores Co.*, 872 F.2d 837, 842 (9th Cir. 1989).

<sup>39</sup> *United States v. Phila. Nat'l Bank*, 374 U.S. 321, 363 (1963); *United States v. Anthem, Inc.*, 236 F. Supp. 3d 171, 192 (D.D.C. 2017).

<sup>40</sup> MERGER GUIDELINES, *supra* note 29, § 4.

efficiencies that overcome the potential for anticompetitive consequences.<sup>41</sup> According to the Guidelines, “a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm’s ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products.”<sup>42</sup> Merger efficiencies must be verifiable, merger-specific, and sufficient to show that the merger will not be anticompetitive.<sup>43</sup> Courts have often ruled in favor of the merging parties because of the plaintiff’s failure to prove its *prima facie* case; however, once the presumption that the merger is anticompetitive is in place, efficiencies have never been sufficient through early 2018 to overcome it.<sup>44</sup> The courts’ lack of robust analysis of healthcare efficiencies, in particular, has spawned some to argue for a clearer, reconsidered standard. For these scholars, the linchpin of their arguments is *St. Luke’s*.

#### IV. OVERVIEW OF *ST. LUKE’S*

In 2012, St. Luke’s, an emergency clinic in Nampa, sought to acquire Saltzer, the largest specialty physician group in Idaho. St. Alphonsus, the only hospital in Nampa, unsuccessfully sought to enjoin the merger.<sup>45</sup> After the district court denied St. Alphonsus’ preliminary injunction, the FTC and the state of Idaho intervened to enjoin the merger. The district court found that the Clayton Act prohibited the merger,<sup>46</sup> and the Ninth Circuit affirmed the ruling.<sup>47</sup> The district court determined that the relevant product market consisted of adult primary

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<sup>41</sup> *Id.* § 10 (2010).

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> *St. Luke’s*, 778 F.3d at 789.

<sup>45</sup> *St. Alphonsus Med. Ctr. v. St. Luke’s Health Sys.*, 2012 U.S. Dist. LEXIS 181363, at \*10–11.

<sup>46</sup> *Id.*

<sup>47</sup> *St. Luke’s*, 778 F.3d at 789.

care physician services, and that the city of Nampa was the relevant geographic market.<sup>48</sup>

Central to the plaintiffs' prima facie case was the post-merger HHI of 6,219 with an increase of 1,607, which was far above the Guidelines' suggested thresholds for anticompetitive findings.<sup>49</sup> The plaintiffs also pointed to the ability of the post-merger entity to negotiate higher reimbursement rates with insurers, which was ultimately harmful to consumers.<sup>50</sup> Furthermore, the plaintiffs argued that entry into the market was historically difficult and would not be timely to counteract the anticompetitive effects of the acquisition.<sup>51</sup> The Ninth Circuit upheld the district court's finding that the plaintiffs presented enough evidence to obtain the presumption that the merger would be anticompetitive.<sup>52</sup>

Upon rebuttal, St. Luke's argued that the distinct procompetitive benefits of the merger were sufficient to overcome the plaintiffs' case.<sup>53</sup> The Ninth Circuit was skeptical towards the use of the efficiencies defense, observing that the Supreme Court has never expressly approved of it.<sup>54</sup> The court noted that four other circuits suggested that efficiencies could rebut a presumption of illegality.<sup>55</sup> Of these circuits, however, none have found that the argued efficiencies were sufficient to overcome the plaintiff's case.<sup>56</sup>

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<sup>48</sup> *Id.* at 784–86.

<sup>49</sup> *Id.* at 786 (citing *ProMedica*, 749 F.3d at 568).

<sup>50</sup> *Id.*

<sup>51</sup> *Id.* at 787–88.

<sup>52</sup> *Id.* at 786.

<sup>53</sup> *Id.* at 788.

<sup>54</sup> *Id.* (citing *Brown Shoe, Co., Inc. v. United States*, 370 U.S. 294, 344 (1962)).

<sup>55</sup> *Id.* at 789.

<sup>56</sup> *Id.*

St. Luke's urged that the merger comported with the goal of integrated care and risk-based reimbursement, which would provide cost savings and better care for consumers.<sup>57</sup> St. Luke's also argued that providing physicians access to St. Luke's electronic medical records system would benefit patients.<sup>58</sup> The court found that the defendant must clearly demonstrate that the merger enhance competition through efficiencies.<sup>59</sup> Further, in a highly concentrated market, proof of "extraordinary efficiencies" was necessary.<sup>60</sup> Even though the district court conceded that the merger would improve the delivery of health care in Nampa, it held that efficiencies would not prevent the exercise of market power after the merger.<sup>61</sup> Moreover, the court distinguished between the goal of moving toward integrated care and actually showing that such care was certain to result.<sup>62</sup> Ultimately, the court held that St. Luke's failed to show that the efficiencies rebutted the plaintiff's case.<sup>63</sup> After the *St. Luke's* decision, there was an uptick in academia focusing on the efficiencies defense.

## V. ARGUMENTS IN FAVOR OF EXPANDING THE EFFICIENCIES DEFENSE

### A. *Expanding Efficiencies in Health Care*

The court's treatment of efficiencies in *St. Luke's* shows the tension between the ACA's incentives to consolidate and enforcement of

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<sup>57</sup> *Id.* at 788.

<sup>58</sup> *Id.* at 791.

<sup>59</sup> *Id.* at 790 (citing *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 137 (E.D.N.Y. 1997)).

<sup>60</sup> *Id.* (citing *H.J. Heinz Co.*, 246 F.3d at 720, 722).

<sup>61</sup> *Id.* at 791.

<sup>62</sup> *Id.*

<sup>63</sup> *Id.* at 791–92.

antitrust law.<sup>64</sup> Case law indicates that efficiencies must be “extraordinary” to overcome a plaintiff’s prima facie case in highly concentrated markets.<sup>65</sup> Using *St. Luke’s* and related cases, many scholars call for a change in the way courts analyze merger efficiencies in the healthcare sphere, contending that the Section 7 standard should be updated to reflect the current state of the industry.<sup>66</sup> The court’s skeptical treatment of efficiencies in *St. Luke’s* is critical to this argument. As Professors Blair, Durrance, and Sokol posit, “[t]he lack of economically informed case law in *St. Luke’s* is a missed opportunity to clarify merger law.”<sup>67</sup> According to these professors, instead of implementing an empirical analysis of physician acquisition, the court abstained from engaging in a robust discussion of efficiencies.<sup>68</sup>

Using *St. Luke’s* to demonstrate a lack of substantive analysis, scholars argue that guidance of the efficiencies defense would lead to consistent treatment by the courts and subsequently provide clarity for parties seeking to merge.<sup>69</sup> To bolster the command for more expansive treatment of efficiencies, such scholars rely both on the quality component of healthcare mergers and the ACA’s incentives for health systems to consolidate.

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<sup>64</sup> Bernard W. Archbold, *Analyzing Qualitative Efficiencies in the Ninth Circuit’s St. Luke’s Decision: A Defense of Non-Price, Qualitative Efficiencies*, 27 GEO. MASON U. C.R.L.J. 343, 369 (2017); Jamie L. Bjorklund, *St. Alphonsus Medical Center v. St. Luke’s Health System: The Uncertain Application of the Efficiencies Defense is Leading to Unpredictable Outcomes in Healthcare Mergers*, 53 IDAHO L. REV. 577, 610 (2017).

<sup>65</sup> *St. Luke’s*, 778 F.3d at 790.

<sup>66</sup> See Bjorklund, *supra* note 64, at 614; Roger D. Blair & D. Daniel Sokol, *Quality-Enhancing Merger Efficiencies*, 100 IOWA L. REV. 1969, 1972 (2015); Ebraheim, *supra* note 13, at 359.

<sup>67</sup> Roger D. Blair, Christine Piette Durrance & D. Daniel Sokol, *Hospital Mergers and Economic Efficiency*, 91 WASH. L. REV. 1, 3–4 (2016).

<sup>68</sup> *Id.* at 38.

<sup>69</sup> Bjorklund, *supra* note 64, at 616–17; Blair, Durrance & Sokol, *supra* note 67, at 3.

*B. Distinct Health Care Market & Quality*

Academia urging for stronger analysis of efficiencies hinges on the fact that quality is integral to the delivery of healthcare services, and mergers may enhance quality of care.<sup>70</sup> Thus, courts should treat the antitrust analysis differently where healthcare mergers are at issue. These scholars purport that health care is distinct from other industries, and lumping it with other commerce places too much emphasis on cost and not enough on quality.<sup>71</sup> Currently, courts rarely identify quality as a substantive component of their analysis.<sup>72</sup> In their study of the use of quality in antitrust cases, Professors Hammer and Sage found little evidence of courts using empirical quality considerations from healthcare research or literature.<sup>73</sup> Their research concluded that the lack of quality analysis is due in part to a fragmented definition of quality.<sup>74</sup> Antitrust law discusses quality in terms of the trade-offs with traditional price concerns.<sup>75</sup> Conversely, “health care professionals tend to view quality as the outcome of a medical process . . . divorced from economic context.”<sup>76</sup> Because of the lack of clarity in quality analysis, “antitrust law often relegates quality and non-price considerations to a secondary position.”<sup>77</sup>

Indeed, both the Agencies and courts lend greater weight and discussion to price, which according to Professors Blair and Sokol, “creat[es] a false distinction between price and quality” and discounts the

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<sup>70</sup> See Archbold, *supra* note 64, at 343–44; Blair, Durrance & Sokol, *supra* note 67, at 34–39; Ebraheim, *supra* note 13, at 350.

<sup>71</sup> Ebraheim, *supra* note 13, at 363.

<sup>72</sup> Bjorklund, *supra* note 64, at 587; Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 547 (2002).

<sup>73</sup> Hammer & Sage, *supra* note 72, at 609.

<sup>74</sup> *Id.*

<sup>75</sup> *Id.* at 556.

<sup>76</sup> *Id.*

<sup>77</sup> *Id.* at 547.

quality of care provided by the merged entity.<sup>78</sup> Healthcare mergers, however, can produce non-price efficiencies such as “offering integrated care, tertiary care, more services, and better specialists,” which ultimately allow merging entities to be more competitive.<sup>79</sup> Blair argues that “[f]irms compete on quality in health care as fiercely as they may on price,” and consumers take quality into consideration when deciding where to receive services.<sup>80</sup> “Thus, when quality improves, consumers are willing to pay more for the same quantity of the good.”<sup>81</sup> By this logic, even if a merger does not successfully bring down prices, the quality gained by way of the merger may be sufficient to render the merger procompetitive.

These scholars contend that, to fully account for the quality advances of mergers, courts should lend more weight to quality via the efficiencies defense.<sup>82</sup> Where courts discuss efficiencies, they do so in terms of price measurements and shy away from substantive quality discussions.<sup>83</sup> Because of the lack of analytical framework for courts to discuss quality, uncertainty is perpetuated both for courts and businesses.<sup>84</sup> In her article, Kristin Madison argues that a measurable definition of quality will allow litigants to better support their arguments and will

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<sup>78</sup> Blair & Sokol, *supra* note 66, at 1971; *see also* Bjorklund, *supra* note 64, at 580.

<sup>79</sup> Bjorklund, *supra* note 64, at 615.

<sup>80</sup> Blair, Durrance & Sokol, *supra* note 67, at 44.

<sup>81</sup> Blair & Sokol, *supra* note 66, at 1975.

<sup>82</sup> Bjorklund, *supra* note 64, at 615.

<sup>83</sup> *See* Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1093 (N.D. Ill. 2012) (discussing cost-based efficiencies and finding that any proposed quality-based efficiencies are wholly speculative); Fed. Trade Comm'n v. Tenet Healthcare, 17 F. Supp. 2d 937, 948 (E.D. Mo. 1998) (finding that cost-based efficiencies are speculative); Fed. Trade Comm'n v. Butterworth Health Corp., 946 F. Supp. 1285, 1307 (W.D. Mich. 1996) (providing weight to cost-based efficiencies); Fed. Trade Comm'n v. Freeman Hosp., 911 F. Supp. 1213, 1224 (W.D. Mo. 1995) (discussing efficiencies in terms of economies reducing administrative and overhead costs).

<sup>84</sup> Bjorklund, *supra* note 64, at 580; Blair, Durrance & Sokol, *supra* note 67, at 70.

provide certainty to businesses anticipating consolidation.<sup>85</sup> According to the preceding arguments, courts should lend more weight to quality analysis to account for merger efficiencies.<sup>86</sup> Such discussion will provide guidance in the business world<sup>87</sup> and will bring antitrust law and the ACA into alignment.<sup>88</sup>

### C. *ACA & Incentives to Consolidate*

Other scholars look to the ACA itself as affirmation that a more flexible standard should govern healthcare consolidation.<sup>89</sup> The ACA sought to mitigate the problems accompanying a fragmented system of health services and to improve overall access and quality.<sup>90</sup> Some scholars argue that the ACA specifically envisioned consolidation<sup>91</sup> as a means to

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<sup>85</sup> Kristin Madison, *Hospital Mergers in an Era of Quality Improvement*, 7 Hous. J. Health L. & Pol'y 265, 298–99 (2007).

<sup>86</sup> See generally Archbold, *supra* note 64, at 372; Bjorklund, *supra* note 64, at 615; Blair & Sokol, *supra* note 66, at 1984; Ebraheim, *supra* note 13, at 360–63.

<sup>87</sup> See Archbold, *supra* note 64, at 374; Bjorklund, *supra* note 64, at 581 (arguing for a “certain and consistent application of the efficiencies defense” to “provid[e] a framework for healthcare entities seeking to merge”); Blair & Sokol, *supra* note 66, at 1995 (arguing that a more robust analysis of quality would help improve business planning).

<sup>88</sup> See Bjorklund, *supra* note 64, at 618 (“[r]eexamining how healthcare mergers will be assessed will bring antitrust law into accord with current healthcare policy . . .”).

<sup>89</sup> See, e.g., Erin C. Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 IND. L.J. 55, 62–63 (2016); Howard, *supra* note 4, at 83–86; Leigh L. Oliver & Robert F. Leibenluft, *A Mixed Bag: Sorting out Efficiencies Arguments in Hospital Mergers*, 30 ANTITRUST ABA 18, 18 (2015).

<sup>90</sup> Greaney, *supra* note 8, at 60.

<sup>91</sup> See *The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition*, Hearing Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the Comm. on the Judiciary H.R., 114th Cong. 82 (2015) (statement of Scott Gottlieb, M.D., Resident Fellow, American Enterprise Institute); Terry L. Corbett, *Healthcare Corporate Structure and the ACA: A Need for Mission Primacy Through a New Organizational Paradigm?*, 12 IND. HEALTH. L. REV. 103, 150–51 (2015); Greaney, *supra* note 8, at 60; Marshall B. Kapp, *Speculating about the Impact of Healthcare Industry Consolidation on Long-Term Services and Supports*, 25 Annals Health L. 1, 5 (2016).

alleviate these problems by bringing down costs and aligning provider incentives.<sup>92</sup> In his article on hospitals and antitrust scrutiny, Ross Bautista went so far as to claim that integration is the best way to “reduce fragmentation, increase efficiency, and thus [to] reduce costs.”<sup>93</sup>

Specific consolidation drivers from the ACA include the move to value-based purchasing,<sup>94</sup> which encompasses the creation of ACOs, as previously discussed. The ACO program is the most explicit example of the ACA incentivizing entities to integrate. ACOs, by definition, involve multiple entities coming together for the purpose of delivering more efficient care.<sup>95</sup> Vertical integration theoretically achieves the ACA’s cost-saving goals.<sup>96</sup> More importantly, such integration could provide the coordinated care that the healthcare system lacks.<sup>97</sup> Professor Thomas Greaney pushes back against this argument, arguing that no part of the

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<sup>92</sup> Blair, Durrance & Sokol, *supra* note 67, at 23–24.

<sup>93</sup> Ross E. Bautista, *The Never-Ending Quest for Clarity Amidst Uncertainty: Hospital M&A and Antitrust Scrutiny*, 54 SAN DIEGO L. REV. 149, 156 (2017).

<sup>94</sup> HEALTH CARE 2020, *supra* note 9. See also Jacqueline Belliveau, *Value-Based Care, Price Transparency Drive Hospital Mergers*, REVCYCLE (Dec. 6, 2016), <https://revcycleintelligence.com/news/value-based-care-price-transparency-drive-hospital-mergers>.

<sup>95</sup> 124 Stat. 119, § 1899. ACOs are networks of health care providers that work together to provide health services to at least 5,000 patients for at least 3 years. ACOs agree to be held accountable for providing quality services, and they share in the cost savings they achieve. *Id.*

<sup>96</sup> Kapp, *supra* note 91, at 12.

<sup>97</sup> *Id.*

ACA explicitly encourages such integration.<sup>98</sup> Greaney calls these scholars' arguments the "ACA-made-me-do-it defense."<sup>99</sup>

Nevertheless, the proponents of expanded efficiencies analysis turn to the ACA as the primary source of legislative intent to encourage mergers for the purpose of increasing efficiencies within the industry.<sup>100</sup> According to these arguments, not only do mergers and acquisitions have the potential to increase quality, but they can also achieve important cost savings.<sup>101</sup> Finally, scholars argue that integration is vital to achieving the ACA's quality and cost-savings goals.<sup>102</sup> Given the ACA's efficiency incentives, these arguments refute a restricted standard that fails to fully account for both quality and cost components of the efficiencies defense.

## VI. ARGUMENTS FOR CONSTRAINING EFFICIENCIES

Despite the preceding arguments for robust and favorable analysis of the efficiencies defense, courts are properly analyzing efficiencies for a variety of reasons. First, such arguments omit discussion of the potential dangers of healthcare mergers to exclude rivals and to circumvent self-referral legislation. In addition, merged entities within the healthcare system typically gain market power and the ability to exploit prices. Moreover, empirical research on integrated health systems has consistently

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<sup>98</sup> *The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition*, Hearing Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the Comm. on the Judiciary H.R., 114th Cong. 23 (2015) (statement of Thomas L. Greaney, Professor of Law, St. Louis University School of Law).

<sup>99</sup> *Id.* In Greaney's view, the ACA sought to improve market competition by establishing health insurance exchanges to facilitate consumer comparison shopping and by requiring the insurance companies to maintain a minimum level of coverage. *Id.* at 18–20. Furthermore, the provider incentives promulgated by the ACA rely on competition "to drive cost containment and quality improvement." *Id.*

<sup>100</sup> See Archbold, *supra* note 64, at 369.

<sup>101</sup> See, e.g., Archbold, *supra* note 64, at 344; Bjorklund, *supra* note 64, at 583; Ebraheim, *supra* note 13, at 350.

<sup>102</sup> See Corbett, *supra* note 91, at 159; Kapp, *supra* note 91, at 13–14.

found that consolidation does not enhance quality of care. Finally, scholars who argue for more expansive treatment of the efficiencies defense inflate the degree to which the Agencies attack mergers in the healthcare industry. For these reasons explored below, courts are properly construing the efficiencies defense.

*A. Potential for Exclusion of Rivals & Facilitation of Referrals*

First, courts are correctly giving limited analysis to the efficiencies defense because of the potential dangers healthcare mergers pose, including facilitation of referrals, foreclosure of competition, and raising of prices above competitive levels.<sup>103</sup> These harms are exacerbated when there are high entry barriers and where mergers occur in highly concentrated markets, as is often the case in hospital markets.<sup>104</sup> In the healthcare setting, the potential for such dangers is further amplified by other factors, such as bundling hospital and physician services, as in *St. Luke's*. Such merger harms complicate healthcare marketplaces in several ways.

First, integrating physician groups within a larger hospital system facilitates the referrals of patients within a single network.<sup>105</sup> When hospitals contract directly with physicians, they may use the relationship to “increase admissions, diagnostic testing, and outpatient services at their

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<sup>103</sup> MERGER GUIDELINES, *supra* note 29, at §§ 1–2. *See also* *Brown Shoe Co.*, 370 U.S. at 323–24 (finding that the foremost “vice” of a vertical merger is “foreclosing the competitors of either party from a segment of the market . . .”). For a thorough explanation of foreclosure via mergers, *see* Greaney & Ross, *supra* note 35, at 216, 221, 226.

<sup>104</sup> MERGER GUIDELINES, *supra* note 29, §§ 5.3, 9. *See also* David M. Cutler & Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 J. AM. MED. ASS'N 1964, 1966 (2013).

<sup>105</sup> Brown & King, *supra* note 89, at 72–73.

facilities.”<sup>106</sup> Such referrals allow physicians to skirt the Anti-Kickback Statute<sup>107</sup> and the Stark Law,<sup>108</sup> two regulatory safeguards against self-referrals.<sup>109</sup> These laws “afford broad leeway with regard to referrals by employed physicians,” which makes it easier for integrated health systems to circumvent the statutes’ prohibitions.<sup>110</sup> Such referrals also have the ability to foreclose competitors from obtaining patients within the market.<sup>111</sup> Physician practices owned by larger networks therefore have the competitive edge over independent groups that must fight to bring in patients.

Second, large entities post-merger may foreclose competition and subsequently raise prices above competitive levels.<sup>112</sup> This danger is amplified in the healthcare setting, where marketplaces are already concentrated.<sup>113</sup> A study by David Cutler and Fiona Morton of hospital market share and consolidation found that, in 2010, half of all hospital markets were highly concentrated.<sup>114</sup> Another third were moderately

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<sup>106</sup> Laurence C. Baker, M. Kate Bundorf & Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, HEALTH AFFAIRS, May 2014, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.1279>.

<sup>107</sup> 42 U.S.C. § 1320a-7b (2018). The Anti-Kickback Statute provides criminal liability for an individual or entity that solicits or receives remuneration in return for or to induce referrals or services reimbursable by the federal government. *Id.*

<sup>108</sup> 42 U.S.C. § 1395nn (2018). The Stark Law prohibits a physician from referring to an entity for a designated health service if the physician has a financial relationship with that entity. *Id.*

<sup>109</sup> 42 U.S.C. § 1395nn(b)–(e).

<sup>110</sup> Greaney & Ross, *supra* note 35, at 212; *see* 42 U.S.C. § 1395nn(b)–(e) (providing exceptions to liability, including those for employees and for hospital ownership); *see also* Brown & King, *supra* note 89, at 72–73.

<sup>111</sup> Blair, Durrance & Sokol, *supra* note 67, at 28.

<sup>112</sup> *See* MERGER GUIDELINES, *supra* note 29, §§ 6–7.

<sup>113</sup> *See* Cutler & Morton, *supra* note 104.

<sup>114</sup> *Id.* Cutler & Morton examined data from the American Hospital Association, focusing on “nonfederal, short-term general and specialty hospitals that have facilities and services

concentrated, leaving only the remaining sixth un-concentrated.<sup>115</sup> This concentration allows a dominating entity to wield market power and raise prices, as discussed below in Subsection B. Furthermore, because of the power of integrated systems, physician groups are increasingly integrating within larger systems to maintain financial stability and to gain leverage against insurance companies.<sup>116</sup> Folding to the power of larger health systems further adds to market concentration, causing less competition in the overall marketplace and allowing the larger systems to maintain market power against remaining independent groups. Where there is appreciable danger for anticompetitive consequences, courts properly impose a high burden on defendants to defeat a presumption that a merger is anticompetitive. Courts should therefore refrain from expanding the efficiencies defense.

### B. Market Power & Price Increases

Another danger of consolidation that rebuts scholars' argument for merger efficiencies is that the merged entity can charge higher prices by gaining bargaining leverage over insurance companies to demand higher reimbursement rates.<sup>117</sup> Studies show that hospital networks have stronger leverage than any provider groups because of their size and patient volume, and so-called "must have" hospitals charge higher prices than other hospitals within the same marketplace.<sup>118</sup> Ostensibly, countervailing the power of insurers is beneficial to the overall hospital market; however, when the market becomes dominated by a large

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available to the public." *Id.* at 1964. They analyzed market information from 306 hospital referral regions across the county. *Id.* Cutler and Morton turned to share of admissions and HHI to discuss the competitive market of the regions. *Id.*

<sup>115</sup> *Id.* at 1966.

<sup>116</sup> See Baker, Bundorf & Kessler, *supra* note 106.

<sup>117</sup> *Id.* at 757.

<sup>118</sup> Chapin White, Amelia Bond, & James Reschovsky, *High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power*, 27 CENTER FOR STUDYING HEALTH SYSTEM CHANGE 4 (Sept. 2013).

integrated system, that system alone has the ability to charge higher prices, and independent hospitals and provider groups in the same market have no leverage to command the same.<sup>119</sup> The disjointed power thus causes wide price variations amongst the prices insurers pay hospitals.<sup>120</sup>

A study conducted by Chapin White showed as much as a 60% variation between the prices insurers pay to the most- and the least-expensive hospitals in a given market.<sup>121</sup> The study further found that such differences were not attributable to labor costs, complexity of services, type of coverage, or whether the hospital had teaching programs.<sup>122</sup> According to the study, such variation resulted from market

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<sup>119</sup> Jennifer R. Conners, *A Critical Misdiagnosis: How Courts Underestimate the Anticompetitive Implications of Hospital Mergers*, 91 CALIF. L. REV. 543, 553 (2003).

<sup>120</sup> See generally White, Bond, & Reschovsky, *supra* note 118.

<sup>121</sup> *Id.* at 2. For comparison, the study found little variation amongst primary care physician prices. This lack of variation correlates with the lack of market power primary care physicians possess. Physicians traditionally operate under solo or small group practices, and they are therefore more “substitutable” to the insurance companies. *Id.* at 3.

<sup>122</sup> *Id.* Massachusetts Attorney General also concluded similar results in a state-wide study committed to determining the causes of price variation. MASS. ATT’Y GEN., REP. FOR ANNUAL PUBLIC HEARING UNDER G.L. C. 118G, § 6½(B) (2010). In the report, the AG found that prices paid by health insurers to hospitals and physician groups varied significantly within the same geographic area and amongst providers that offered similar service. *Id.* at 3. Further, these variations were not attributable to the quality of care provided, the sickness of the population, the complexity of services, how many patients relied on Medicare or Medicaid, or whether the provider was in an academic facility. *Id.* The study concluded that price variations correlated to market leverage. *Id.* at 4. A similar study was conducted by T. Scott Thompson in California, where concentration and insurance premiums varied considerably amongst the regional divides. See generally T. Scott Thompson, *ACA Exchange Premiums and Hospital Concentration in California*, ANTI-TRUST HEALTH CARE CHRONICLE 27 (Jan. 2015). Thompson concluded that there was a clear positive relationship between insurance premiums and HHI increases. *Id.* at 30. Importantly, the least concentrated areas that had more than 5 competitors in the region had lower average premiums. *Id.*

power.<sup>123</sup> Another study found that hospital prices in monopoly markets were more than 15% higher than in areas with four or more competitors.<sup>124</sup> Statewide studies of hospital systems also find a positive correlation between market power and price increases.<sup>125</sup>

Research further supports that patients ultimately bear the cost of these higher rates.<sup>126</sup> A study conducted by Professor Jeff Goldsmith on health care integrated delivery networks found that per patient expenditures in hospital systems and multihospital systems are 10-20% higher than in independent groups, which adds up to \$1,200-\$1,700 more per patient, per year.<sup>127</sup> Prices increases are particularly dangerous when a merger-to-monopoly occurs, eliminating all competition in a given market. The cost of an inpatient stay at a hospital in a monopoly market is \$1,900 higher than markets with four or more competitors.<sup>128</sup> Given the extensive data supporting price variation and market power, “[p]roposed hospital consolidation should be scrutinized carefully to ensure that competition is protected and that patients and payors are unlikely to suffer from price increases.”<sup>129</sup>

### C. Consolidation Does Not Lead to Quality Improvement

Another reason to maintain skepticism of the efficiencies defense is that there is little empirical evidence that consolidation actually enhances quality of care, as merging parties often argue. According to the DOJ,

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<sup>123</sup> White, Bond, & Reschovsky, *supra* note 118, at 3.

<sup>124</sup> Catherine Sampson, *FTC: Hospital Mergers and Acquisitions May Create Monopolies*, REVCYCLE INTELLIGENCE (May 24, 2016), <https://revcycleintelligence.com/news/ftc-hospital-mergers-and-acquisitions-may-create-monopolies>.

<sup>125</sup> See, e.g., Mass. AG, *supra* note 122; T. Scott Thompson, *supra* note 122.

<sup>126</sup> See Jeff Goldsmith, et al., *Integrated Delivery Networks: In Search of Benefits and Market Effects*, NATIONAL ACADEMY OF SOCIAL INSURANCE 27–28 (Feb. 2015).

<sup>127</sup> *Id.* at 12.

<sup>128</sup> Sampson, *supra* note 124 (quoting Edith Ramirez, F.T.C. Chair).

<sup>129</sup> Thompson, *supra* note 122, at 33.

“most studies find that increased hospital concentration is associated with increased prices.”<sup>130</sup> Furthermore, “[e]ven if a hospital merger is likely to create cognizable efficiencies, those cognizable efficiencies likely will not be sufficient to reverse a hospital merger’s potential to harm consumers in the relevant market.”<sup>131</sup>

A growing number of studies suggest that integration has little bearing on quality and instead leads to increased expenditures for patients.<sup>132</sup> According to the Goldsmith study, there is “scant evidence in the literature of either societal benefits or advantages accruing to providers from [integrated delivery network] formation.”<sup>133</sup> Conversely, “there is growing evidence that hospital-physician integration has raised physician costs, hospital prices and per capita medical care spending.”<sup>134</sup> Moreover, hospital mergers have the potential to lower the quality of care, because lack of competition obviates hospitals’ incentives to innovate and compete over the non-price elements of patient care.<sup>135</sup> These findings do not suggest that quality is a key component of healthcare consolidation, but

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<sup>130</sup> U.S. DEP’T OF JUSTICE AND F.T.C., IMPROVING HEALTH CARE: A DOSE OF COMPETITION-Report by F.T.C and U.S. Dep’t of Justice (June 25, 2015) (discussing that some studies find that merged parties have lower costs, and how one study in particular found that cost savings varies depending on the extent of consolidation).

<sup>131</sup> *Id.*

<sup>132</sup> *Data Brief, Impact of Hospital Consolidation on Health Insurance Premiums*, AMERICA’S HEALTH INSURANCE PLANS 2 (June 2015), [https://www.ahip.org/wp-content/uploads/2015/06/ProviderConsolidation\\_DataBrief\\_6.25.15.pdf](https://www.ahip.org/wp-content/uploads/2015/06/ProviderConsolidation_DataBrief_6.25.15.pdf). See also Marina Lao, Francine Lafontaine, & Debbie Feinstein, *Not just an opinion: competition really is key to healthy health care markets*, F.T.C. (Jul. 8, 2015), <https://www.ftc.gov/news-events/blogs/competition-matters/2015/07/not-just-opinion-competition-really-key-healthy-health>.

<sup>133</sup> Goldsmith, et al., *supra* note 126, at 2.

<sup>134</sup> *Id.* According to the data, integrated delivery systems’ flagship hospital services are more expensive on two levels: on a cost-per-case basis as well as a total-cost-of-care basis than the services of their most significant in-market competitor. *Id.* at 27–28.

<sup>135</sup> Conners, *supra* note 119, at 549–50.

rather than market power and removal of competition primarily motivates such consolidation.<sup>136</sup>

Other studies also find no measurable correlation between price and quality.<sup>137</sup> A report to Congress from the Organisation for Economic Co-operation and Development (“OECD”) concludes that price increases do not indicate quality advancements.<sup>138</sup> According to the OECD, the U.S. spends more on health care than any of the other 33 member countries of the OECD.<sup>139</sup> Despite such spending, the U.S. lags behind other countries in numerous quality measures. For example, the U.S. ranks 26th in life expectancy and 31st in infant survival rates.<sup>140</sup> Although the quality of care has steadily increased in the U.S., it does so at a slower pace than the other OECD countries.<sup>141</sup> Edith Ramirez, the FTC Chair, proposed that competition is essential to quality of care, because hospitals compete to attract patients, and such competition leads to better price and quality benefits for consumers.<sup>142</sup> Thus, competition, not consolidation, leads to cost and quality benefits for consumers. Taken together, this

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<sup>136</sup> Data Brief, *supra* note 132.

<sup>137</sup> See *Examining Consolidation in the Health Insurance Industry and its Impact on Consumers: Hearing Before Subcomm. on Antitrust, Competition Policy & Consumer Rights of the Subcomm. on the Judiciary*, 114th Cong. 3 (2015) (statement of Paul B. Ginsburg, Norman Topping Chair in Medicine and Public Policy, Sol Price School of Public Policy); MEDICARE PAYMENT ADVISORY COMM’N, *Report to the Congress: Medicare Payment Policy* 6 (Mar. 2014).

<sup>138</sup> MEDICARE PAYMENT ADVISORY COMM’N, *supra* note 137, at 29.

<sup>139</sup> *Id.* at 28.

<sup>140</sup> *Id.*

<sup>141</sup> *Id.* See also Rabah Kamal and Cynthia Cox, *How has the quality of the US healthcare system changed over time?* PETERSON-KAISER HEALTH SYSTEM TRACKER (Sept. 9, 2015), [https://www.healthsystemtracker.org/chart-collection/quality-us-healthcare-system-changed-time/?\\_sf\\_s=measuring+quality#item-mortality-rates-endocrine-nutritional-metabolic-diseases-fallen-last-15-years-u-s](https://www.healthsystemtracker.org/chart-collection/quality-us-healthcare-system-changed-time/?_sf_s=measuring+quality#item-mortality-rates-endocrine-nutritional-metabolic-diseases-fallen-last-15-years-u-s).

<sup>142</sup> Sampson, *supra* note 124 (quoting Edith Ramirez, F.T.C. Chair).

research suggests that rigorous enforcement of antitrust laws is crucial in maintaining healthcare quality.

*D. Scholars Inflate Degree of Merger Scrutiny*

Finally, scholars arguing for expanded analysis of efficiencies fail to take into account that the Agencies conduct an extensive multi-step review before bringing suit.<sup>143</sup> After such review, the vast majority of mergers may proceed.<sup>144</sup> In 2016, 1,832 transactions were reported to the Agencies.<sup>145</sup> Of these transactions, the Agencies brought challenges to 47, or 2%.<sup>146</sup> This percentage suggests that the Agencies only brings enforcement actions to mergers that have an appreciable danger of being anticompetitive. Moreover, the Agencies have the ability to examine merger efficiencies during the review and can abstain from challenging the merger if they find that such efficiencies would overcome the potential for anticompetitive consequences.

Furthermore, scholarly arguments do not discuss the placement of the efficiencies defense within the broader burden-shifting framework required by Section 7 of the Clayton Act. The current standard is such that the plaintiff bears the ultimate burden of persuasion.<sup>147</sup> The plaintiff has the onus to first obtain a presumption of anticompetitive harm. The efficiencies defense comes into play *only* after the plaintiff makes a prima facie showing that the merger is likely to be anticompetitive.<sup>148</sup> Therefore, once efficiencies are argued, there is already a strong likelihood of

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<sup>143</sup> *Merger Review*, F.T.C. (2016), <https://www.ftc.gov/news-events/media-resources/mergers-and-competition/merger-review>.

<sup>144</sup> *Id.*

<sup>145</sup> *FTC, DOJ Issue Fiscal Year 2016 Hart Scott Rodino Premerger Notification Report*, F.T.C. (Oct. 4 2017), <https://www.ftc.gov/news-events/press-releases/2017/10/ftc-doj-issue-fiscal-year-2016-hart-scott-rodino-premerger>.

<sup>146</sup> *Id.*

<sup>147</sup> *See Baker Hughes, Inc.*, 908 F.2d at 991.

<sup>148</sup> *See St. Luke's*, 778 F.3d at 788.

anticompetitive consequences, and the defendant should have a high burden of proof to rebut this presumption. Finally, for efficiencies to succeed, they must be merger-specific, meaning that they cannot be possible absent the merger.<sup>149</sup> This barrier ensures that parties do not abuse their reliance on quality to justify otherwise anticompetitive mergers. For these reasons, there is a strong argument to constrain the use of the efficiencies defense.

## VII. CONCLUSION

The healthcare industry has undergone substantial change since the ACA was passed. The high level of consolidation within the industry and the subsequent lack of flexibility from the courts is a source of frustration for scholars seeking to overcome obstacles to quality improvement. Given the high concentration of the market and the potential anticompetitive dangers of mergers,<sup>150</sup> it follows that courts are properly constraining the efficiencies defense in favor of protecting consumers from powerful entities. Restricting the use of the efficiencies defense follows the empirical evidence, which shows that consolidation tends to increase costs and has little bearing on quality. Despite proponents' arguments for expanding the use of efficiencies, courts should maintain the current standard following the proposition that competition is the best means to achieving low costs and high quality of care.

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<sup>149</sup> MERGER GUIDELINES, *supra* note 29, at § 10; *St. Luke's*, 778 F.3d at 790–91.

<sup>150</sup> According to the Health Care Cost Institute, in 2017, the average hospital and system HHIs were 1,984 and 2,969, respectively. *Healthy Marketplace Index: Hospital Concentration Index*, HEALTH CARE COST INST. 2 (2017). “The higher system-level HHIs imply that inpatient services are more concentrated at the system level than the hospital level.” *Id.*