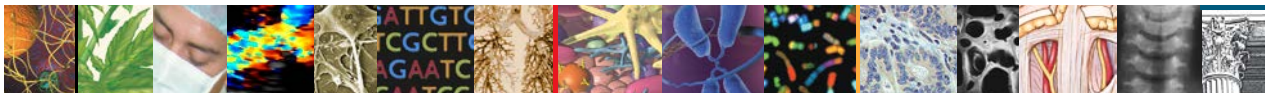

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Perspective

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Antitrust Enforcement in Health Care — Controlling Costs, Improving Quality

Edith Ramirez, J.D.

The success of health care reform in the United States depends on the proper functioning of our market-based health care system. Antitrust laws play a crucial role in ensuring that consumers benefit from robust market competition. In health care, as in other sectors, competition leads to lower costs and higher-quality services and encourages investment and innovation. So the increasing consolidation that's occurred among health care providers over the past two decades represents a worrisome trend. We have seen the pace of merger activity accelerate, and left unchecked, consolidation risks undermining some of the key objectives of health care reform. The Federal Trade Commission (FTC), which I chair, is charged with stopping mergers that will most likely reduce competition and harm consumers.[1] Ensuring that health care provider markets remain competitive is one of our chief aims.

The current consolidation wave could have substantial consequences for health care reform efforts that depend heavily on competition to control costs and improve quality. Providers compete to be included in a health plan's network, which offers a good source of patients. Vigorous competition for inclusion in a network enables insurers to negotiate lower reimbursement rates, which lead to lower insurance costs for consumers and employers. Providers must then compete to attract patients — a need that drives them to improve the quality of their services. Consolidation risks upsetting this competitive dynamic and harming consumers.

The FTC intervenes when there is strong evidence that a merger between health care providers is likely to result in market power that will lead to an increase in prices — through higher insurance premiums and copayments — without corresponding quality improvements. Earlier this year, the U.S. Court of Appeals for the Sixth Circuit upheld the FTC decision to block a hospital merger in Toledo, Ohio, between the area's largest health care system, ProMedica, and one of its rivals, St. Luke's Hospital. The FTC showed that health plans could obtain more competitive prices from ProMedica when St. Luke's existed as a suitable alternative. The loss of that alternative would

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have increased ProMedica's negotiating clout and left health plans vulnerable to ProMedica's price demands.

Similar concerns may arise when physician groups combine or when doctors sell their practices to hospitals that already have physicians practicing the same specialties as the purchased groups. Competition among physician groups provides patients with options and helps keep costs lower.[2] Extensive evidence that consolidation of health care providers leads to higher prices without corresponding improvements in quality supports the FTC's continued vigilance over these markets.[3]

Critics question whether promoting competition should still be a central aim of the FTC's agenda when it comes to health care markets. They claim that active enforcement of antitrust laws undermines efforts to contain costs through provider collaboration and is therefore at odds with the policy aims of the Affordable Care Act. In some states, legislation has been proposed that would exempt health care providers that engage in collaborative activity, including joint ventures and mergers, from antitrust review. At their extreme, these bills would encourage providers to negotiate collectively with health plans in order to extract higher rates, in effect allowing providers to fix their prices. By permitting conduct that would ordinarily violate antitrust laws, the bills would lead to higher prices and lower-quality care — undercutting the very objectives they aim to achieve. More fundamentally, the proposed legislation betrays a misunderstanding of the crucial role that competition plays in the health care sector.

Antitrust analysis takes into account both cost and quality considerations. When reviewing a hospital merger, for instance, the FTC focuses not only on whether the transaction will most likely lead to anticompetitive consequences such as higher prices or other harms, but also on whether it will raise the quality of health care services. For quality-related claims to succeed, however, they must be backed by evidence that quality improvements are both likely and attainable only by means of a merger.

This was a central issue in another recent case involving the acquisition of an independent physician group in Idaho, Saltzer Medical Group, by St. Luke's Health System, the state's dominant health system. Joined by Idaho's attorney general, the FTC charged that the merger — which would have given the combined entity an 80% market share in adult primary care physician services in Nampa, Idaho — would reduce competition and lead to higher prices. The parties argued that they needed to consolidate in order to shift from a fee-for-service model to a financially and clinically integrated, risk-based system that would reward providers on the basis of patient outcomes instead of the number of services provided. Such a system could succeed, they claimed, only if the organization employed a critical mass of doctors.

While acknowledging the potential benefits of integrated care, at trial the FTC pointed to the lack of evidence that a merger was necessary to achieve those goals. For example, according to St. Luke's, a central benefit of the transaction would be the implementation of a shared electronic health records (EHR) system, but an effort to provide nonaffiliated physicians access to its EHR system was already well under way. The FTC also showed that there are different ways, short of a merger, for hospitals to achieve the benefits of clinical integration, including through the use of clinical practice protocols to ensure consistent treatment and financial incentives for meeting quality-of-care goals. This argument was supported by the fact that other physician practices in Idaho, including groups smaller than Saltzer, were already engaging in risk-based contracting and integrated care.

Last January, a federal district court judge in Boise, Idaho, ultimately agreed with the FTC and ordered the dissolution of the acquisition. In his ruling, the judge acknowledged that the deal had the potential to improve patient outcomes, but he found that the parties' stated objectives could be achieved in ways other than through consolidation. The case is currently on appeal.

Health care providers considering integration can look to these and other cases for direction, as well as to extensive guidance provided over the past two decades. In the 1996 Statements of Antitrust Enforcement Policy in Health Care, the FTC and the Department of Justice set out the main factors they consider when assessing whether an arrangement among health care providers may violate antitrust laws. More recently, we issued a policy statement in 2011 providing antitrust guidance to providers contemplating the formation of accountable care organizations. The FTC

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has also issued advisory opinions that offer concrete guidance in the area of provider collaboration.

The FTC supports the key aims of health care reform, and we recognize that collaborative and innovative arrangements among providers can reduce costs, improve quality, and benefit consumers. But these goals are best achieved when there is healthy competition in provider markets fostering the sort of dynamic, high-quality, and innovative health care that practitioners seek and patients deserve.

The views expressed in this article are those of the author and do not necessarily represent the views of the Federal Trade Commission.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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Integrating Oral and General Health Care

Bruce Donoff, D.M.D., M.D., John E. McDonough, Dr.P.H., M.P.A., and Christine A. Riedy, Ph.D., M.P.H.

During World War II, the U.S. armed forces faced a surprising obstacle to recruiting sufficient field-ready personnel for the war effort: 10% of potential recruits failed service requirements related to oral health (such as having six opposing teeth), and many who met the requirements had severely compromised teeth that required tremendous resources to repair. So at the end of the war, "many dentists, military officers, political leaders, and others vowed to solve the Nation's rampant dental problems."[1] On June 24, 1948, President Harry Truman signed the National Dental Research Act "to improve the dental health of the people of the United States" by establishing the National Institute of Dental Research, now known as the National Institute of Dental and Craniofacial Research (NIDCR).

Yet today, Americans still face serious challenges in oral health that result in lost work and school hours and impose heavy costs on the health care system and society.[2] Furthermore, there is evidence that coordinating and integrating oral health into medical coverage and care reduces costs, especially for patients with chronic diseases such as diabetes or cardiovascular disease.[3] We believe that it's time to mobilize once again to improve oral health in the United States, this time in a more fundamental way — by ending medicine's artificial and harmful separation between the mouth and the rest of the body. New and compelling evidence suggests that in order to prevent disease and improve health, oral health must be a core component of comprehensive health care.

The Surgeon General's report on oral health in 2000 concluded that oral health problems not only reflect general health conditions; they can exacerbate and sometimes even trigger them.[4] Periodontal inflammation affects diabetes, heart disease, and chronic obstructive pulmonary disease, as well as perinatal health in mothers and infants.[2,4] Investment in oral health improves general health and reduces medical costs.[3] The 2007 case of Deamonte Driver, a 12-year-old Maryland boy who died when bacteria from an untreated tooth infection spread to his brain, generated sufficient awareness and legislative support that dental coverage for children was included in the federal reauthorization of the Children's Health Insurance Program (CHIP) in 2009.

Still, 15 years of research, reports, and recommendations addressing the dental–medical divide have resulted in little serious action to address our country's oral health deficiencies. Although the changes to CHIP have improved access to services for disadvantaged children, we are failing to address the serious oral health needs of adults, even though an increasing percentage of Americans 65 years of age or older have chronic diseases that are affected by poor oral health. Furthermore, disparities in coverage of and access to dental care services result in the imposition of a high-cost burden on hospital emergency departments.[5] We believe that a national effort is needed to integrate oral health

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