The American Antitrust Institute

September 11, 2014

Hon. Janet L. Sanders
c/o Antitrust Division
Office of the Attorney General
One Ashburton Place
Boston, Massachusetts 02108

Re: Comments on the Proposed Final Judgment in Massachusetts v. Partners Healthcare System, Inc. et al., Civ. No. 14-2033 (BLS)

Dear Judge Sanders:

The American Antitrust Institute (AAI) is an independent and non-profit national research, education and advocacy organization devoted to advancing the role of competition in the economy, protecting consumers, and sustaining the vitality of the antitrust laws. *See generally* www.antitrustinstitute.org.[1] AAI has an interest in this matter not only because it will affect consumers in a large and important health care market, but because Massachusetts' national leadership in health care innovation and regulation, as well in as antitrust enforcement, could make the settlement an unfortunate precedent for resolution of anticompetitive hospital mergers by other states. As we shall explain, the proposed remedy is not in the public interest because it will likely fail to restore competition lost as a result of the acquisitions by Partners Health Care Systems, Inc. ("Partners") of South Shore Health and Educational Corporation ("South Shore") and Hallmark Health Corporation ("Hallmark"), and it will embroil the Attorney General's Office and the court in extensive regulatory oversight for which they are ill suited.[2] Therefore, it should be rejected.

I. Introduction and Summary

The Attorney General's Office and Massachusetts health care regulators have recognized that Eastern Massachusetts is a competitively unhealthy hospital market

[1] AAI is funded by voluntary contributions to its general treasury. No party or other entity with an interest in this matter has made any contributions towards the funding or preparation of these comments. These comments have been approved by AAI's Board of Directors. The individual views of members of the Board of Directors or AAI's Advisory Board may differ from AAI's positions.

[2] We address the Proposed Final Judgment filed on June 24, 2014. While the Attorney General and Partners are apparently renegotiating the Hallmark aspects of the deal in light of the recent objections by the Massachusetts Health Policy Commission ("HPC"), and this could resolve some of our concerns about the details of the settlement, our fundamental concerns about the effectiveness of using a regulatory decree to resolve anticompetitive horizontal mergers undoubtedly will remain.

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dominated by Partners. In particular, Partners' market power is demonstrated by its ability to maintain substantially higher prices than other hospital systems for comparable services, and by the fact that the higher prices are not justified based on higher quality. The complaint alleges these two acquisitions will make matters worse: they are anticompetitive, will raise prices, and violate the antitrust laws. After extensive analysis, the Health Policy Commission confirmed that each of these acquisitions would lead to substantially higher prices for payers large and small.[3] Although the acquisitions offer some benefits, the HPC found much of the claimed efficiency benefits unsubstantiated or not "merger specific" (i.e. could be achieved without the mergers), and that the benefits would be outweighed by likely increases in medical costs. HPC Hallmark Final Report at 64-69; HPC SSH Final Report at 47-56. Moreover, Partners and South Shore are in "strong financial condition," while Hallmark's financial position is "positive." HPC SSH Final Report at 11; HPC Hallmark Final Report at 17.

The typical and favored resolution of an anticompetitive merger is to block the merger or require divestitures of other business units to replace the lost competition. The courts and antitrust enforcement officials have been clear that "conduct," or behavioral, remedies are disfavored because they present often-insuperable monitoring and oversight challenges, among other reasons. Given the HPC's findings, and the recent success of the Federal Trade Commission in blocking comparably anticompetitive hospital mergers,[4] there is little reason to doubt that the Attorney General could have obtained an injunction to block the mergers here. But rather than block the acquisitions, the Attorney General has proposed a complex, highly regulatory consent decree.

Included in our submission is a Declaration of John E. Kwoka, Jr., the Neal F. Finnegan Distinguished Professor of Economics at Northeastern University, and a Senior Fellow of the AAI, which explains why remedies of this sort are generally inadequate to restore competition in horizontal merger cases such as this, and details some of the specific inadequacies in the proposed remedy. Among other things, Professor Kwoka explains that the novel component contracting remedy—the apparent centerpiece of the settlement—does not purport to resolve the anticompetitive effects from these acquisitions, and in any event is likely to be ineffective in curbing Partners' bargaining leverage. He also explains the limitations of price regulation—even when it is adopted by an expert regulatory agency, much less a court—and points out how the price caps in the proposed settlement fall short of an effective price regulatory regime.

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[3] *See* Mass. Health Pol'y Comm'n, Review of Partners HealthCare System's Proposed Acquisition of Hallmark Health Corporation Pursuant to M.G.L. c. 6D, § 13: Final Report at 2 (Sept. 3, 2014) ("HPC Hallmark Final Report"); Mass. Health Pol'y Comm'n, Review of Partners HealthCare System's Proposed Acquisition of South Shore Hospital and Harbor Medical Associates Pursuant to M.G.L. c. 6D, § 13: Final Report at 2 (Feb. 19, 2014) ("HPC SSH Final Report").

[4] *See* In the Matter of Reading Health Sys., FTC Dkt. No. 9395 (Nov. 16, 2012); *FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069 (N.D. Ill. 2012); *FTC v. St. Luke's Health Sys. Ltd.*, 2014 WL 407446 (D. Idaho Jan. 24, 2014); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 568 (6th Cir. 2014).

While the scope of the court's review of the settlement may be limited, it is not as limited as suggested by the Attorney General. Whether under Tunney Act precedent or consent decree precedent more generally, a settlement may be rejected when it is inconsistent with the public interest, as here, where: (a) there is no reasonable basis to believe that the remedy will adequately resolve the competitive harms alleged in the complaint; and (b) the settlement will be difficult to implement because it involves excessive judicial oversight. Indeed, the two grounds are related: in significant part, it is because courts are ill equipped to act as economic regulators that the settlement is unlikely to achieve its aims.

We make the following points:

- The court has ample legal authority to reject the settlement as not being in the public interest.

- Conduct remedies are clearly inferior to blocking an anticompetitive merger or other structural relief, and are typically unsuccessful. Antitrust enforcers and courts lack the expertise and institutional capability to adequately regulate firms with market power, and to counteract the firms' natural incentives to exploit it. Accordingly, the federal enforcement agencies and courts have rejected these types of conduct remedies in hospital and other mergers between direct competitors. And where remedies like these have been used in the past they have failed.

- The proposed settlement is generally flawed for several reasons:

    - The settlement is time limited and does nothing to alter Partners' increase in market power resulting from the mergers. Accordingly, prices can be expected to rise once the price caps are removed, as has been the case in the few other instances where caps have been tried.

    - The settlement is highly complex and technical, with numerous ambiguities that will likely require extensive and continuing court involvement to resolve. The proposed independent monitor will be helpful, but administering the regulatory decree will still require significant judicial resources.

    - Conduct remedies are particularly problematic where, as here, the product is highly complex, the market is undergoing significant changes, and enforcement depends on parties in long-term business relationships with the enjoined firm (here, payers) willing to complain when violations occur.

- The major elements of the proposed remedy are inadequate to protect consumers from the loss of competition. Besides the fact that they are time limited, the price caps are flawed because:

    - The price caps are limited in scope, with the total medical expenditure (TME) cap covering only 11% of Partners' commercial business. Moreover, the caps do not cover quasi-private plans such as Medicaid Managed Care and Medicare Advantage.

    - The proposed price regulation would be difficult to administer—even by a regulatory agency, much less a court—and fails to take into account important considerations, such as how to deal with changes in the scope and types of services.

    - The price caps may be ineffective insofar as the parties' prices, absent the mergers, would increase by less than the general inflation or medical inflation in the index used in the settlement.

    - The price caps do nothing to address the potential diminution in quality competition, and perversely provide incentives to reduce quality.

    - If the price caps are exceeded in any year, ultimate health care or insurance consumers may not benefit from the refund mechanism.

    - To the extent it is relevant, the price caps do nothing about Partners' existing supra-competitive pricing and rate advantage over other providers.

- Besides being time limited, the component contracting provision is flawed because:

    - Component contracting will do little or nothing to alter Partners' ability and incentives to increase prices post-merger.

    - The settlement does not provide sufficient protection from actions Partners could take to make component contracting unattractive to payers, such as offering pricing differentials for bundled and non-bundled components and engaging in subtle forms of retaliation against payers that seek to take advantage of the unbundling option.

    - There are reasons to be skeptical that payers and consumers will find it attractive to use component contracting, especially when the Partners physicians who are part of a payer's network can be expected to steer patients to out-of-network Partners' providers.

- Component contracting works at cross purposes with the purported efficiency justification of the mergers, namely the deep integration of South Shore and Hallmark into the Partners network.

Our comments begin by discussing the appropriate standard of review for consent decrees. We then discuss the standards for merger remedies. We assess both the price cap and component contracting provisions, and find them both inadequate. We conclude that the proposed remedy for the anticompetitive mergers is not in the public interest and should be rejected.[5] The Attorney General should seek to block the mergers and use other litigation or regulatory tools to address the broader issue of Partners' market power in the Massachusetts health care market.

II. Standard of Review of Consent Decrees

Regardless of whether federal precedent under the Tunney Act is precisely on point, courts have a significant role to play in approving any consent decree because, of course, a consent decree is an order of the court that it will be called upon to enforce.[6] "[W]hen the district judge is presented with a proposed consent judgment, he is not merely a 'rubber stamp.'" *S.E.C. v. Levine*, 881 F.2d 1165, 1181 (2d Cir. 1989) (non-Tunney Act); *see also United States v. SBC Communs., Inc.*, 489 F. Supp. 2d 1, 15 (D.D.C. 2007) ("the Court is not to 'rubber-stamp' proposed settlements"). In reviewing a proposed settlement, the court must find that the proposal is not only in the parties' interests, but also in the "public interest." *United States v. Gillette Co.*, 406 F. Supp. 713, 717 (D. Mass. 1975).

This means, among other things, that the government must establish "a reasonable basis upon which to conclude that the [settlement] will adequately remedy the competitive harms alleged in the government's complaint." *United States v. Republic Servs., Inc.*, 723 F. Supp. 2d 157, 161 (D.D.C. 2010); *United States v. Abitibi – Consolidated Inc.*, 584 F. Supp. 2d 162, 165 (D.D.C. 2008) ("settlement should be rejected" if there is no factual basis for concluding that it provides "reasonably adequate remedy for the harm

[5] We have no quarrel in principle with a conduct remedy for Partners' anticompetitive joint contracting practices, which, according to the complaint, independently violate the antitrust laws. *See* Complaint for Injunctive Relief ¶¶ 32-35, 42-44. However, the terms of the proposed remedy (Proposed Final Judgment ¶¶78-90) seem unduly complex. *See* Kwoka Decl. ¶ 20 (attached).

[6] As one commentator explains, "Even in the absence of the Tunney Act, such as in the context of non-antitrust consent decrees or decrees preceding the Act, a court is entitled to some review of a proposed decree and has the discretion to refuse to enter one that would adversely affect the court or represent an inappropriate use of judicial power. The Act serves an important role in enhancing that ability and authority." Lawrence M. Frankel, *Rethinking the Tunney Act: A Model for Judicial Review of Antitrust Consent Decrees*, 75 Antitrust L.J. 549, 580-81 (2008). In fact, the lead case cited by the Attorney General in support of the appropriate standard of review is a Tunney Act case. *See* Mem. of the Comm. of Mass. in Support of the Entry of Final Judgment at 3, 6 (citing *United States v. Gillette Co.*, 406 F. Supp. 713 (D. Mass. 1975)); *see also United States v. Microsoft Corp.*, 56 F.3d 1448, 1458 (D.C. Cir. 1995) (public interest standard not altered by Tunney Act).

predicted in the Complaint"). The fact that the relief obtained in settlement in some respects goes beyond what could be obtained in a litigated judgment does not relieve the government from establishing a reasonable basis that the harms alleged in the complaint will be remedied. *Cf. SBC Communs.,* 489 F. Supp. at 15 ("Court cannot look beyond the complaint in making the public interest determination."). Moreover, while courts "accord deference to the government's predictions about the efficacy of its remedies," *id.* at 17, the "government" here includes the Health Policy Commission, not just the Attorney General. Indeed, the Legislature has specifically given the HPC the task of determining the market impact of health care mergers, and provided that the HCP's final reports "may be evidence" in an antitrust action brought by the Attorney General. G. L. c. 6D, § 13(h).

Moreover, if "the district judge can foresee difficulties in implementation, we would expect the court to insist that these matters be attended to." *United States v. Microsoft Corp*., 56 F.3d 1448, 1462 (D.C. Cir. 1995); *United States v. Apple, Inc*., 889 F. Supp. 2d 623. 631 (S.D. N.Y. 2012) (considering "foreseeable difficulties in implementation"); *see also Original Great Am. Chocolate Chip Cookie Co. v, River Valley Cookies, Ltd.*, 970 F.2d 273, 277 (7th Cir. 1992) (Posner, J.) ("Courts should be, and generally are, reluctant to issue 'regulatory' injunctions, that is injunctions that constitute the issuing court an ad hoc regulatory agency to supervise the activities of the parties.").

Where, as here, the proposed settlement will not adequately remedy the anticompetitive harms that are alleged in the complaint and confirmed by the HPC,[7] and the settlement will entangle the court in a regulatory role for which it is not suited, there is ample ground for rejecting it as not in the public interest.

III. The Remedy Is Inadequate to Restore Competition

A. The Standard for Merger Remedies

"The relief in an antitrust case must be 'effective to redress the violations' and 'to restore competition.'" *Ford Motor Company v. U.S.*, 405 U.S. 562, 573 (1972) (quoting *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 326 (1961)). In the merger context, "a successful merger remedy must effectively preserve competition in the relevant market." U.S. Dep't of Justice, Antitrust Div. Policy Guide to Merger Remedies at 1 (June 2011) ("DOJ 2011 Merger Remedies Guide"), *available at* http://www.justice.gov/atr/public/guidelines/272350.pdf; *see also* David A. Balto & Richard G. Parker, *The Evolving Approach to Merger Remedies*, Antitrust Rep. (May 2000), *available at* http://www.ftc.gov/speeches/other/remedies.htm ("The foremost

[7] The HPC's findings of anticompetitive harm provide support for analyzing "[t]he decree . . . on the assumption that the government would have won." *Gillette*, 406 F. Supp. at 716 n.2. *But cf. Microsoft*, 56 F.3d at 1461 & n.8 (disagreeing with *Gillette* where there are no findings by the court that the defendant has actually engaged in illegal practices). That is particularly true because the Legislature has expressly provided that the HPC's final reports may be evidence in the action. G. L. c. 6D, § 13(h).

obligation of antitrust enforcers is to make sure that a merger does not reduce competition to any significant extent").

As the Department of Justice has explained, "Structural relief [i.e., blocking the merger or requiring divestiture] is the preferred remedy in all merger cases, because it is 'relatively clean and certain, and generally avoids costly government entanglement in the market.'" Response of the United States to the Amicus Brief of Center for a Competitive Waste Industry at 4, *United States v. Republic Servs., Inc.*, 723 F. Supp. 2d 157 (D.D.C. 2010) (No. 08-2076) (quoting Antitrust Division Policy Guide on Merger Remedies at 7 (Oct. 2004) ("DOJ 2004 Merger Remedies Guide")). "A conduct remedy, on the other hand, typically is more difficult to craft, more cumbersome and costly to administer, and easier than a structural remedy to circumvent." DOJ 2004 Merger Remedies Guide at 8; *see also* Philip J. Weiser, *Reexamining the Legacy of Dual Regulation: Reforming Dual Merger Review by the DOJ and the FCC*, 61 Fed. Comm. L. J. 167, 176 (2008) ("in cases involving direct horizontal overlap between the two merging firms, the antitrust agencies are extraordinarily skeptical that any form of behavioral remedy will be appropriate").[8]

The Supreme Court explained the strong preference for structural relief over 50 years ago:

> [A]n injunction can hardly be detailed enough to cover in advance all the many fashions in which improper influence might manifest itself. And the policing of an injunction would probably involve the courts and the Government in regulation of private affairs more deeply than the administration of a simple order of divestiture. We think the public is entitled to the surer, cleaner remedy of divestiture.

E.I. du Pont de Nemours & Co., 366 U.S. at 334; *see also California v. Am. Stores Co.*, 495 U.S. 271, 285 (1990) (noting that divestiture is "the remedy best suited to redress the ills of an anticompetitive merger").

As we explain below, it is extraordinarily difficult to design conduct remedies that can effectively restore competition. Conduct remedies are based on an often-faulty premise that "the conduct of a profit-maximizing firm with market power can be effectively constrained by the imposition of operating rules combined with administrative oversight." John E. Kwoka & Diana L. Moss, *Behavioral Merger Remedies: Evaluation and Implication for Antitrust Enforcement*, 57 Antitrust Bull. 979, 997 (2012). In particular, conduct remedies fail because they involve asymmetry of information, often lack sufficient specificity, do not mitigate the firm's incentives to evade the decree, are

[8] While the 2011 version of the DOJ Merger Remedies Guide reflects a liberalization of the Department of Justice's view towards conduct remedies in resolving vertical mergers, the Department has remained that clear that it "will pursue a divestiture remedy [or block the merger] in the vast majority of cases involving horizontal mergers." DOJ 2011 Merger Remedies Guide at 5; *see also* Deborah L. Feinstein, *Editor's Note: Conduct Remedies: Tried But Not Tested*, 26 Antitrust, at 5, 6 (Fall 2011) ("Divestitures continue to be the remedy of choice—and with extremely rare exceptions—the only remedy for horizontal mergers at both the FTC and DOJ.").

costly to implement and monitor, require dispute resolution, and, as time-limited actions, do little to address entrenched market power. *Id.* at 998-1004.

Professor Kwoka has studied the use of conduct remedies in merger cases. He finds that conduct remedies are typically unsuccessful in preventing harm to consumers and competition. He explains:

> Conduct remedies do not preserve the same number of independent entities; rather, they allow industry consolidation. Conduct remedies do not preserve incentives for independent conduct; rather, they seek to thwart the natural incentives of the merged entity to behave as a single firm. Conduct remedies are not self-enforcing; rather, they require costly monitoring in an effort to secure compliance.

Kwoka Decl. at ¶ 8.

His review of retrospective merger studies tends to confirm the lack of effectiveness of conduct remedies:

> Within my database on carefully studied mergers are those that were subject only to conduct remedies. If these remedies were fully effective, these mergers should show no postmerger price increase net of other factors such things as general cost changes. But the data in fact show that mergers subject to conduct remedies resulted in price increases that averaged 16.0 percent—far above any benchmark, and indicative of the failure of conduct remedies to prevent harm to consumers and competition.

Id. at ¶ 10.[9]

Consistent with their deep skepticism of conduct remedies, the federal antitrust enforcement agencies have specifically rejected conduct remedies in hospital merger cases. As the Director of the FTC's Bureau of Competition recently explained:

> While parties in provider transactions often urge adoption of conduct remedies, the Commission generally rejects such requests. Conduct remedies do not restore the competitive status quo and raise several concerns. They are an inferior sub-stitute for allowing competition among separately owned providers to determine market behavior.[10]

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[9] *See* John E. Kwoka, Jr., *Does Merger Control Work? A Retrospective on U.S. Merger Enforcement Actions and Merger Outcomes*, 78 Antitrust L. J. 619, 619 (2013). The cases in the database in which conduct remedies were imposed were comprised of two post-consummation hospital challenges, and two cases in which conditions were imposed that did not require continuing oversight. *See id.* at 645-47.

[10] Deborah L. Feinstein, Director, Fed. Trade Comm'n Bureau of Competition, Antitrust Enforcement in Health Care: Proscription, not Prescription, Remarks at Fifth National Accountable Care Organization Summit at 15 (June 19, 2014), *available at* http://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech .pdf. Feinstein noted that the FTC made an exception for the merger of Evanston and Highland Park hospitals, and accepted a conduct remedy because of "unique

The FTC has also noted that conduct remedies are also ineffective because there are "greater long term costs associated with monitoring the efficacy of a conduct remedy than with imposing a structural solution." *In the Matter of ProMedica Health Systems, Inc.*, No. 9346, 2012 WL 1155392, at *48 (FTC Mar. 28, 2012) (internal quote marks and citation omitted). Courts have agreed with the FTC's stance and refused conduct remedies in two recent hospital mergers. In *St. Luke's*, the District Court of Idaho dismissed the suggested remedy of merging parties using separate negotiating teams with payers. *FTC v. St. Luke's Health System, Ltd.*, 2014 WL 407446 at *25 (D. Idaho, Jan. 24, 2014). In *ProMedica*, the Sixth Circuit also upheld the FTC's decision to reject the proposed remedy of separate negotiating teams. *ProMedica Health System, Inc. v. FTC*, 749 F.3d 559, 573 (6th Cir. 2014).[11]

While, as noted above, the Department of Justice ordinarily frowns upon purely conduct remedies for horizontal mergers, particularly where there are no impediments to structural relief, the Department has conveyed that, "recognizing that Massachusetts has a unique regulatory system [i.e., the Health Policy Commission], it "supports [the Attorney General's] efforts here and the conclusions [the Attorney General's Office] has reached with respect to the consent judgment." Motion Hearing Trans. at 42-43 (June 30, 2014). However, commentators have noted the significance of the fact that "the Antitrust Division . . . has not signed on to the proposed consent agreement . . . although the Department was investigating Partners alongside the Attorney General's Office." Robert F. Leibenluft & Leigh L. Oliver, *State Attorneys General Respond to Hospital Consolidation With Conduct Remedies That Aim to Strike a Balance Between Increased Concentration and Competition Laws*, 27 Antitrust Health Chron. 25, 29 (July 2014). Moreover, the Department's reference to the "unique regulatory system" in Massachusetts hardly seems to justify a conduct remedy here when the regulation in the decree is not being outsourced to regulators, and the HPC itself finds the proposed relief to be inadequate.

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circumstances"—the merger had occurred seven years prior to the enforcement action, integration had occurred, and there was a risk of patient safety with respect to cardiac services. Since that time, the FTC has "repeatedly rejected this sort of conduct remedy." *Id.* n. 43.

[11] States have occasionally permitted a hospital merger subject to a conduct remedy. However, those cases generally involve firms in financial distress, mergers that were necessary to achieve substantial efficiencies (or avoid substantial inefficiencies), and/or other unique circumstances not present in this case. For example, the Pennsylvania Attorney General's Office points to the 2001 Pittsburgh Children's Hospital case, where the merger avoided the potential establishment of a wasteful second pediatric hospital. *See* Comments of the Pennsylvania Office of Attorney General, August 28, 2014, at 2. In New York, the Attorney General recently settled a hospital merger with a conduct remedy where the hospitals operated in "challenging economic environment" and had "suffered financial losses in recent years" making it "highly questionable they can independently surmount these challenges without negatively impacting the availability of vital health care services in the Mohawk Valley." Press Release, New York State Office of the Attorney General, A.G. Schneiderman Announces Settlement With Utica Hospitals To Address Competitive Concerns (Dec. 11, 2013), *available at* http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-utica-hospitals-address-competitive-concerns.

With this background we turn to the flaws in the proposed remedy before the court.

B. General Flaws in the Proposed Final Judgment

Time limitation. The proposed settlement is at best a temporary solution that does not anticipate future market changes. The settlement has a ten-year lifespan, after which the new combined Partners entity can utilize its market power in any way it chooses. Moreover, the price caps last less than seven years. There is no basis to believe that the market will become *more* competitive during this time so that price constraints will become unnecessary. When the decree ends, Partners will be a much larger entity and the problems that the Attorney General is trying to address through this settlement will only be magnified. As the HPC explains:

> [W]ithout lasting change to the market structures and incentives that underlie the operation of bargaining leverage, there are inherent limitations to the capacity of time-limited price constraints to contain costs long-term. The proposed settlement does not permanently alter those features of the Partners system, such as its size and market share, which contribute to its current market power to command higher prices and other favorable contract terms. Rather, the settlement allows Partners to grow by acquiring Hallmark's hospitals, outpatient centers, associated physicians, and other providers. Thus, at the expiration of price constraints, Partners would likely enjoy even greater leverage to command supra-competitive rates and other favorable contract terms.

HPC Hallmark Final Report at 44.[12]

As the HPC and the academic economists comments point out, the few instances where price caps have been used in hospital mergers confirm that when price caps end, prices go up sharply, as one would expect if the price caps actually constrain price growth when they are in effect. *See id.* at 44 n.166; Comments of Academic Economists, July 21, 2014, at 6-7. For example, in the merger of Blodgett Memorial Center and Butterworth Hospital in Grand Rapids, Michigan, which was approved over the objection of the FTC, the merging hospitals agreed to freeze prices. *See FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1303 (W.D. Mich. 1996). But prices jumped substantially after the price cap ended. *See* David Balto and Meleah Geertsma, *Why Hospital Merger Antitrust Enforcement Remains Necessary: A Retrospective on the Butterworth Merger*, 34 J. Health L. 129, 148-49 (2001). Likewise after the two-year price

[12] To be sure, the proposed settlement contains a physician growth cap and a hospital acquisition restriction that arguably prevent the market from getting more concentrated *after* the mergers are allowed, although it is unclear how much of an actual constraint these restrictions will be. *See, e.g.,* HPC Hallmark Final Report at 10 (noting that, for the next three years, Partners can acquire 550 more physicians and remain under the cap). In any event, such restraints do nothing to address the anticompetitive harm at issue, including from Partners adding some 465 physicians from South Shore and Harbor, and economically integrating some 400 physicians from Hallmark.

cap imposed by the New York State's Attorney General on a merger between Long Island Jewish Medical Center and North Shore Health System ended, the merged hospital reported greater "negotiating clout" and raised prices. Stewart Ain, *After Merger's Bumpy Start, North Shore-L.I.J. is Clicking*, N.Y. Times, Dec. 17, 2000, http://www.nytimes.com/2000/12/17/nyregion/after-merger-s-bumpy-start-north-shore-lij-is-clicking.html?module.

Institutional competence. The proposed remedy also fails the basic institutional competence test. While courts may be skilled at merger review, the Attorney General and the court are not regulators and lack the capability and expertise to regulate the market once a merger has been completed. The proposed settlement is lengthy (48 pages, plus a 23-page attachment devoted to price regulation, plus 12 pages of exhibits), complex, and highly technical. And while a compliance monitor no doubt will be helpful (indeed, essential) in assisting the Attorney General obtain information to secure compliance, a monitor is no panacea.

The decree is hardly self-enforcing. It requires the court to enforce numerous ambiguous terms, and indeed provides that in at least ten specific instances the parties (either Partners or the Attorney General) may petition the court to resolve disagreements over implementation.[13] The list includes disputes over:

(1) whether a physician should continue to be treated as a Harbor physician;

(2) whether a material change to a contracting component will undermine the goals and objectives of the component contracting option;

(3) whether a physician group that is not a corporate affiliate may become a member of a Partners Hospital PHO based on sufficient clinical integration;

(4) extending the end of Emerson's implementation period;

(5) increasing the AMC PCP Cap based on four criteria;

(6) determining the annual budget for compliance monitoring;

(7) whether a statutory or regulatory change prevents compliance;[14]

(8) whether the compliance monitor is requesting irrelevant information or data concerning the unit price growth cap;

(9) whether the compliance monitor is requesting irrelevant information or data concerning the TME growth cap; and

(10) whether unanticipated market conditions that affect utilization justify an increase in the TME growth cap.

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[13] Proposed Final Judgment, ¶¶ 33, 70, 88. 90, 103, 128, 148, Att. A at 10, 17, 22.

[14] The proposed decree appears to provide that if a statutory or regulatory change increases Partners' consolidated costs by more than .5% of its consolidated commercial revenue, Partners will no longer be bound by the decree. *Id.* at ¶ 148.

It seems obvious that oversight of the decree will require a significant amount of the court's time and resources over the next ten years. However, unlike a regulatory agency, the judiciary lacks the time and resources to devote to regulatory oversight. Such judicial economy concerns militate against approving the settlement. *See Microsoft,* 56 F.3d at 1462 (court should be mindful of "difficulties in implementation"); *Original Great Am. Chocolate Chip Cookie,* 970 F.2d at 277-78 ("the cost (broadly conceived) of regulatory decrees to the judiciary is a factor weighing against the grant of equitable relief").

Incentives and information. The proposed remedy suffers from the dual problems on which conduct remedies generally founder, from an economic point of view, namely incentives and information. Kwoka Decl. ¶ 11. As to incentives, Professor Kwoka explains,

> The incentive problem arises since conduct remedies are employed essentially to make a merged company act against its own self-interest, that is, in ways that do not fully utilize the market power inherent in its size and structure. The company can therefore be expected constantly to seek methods of crowding the border of stated rules and to identify alternative methods not proscribed by the rules to achieve its objectives. These alternatives will be greater to the extent that (a) the product or transaction is complex, since complexity offers more opportunities to evade the intent of any rule, and (b) the remedy or rule is in existence for a long period of time, since the passage of time changes circumstances and creates new ways to evade the intent of any rule.

Id.

Professor Kwoka notes, "Both of these features attend the conduct remedy proposed for this transaction. The remedy, like the health care products at issue, involves complex contractual arrangements that have numerous features and trade-offs, altogether unlike, say, the price of a single homogeneous good transacted between buyer and seller. Moreover, the remedy is intended to be in existence over a period of a decade, during which time it is impossible to imagine the changes likely to occur in the health care market and equally impossible now to write down the remedy provisions necessary to effect the same result in those changed circumstances." *Id.* at ¶ 12.

And as to information, while a compliance monitor will certainly help, Professor Kwoka explains that "[t]he information necessary to enforce a conduct remedy lies primarily with the merged company and is only imperfectly perceived by the antitrust agency or outside monitor." *Id.* at ¶ 13. Effective enforcement will depend on firms that are willing to complain when provisions of the decree are violated. But payers may be particularly unwilling to complain and avail themselves of the proposed conduct remedies for fear of retaliation. As Professor Kwoka explains:

> While overt retaliation may be apparent, the relationship between the parties may be multifaceted and ongoing, and can afford ample

> opportunities for the merged company to exact a penalty against complainants without that being evident and unambiguous. The targeted party, knowing that at the end of the day it will still be locked into a business relationship with the merged company, may understandably and rationally be reluctant to report its concern.

Id.

C. Flaws in Specific Provisions

Price Growth Restrictions. The FTC and Department of Justice Antitrust Division have flatly rejected the use of price caps: "The Agencies do not accept community commitments [i.e., promises not to raise prices] as a resolution to likely anticompetitive effects from a hospital (or any other) merger. The Agencies believe community commitments are an ineffective short-term regulatory approach to what is ultimately a problem of competition." U.S. Dept. of Justice & Fed. Trade Comm'n, *Improving Health Care: A Dose of Competition*, ch. 4, at 29 (2004) ("*Health Care Report*");[15] *see also FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 67 (D.D.C. 1998) (rejecting effort to approve a merger based on a commitment not to raise prices).

There are several reasons to be skeptical about the effectiveness of the proposed price cap remedy here, besides the fact that, as noted above, it is time limited:

First, the price caps are limited in scope. As the HPC notes, the unit price growth cap does nothing to prevent price increases projected as a result of shifts in patient flow from lower-priced providers to higher-priced Partners providers. Comments of Health Policy Commission, July 17, 2014, at 16. And the TME cap, which could address this issue, applies only to Partners' patients utilizing "Risk Arrangement" contracts, which is just "11% of Partners' total commercial business." *Id.* Therefore, 89% of Partners' business goes "unmonitored" by the TME cap. Moreover, neither of the price caps applies to Medicaid Managed Care ("MMC"), which accounts for over 832,000 subscribers,[16] or Medicare Advantage ("MA"), which accounts for over 242,000 subscribers.[17] These privately run MMC and MA plans act as cost-effective and efficient

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[15] The Agencies explain that "such commitments do not solve the underlying competitive problem when a hospital merger has changed market circumstances in ways that increase the likelihood that market power will be exercised." *Health Care Report*, ch. 4, at 29, available at http://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice; *see also* Mary Lou Steptoe & David Balto, *Finding the Right Prescription: The FTC's Use of Innovative Merger Remedies*, 10 Antitrust, at 16, 20 (Fall 1995) ("The FTC has consistently rejected these [price regulation] proposals on the grounds that it is not a price-regulatory agency, compliance is difficult to monitor, and competition is the proper driving force for pricing decisions.").

[16] Medicaid Managed Care Enrollment Report, Center for Medicare and Medicaid Services 4 (July 1, 2011), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

[17] Medicare Advantage/Part D Contract and Enrollment Data, CMS.gov (July 2014), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-

alternatives to their government run counterparts. With no caps on price increases to these quasi-private plans, both the state of Massachusetts and plan beneficiaries could see increased prices.

Second, as Professor Kwoka points out, "Price regulation is an inherently difficult and complicated task, as demonstrated by the need for a 23 page explanatory attachment and 12 additional pages of examples." Kwoka Decl. ¶ 19 (also noting complexity of adjustments to the TME). But as complex as the settlement is, Professor Kwoka finds that it falls short in many respects. *Id.* ¶ 17 ("[P]rice regulation requires careful design, on-going monitoring, mid-course adjustments, attention to adverse side effects, and more."). The academic economists point out that price regulation, even by a regulatory agency, "is likely to be most successful in mature industries where price and quality are relatively easy to measure, demand and cost are relatively stable, and innovation is limited. These conditions do not characterize healthcare markets of today." Comments of Academic Economists at 4. On the contrary, "There is widespread agreement that price is extremely hard to measure in the healthcare sector." *Id.* at 6.

Among the limitations of the unit price growth cap is that it applies to total payments by a particular payer to providers in the Partners Network "associated with the set of services provided by [the] providers." Proposed Final Judgment, Att. A at 6. But what happens when the nature of the services changes? As Professor Kwoka notes, "price cap plans must allow for some services in the index to disappear and other new services to be integrated in a fashion that correctly accounts for market adjustments. This is particularly important when plans are expected to last for many years, as is the case here." Kwoka Decl. ¶ 18. But he does not find attention to this and other necessary features of effective price controls. *Id.*; *see also* Leibenluft & Oliver at 30 ("It may also be difficult to assess reimbursement increases in future contracts if there are substantial changes in the nature or quality of the services furnished by the hospital, their patient mix, or the payment methodology, e.g., to involve risk-sharing or value-based purchasing.").[18]

Third, price caps allowing price increases consistent with inflation may be ineffective insofar as prices, absent the merger, would increase by less than the relevant inflation index. And as the Academic Economists point out, "if the cost curve does 'bend,' residents of Massachusetts will reap more of the benefits in a less concentrated provider market, and this settlement enables the opposite." Comments of Academic Economists at 5; *see also Cardinal Health*, 12 F. Supp. 2d at 65 ("promise not to raise price

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andReports/MCRAdvPartDEnrolData /Monthly-MA-Enrollment-by-State-County-Contract-Items/MA-Enrollment-by-SCC-201407.html?DLPage=1&DLSort=1&DLSortDir=descending.

[18] Moreover, as the HPC points out, "Partners appears to retain certain flexibility to allocate price increases across providers to maximize revenue and market position. For example, without an individual price cap, Hallmark providers may experience unit price growth faster than the rate of general inflation." HPC Comments at 3.

prices fails to ensure that prices will . . . fall by the amount they would have absent the merger").

Fourth, health care quality is just as important as price, and competition is an important driver of quality. But a price cap cannot protect against a diminution of quality or staffing. On the contrary, it may lead to reductions in quality. Again, Professor Kwoka explains: "The logic is rooted in incentives: if the firm cannot raise price, the sole means of increasing profit is to reduce costs, which may compromise quality. While there are mechanisms in some price cap plans to blunt this effect, this proposed plan does not contain them." Kwoka Decl. ¶18; *see* DOJ 2004 Merger Remedies Guide at 8 ("[A] requirement that the merged firm not raise price may lead it profitably, and inefficiently, to reduce its costs by cutting back on quality—thereby effecting an anticompetitive increase in the 'quality adjusted' price"). At the same time, a price cap does not replace the loss in competitive incentives to cut wasteful spending.[19]

Fifth, the price cap mechanism does not necessarily benefit ultimate health care consumers because if Partners exceeds the cap in any period, leading to higher premiums, the retroactive refunds called for under the settlement may simply be pocketed by payers. Although the proposed judgment states that the intent of the parties is that "this remedy be for the benefit of the market and as such all refunds to the Payers should be reflected in the cost to the consumers of the Health Insurance Products to which such refunds are applicable," Proposed Final Judgment, Att. A at 14, no apparent mechanism ensures such a result.

Finally, to the extent it is relevant whether the purported benefits of the settlement extend beyond the remedies available if the state prevailed in the lawsuit, it is important to recognize that the price cap is based on Partners' already supra-competitive prices. As Professor Kwoka states, "There is no effort in the plan to determine whether initial prices are set at a correct level. Indeed, since the record indicates that Partners' prices are in fact significantly above the norm, this plan would enshrine that enduring benefit to Partners." Kwoka Decl. ¶17. The HPC has confirmed that Partners' hospitals generally receive the highest prices in their region, and Partners' physician groups also receive higher prices than nearly all other physician groups in Massachusetts. *See* HPC Comments at 10. And the HPC notes that "one consequence of the exercise of Partners' bargaining leverage, historically and anticipated in connection with this transaction, is the perpetuation or exacerbation of supra-competitive rate differences between Partners and competing providers." HPC Final Hallmark Report, Ex. B, at 2; *see also* Leibenluft & Oliver at 30 ("[T]he price caps in Massachusetts are tied

[19] As the HPC explains, "[H]ospitals with stronger market leverage can earn higher revenues from commercial payers and therefore have less pressure to constrain their expenses," whereas "hospitals with limited market leverage receive lower rates of commercial reimbursement and, under greater financial pressure, tend to be more aggressive at maintaining lower operating expenses." Mass. Health Pol'y Comm'n, 2013 Cost Trends Report Pursuant to G.L. c. 6d § 8(G): Annual Report at 34 (Jan. 8, 2014); *see also* Medicare Payment Advisory Comm'n, *Report to Congress: Medicare Payment Policy* 46, 62-64 (March 2009) (explaining that hospitals with market power tend to have higher costs and lower Medicare margins).

to inflation or medical inflation, but they do nothing to remedy a disparity in rates between Partners and other health care providers in the region or to drive competition to pass on any savings beyond what is required by the nature of the cap.").

Component Contracting. The purpose of the component contracting provision is to attempt to counteract the increase in leverage that Partners will secure by adding key hospitals and physician groups to its network, and perhaps reduce its existing leverage, by prohibiting it from making "all or nothing" demands on payers. So, for example, if payers "must have" Partners academic medical centers (AMCs) in their networks, they will not be forced to accept Partners' community hospitals in general, or South Shore or Hallmark in particular. Although this "anti-tying" relief sounds good in principle, and goes beyond what could be obtained by litigating the complaint as drafted,[20] there are many flaws in this approach.[21]

As an initial matter, the component contracting will do little or nothing to alter Partners' ability and incentives to increase prices post-merger. The provision does not purport to address the direct loss of competition from the transaction by allowing separate negotiations between payers and various "components." Such an approach would not work even if it were so designed because separate negotiators cannot be forced to not maximize their employer's profits. *See* Kwoka Decl. ¶ 14 & n.3; Comments of Academic Economists at 4-5.

Having separate negotiating teams as a remedy was tried once before, in the Evanston hospital merger case, and was a dismal failure. In *Evanston*, the merger was consummated seven years earlier and there had been substantial integration, so divestiture was not a realistic option. In addition, the FTC believed that patient safety, especially with respect to cardiac services, was threatened by divestiture. Faced with these challenges, the FTC took a gamble on the unique remedy of separate negotiating teams. However, after separate, independent negotiating teams for Evanston and Highland Park Hospital were offered, apparently no insurer chose to deal with the entities separately. See Academic Economists Comments at 5. And the one academic study of separate negotiations has concluded it would not prevent price increases. Gautam Gowrisankaran et al., *Mergers When Prices are Negotiated: Evidence from the Hospital Industry* 29-30 (July 2014) (forthcoming Am. Econ. Rev. 2014), *available at* http://www.u.arizona.edu/~gowrisan/pdf_papers/hospital_merger_negotiated_

[20] The Attorney General has not explained why Partners' continued contracting on behalf of Hallmark if the merger were blocked could not be challenged under the same theory it has challenged Partners' contracting on behalf of unowned affiliate physician groups, or why a tying claim could not be brought to challenge Partners' bundling of its AMCs with community hospitals. To be sure, it is inappropriate for the court to consider claims that the Attorney General *could* have brought in evaluating whether the settlement is in the public interest. But if the Attorney General wants to use the "extra complaint" benefits to justify the settlement, then it seems fair to ask why a different complaint could not be brought to achieve them.

[21] To the extent that component contracting offers potential benefits, the units that have been defined are so broad and encompassing as to undermine the remedy's benefits. Payers need to be able to unbundle within the AMC and community hospital units in order to have real choice.

prices.pdf ("Empirically, separate negotiations do not appear to solve the problem of bargaining leverage by hospitals.").

The Attorney General suggests that the component contracting requirement may indirectly temper price increases because if Partners sought to raise the price of South Shore or Hallmark, a payer could reject the demand and still be able to obtain the rest of Partners' components. However, the HPC explains why "component contracting is unlikely to be effective in eliminating a provider organization's ability and incentives to raise prices where, as here, the provider organization consists of components that are direct competitors." HPC Final Hallmark Report at 43. And that is because "[e]ven if a payer could construct an insurance network for local residents that did not include Hallmark [or South Shore], it would still need alternate hospitals to serve those patients, and Partners owns the next most popular hospitals as well." *Id.* at 43 n.160. "Thus, a payer threatening to exclude Hallmark [or South Shore] from its network would not necessarily be able to leverage the loss of this patient volume in contract negotiations, since a significant portion of these patients would simply seek care from other Partners providers." *Id.*, Ex. B at 5-6 (citing unilateral effects analysis in Horizontal Merger Guidelines); *see also FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d at 1086 (fact that payers would not have to contract on a system-wide basis "does nothing to limit the ability [of hospital system] to raise prices" for the merged hospitals).

Second, the component contracting remedy is also flawed because the proposed settlement does not provide sufficient protection from actions Partners can take to make component contracting unattractive. While Partners cannot make inclusion of one component expressly contingent on a payer's acceptance of another component, it is unclear whether differential pricing is permitted (i.e., lower prices for taking a bundle than for taking the components separately). As Professor Kwoka observes, the component contracting provision "states that there shall be no contingent offerings of components . . . [y]et nothing seemingly prevents the merged system from pricing and structuring its component offerings so as to induce the same result." Kwoka Decl. ¶15. "[T]here is no simple statement of principles that [would] preclude [bundling] strategies; the possibilities are extremely difficult to enumerate ex ante and extremely difficult to prevent ex post." *Id.*

Another provision prohibits discrimination or retaliatory actions against a payer who chooses not to take a component. However, it will be difficult to determine whether any form of discrimination or retaliation has occurred. Even assuming a payer was willing to complain, the proposed remedy's reference to the principle that component contracting shall be offered on a "fair and non-discriminatory basis" hardly provides any standards for enforcement. Given the many pricing and contracting variables Partners could use to make component contracting unattractive, and the unique contractual arrangements with each payer, it will be particularly difficult and time consuming for the Attorney General and the court to enforce this provision, assuming there is a demand for component contracting in the first place.

Finally, there are sound reasons to be skeptical about whether payers will use component contracting. The HPC raised questions about the extent to which payers would pursue the component contracting option. The HPC explained:

> Another consideration is how component contracting will operate in the context of a shift to integrated care delivery structures, and whether purchasers and consumers find more limited networks that include only components of provider systems appealing. The effectiveness of component contracting is premised on the potential exclusion of certain providers within a provider system from payer networks. This may present care coordination and referral challenges for both consumers and providers, especially in the context of a shift to global payment arrangements, which generally seek to reimburse providers for coordinating care across their entire networks.

HPC Final Hallmark Report, Ex. B, at 6.

Partners will still have the incentive and ability to encourage its physicians and hospitals to direct patients to its own hospitals, even if they are out of network. For example, assume a payer chooses Partners' community hospitals and physicians but selects a rival academic medical center. If the patient needs tertiary care services, the Partners physician can be expected to discourage the use of the rival academic medical center where the physician lacks privileges. The patient will rebel at being forced to go "out of system," and these complaints ultimately will limit the ability of payers to negotiate for component contracts. See *id.*, Ex. B, at 6 n.21. Moreover, insofar as clinical integration among the components is more extensive than between the components and non-Partners' providers, as one would expect, then the attractiveness of component contracting will be further limited.

In short, the component contracting provision seems to be at cross-purposes with the purported efficiency justification for the mergers, namely the deep integration of South Shore and Hallmark into the Partners' network.

IV. Conclusion

AAI has long been a champion of state antitrust enforcement. Just as the States can be "laboratories of democracy," they can and have been antitrust innovators. Indeed, Massachusetts has led the way. For example, Massachusetts was a leader of a group of states that brought a joint suit with the Justice Department against Microsoft, and it was the only state to challenge the effectiveness of the Justice Department settlement up through an appeal to the D.C. Circuit. *See Massachusetts v. Microsoft Corp.*, 373 F.3d 1199 (D.C. Cir. 2004). However, some innovations, like the conduct remedy here, are better left on the drawing board.

In theory, it might make sense to allow an anticompetitive merger that is necessary to achieve substantial efficiencies if the anticompetitive effects could be mitigated by an effective conduct remedy. But that is not the situation here. The HPC

reports indicate that significant efficiencies would not likely be sacrificed by stopping the mergers. *See, e.g.*, HPC Hallmark Final Report at 69 (questioning "how corporate ownership is instrumental to improving clinical quality in ways the parties' longstanding affiliation has not, or that implementation of care delivery reforms necessarily requires ownership of Hallmark"); HPC SSH Report at 2 (noting that given South Shore's "historically strong quality performance, and their own experience managing populations through risk-based payments, it is unclear how corporate integration of the parties is instrumental to raising quality performance in the South Shore region"). And, as we have demonstrated, there is no reasonable basis to believe that the price caps and component contracting would be effective in preventing the competitive harms alleged in the complaint and confirmed by the HPC.

It is evident that the acquisitions of South Shore and Hallmark will further cement Partners' already substantial market power in Eastern Massachusetts. In a best-case scenario, the proposed remedies act as a porous stopgap to constrain Partners from raising its already supra-competitive prices. To ensure even that limited outcome, the Attorney General and the courts will have to become vigilant health care price regulators, a task for which neither is well suited, even with the assistance of a monitor. Accordingly, the court should reject the proposed settlement as not in the public interest.

Respectfully submitted,

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