



**Health Care Consolidation:
What You Need to Know
The National Press Club, Fourth Estate
Health Affairs
JKTG Foundation
Alliance for Health Reform
Tuesday, December 15, 2015**

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Marilyn Serafini: Let's go ahead and get started. I want to be respectful of everybody's time. I'm sure that some other reporters are going to trickle in. Welcome, to today's briefing on the subject of healthcare consolidation. I would like to thank our partners Health Affairs and the Jayne Koskinas Ted Giovanis (JKTG) Foundation for their support of this briefing. I'm actually going to turn it over to Alan Weil, who is the Editor of Health Affairs, to get us started.

Alan Weil: Thank you, Marilyn. I'm Alan Weil Editor-in-Chief of Health Affairs. We're really happy to have you here. It's a great pleasure to have a panel full of lawyers. We don't get to do that very often, so it's a particular joy. I'm just going to give literally a two minute introduction to the topic, so that we're clear how important this morning's conversation is for healthcare. The consistent theme in healthcare right now is consolidation, but there's tremendous variability in how that's playing out in different parts of the healthcare sector. We have consolidation within the healthcare provider community both horizontally and vertically. We have hospitals and physician practices merging and consolidating. We also have it vertically with alignment between hospitals, physicians, home-health agencies, and the like. We have consolidation going on in the pharmaceutical industry. We have consolidation going on in the insurance industry. So at one level you'd think, well, this is all consolidation, and we just need to figure out whether that's a good or a bad thing, but it turns out that the rationale offered for these different sectors is quite variable in that horizontal mergers are really designed, purportedly, to build efficiencies and to improve information flow within a sector. Similarly vertically, we're changing payment models, and that suggest the need for alignment between hospitals, physicians, and other healthcare providers to provide more continuity of care. In the pharmacy space in addition to the tax issues, which I don't know that we'll get into today having to do with international borders, there's the high cost of drug discovery and bringing products to markets. In insurance the rationale is everyone else is doing it, and if we don't do it, we can't negotiate effectively against a consolidated provider system, so, a consistent theme of consolidation but tremendous variability in the rationales offered. At Health Affairs we publish a lot that's relevant, but it turns out that the legal structure and the evidence base for whether these mergers are a good or a bad thing ultimately for consumer is pretty thin. The legal structure, really, comes out of an industrial era, and the economic analysis around consolidation doesn't primarily come out of healthcare, and it certainly doesn't come out of insurance. The changes coming out of those two fields are an important backdrop. So we've got a lot to cover. I'll turn it back to Marilyn to introduce our speakers this morning.

Marilyn Serafini: Fantastic. Thank you, Alan. The one thing I wanted to point out, in your packets, you do have a piece that comes from the L.A. Times on inversions. We are not going to focus so much on inversions today. Of course, we are going to focus; we are going to talk quite a bit about pharmaceutical industry consolidation. But the reason that we put this piece in here, even though we're not going to get much into it today, is that there is legislative activity brewing in this area. If you're not familiar with inversions, these are deals that involve foreign companies and moving headquarters overseas with the purpose of avoiding taxes or [of] lowering taxes. You do have a piece in here about this, and there could be legislation, we understand, coming up as early as January or February. With that let me introduce our speakers today. On the other side of that we have Debbie Feinstein. She's director of the Bureau of

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Competition at the Federal Trade Commission. She has also been a partner at Arnold & Porter heading their U.S. antitrust practice group. You have full biographies in your packets, so I'm just going to give you the highlights here. On Debbie's other side is George Slover. He's senior policy counsel at Consumer's Union. He has served in all three branches of the government here including the House Judiciary Committee, the House Energy and Commerce Committee, and the Department of Justice in their Antitrust Division. To my left is Andrea Marino. She's a partner and co-chair of Goodwin Procter's antitrust practice. As all of our panelists today, she has done double duty or triple duty. She's been at the FTC. She's been at the Department of Justice. So we have a really exciting panel today. I am going to turn it over to each of them to give us some introductory remarks, and then we'll open it up for your questions. I am going to open it up first to Debbie.

Deborah Feinstein: Well, thanks. It's really a pleasure to be here. I have to start with the usual caveat that my views are my own and not necessarily those of the commission or any individual commissioner. I want to talk to you briefly because I'm interested in your questions about what you want to hear about, about a couple of areas. I want to start with a couple of overview points. First the Federal Trade Commission and the Department of Justice Antitrust Division share jurisdiction in the antitrust area. Typically the FTC does a provider-side transaction, so hospitals and pharmaceuticals, the Department of Justice looks at insurance mergers. So I'm not going to be able to talk with any specificity about the insurance mergers because that's what DOJ covers. I can talk to you about general types of arguments and how they might be addressed if they're not specific to particular mergers. The second thing I want to make clear, because I think it's very different than a number of the agencies that you cover is we are not a regulatory body. We get called the regulators all of the time. We're not. We're law enforcement agency. The reason that matters is we can't simply decree things. We can't simply say this is legal, this is not legal, here's the framework that you have to apply or you violated our rule. We have to go to court if we want to challenge a transaction or a practice either [to] federal court or [to] our own administrative court. That's just - you have to bear that in mind when you think about what it is that we do. I want to talk about a couple of areas that we've been focusing on lately. One is hospital mergers. Primarily our focus has been on horizontal combination, hospitals that are competing with each other, competing both to negotiate with insurance companies and competing to actually get patients in the door in the same geographic area. There are hundreds of these transactions a year. We challenge a handful of them when we find that they're problematic. A little history is important. Hospital mergers and the FTC's concern about them is not something new. This has been going on for decades, and candidly the FTC was on a bit of a losing streak in the '90s. They sort of sat back and regrouped and took a really hard look at what they were doing and why. The agency was finding that these deals were problematic but the courts were not finding it. So the Bureau of Economics did a number of retrospective studies. They looked at transactions that had gone through that we thought might be problematic and, low and behold, found that there was quite clear evidence that these were in fact increasing prices. They used that to develop better models to determine the likelihood that a transaction would increase prices and use that as a way to start explaining the story. Lately the governments been on more of a winning streak when it's come to hospital mergers. We're continuing to bring challenges. We brought one about a month ago to a combination of West Virginia hospitals, and last week we brought a challenge to a

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combination of Pennsylvania hospitals. I should not that our analysis does take into account things such as quality and cost savings and other benefits. We take very seriously a couple of things, one, whether a company is failing. If there are hospitals that are in fact about to go bankrupt and are about to close their doors, acquisition by a nearby competitor is better than the hospital simply closing the door. And so that is something that we take into account. We look at the quality implications. If we were to see actual evidence that a transaction would increase quality even if it meant a little bit of a price increase because that would be a quality adjusted neutral, right? If you pay five dollars for something that's this good, but you pay ten dollars for something that's [only] twice as good, that's not necessarily viewed as a price increase because when you look at the quality adjustment it might not be so problematic. That might be, on balance, good for consumers. We haven't seen that case. We haven't seen the case where the transaction is otherwise anticompetitive, but the quality outweighs the competitive concerns, but it's something that we're alert to. Finally something to note on hospital mergers is we frequently hear that there is a conflict between the Affordable Care Act and antitrust enforcement. It might be the question that I've gotten most in the two and a half years of [doing] this job is, isn't there a conflict between the antitrust laws and the ACA? I would say an emphatic no. If you look at the ACA, it specifically says it's not meant to supplant competition. We think that it is quite clear that the goals of the ACA and antitrust are in harmony not in conflict. What we often find is that there are other practical ways of achieving coordinated care and alternative payment models beyond merging with a close competitor. The final thing to say is often when we do find a problem the remedy in most transaction outside of the hospital area are divestitures, good example, grocery stores. You have two nearby grocery stores in a market, the solution is one of the grocery stores gets sold to somebody else, and competition is restored. Often in hospital mergers, we get promises, that [which] are proffered to us from the hospitals, that they will simply agree to price caps, agree not to change their behavior, agree to increase prices only at the rate of inflation. Those are not remedies that the FTC finds acceptable for a couple of reasons. One, we can't guess what the right price is. Prices may go up, prices may go down. Second [Two]; the literature makes quite clear that when you put a price cap on something, the quality diminishes. There's no way to make people promise to increase quality, to innovate as much as they otherwise would. We find these sorts of conduct remedies problematic. I think that's why you see more than the usual number of hospital cases get litigated because often they're two hospital combinations. There is no divestiture that will work because that would undo the deal entirely. That's why I think you sometimes see litigation there. All the things that I've said about hospital mergers really apply to other provider mergers. We've brought cases against outpatient clinic combinations. We've brought challenges against combinations of physician-practice groups as well. We've looked at and not yet brought a case, vertical transactions when a hospital acquires a physician group. It's an issue that could be problematic, but it depends on the facts and that's not a case that we've brought yet. There's lots more to talk about, but I want to make sure that we have time for questions and the like. Let me turn for a minute to pharmaceutical transactions. At one level, it's interesting because the pharmaceutical arena is really quite fragmented in the sense that there are literally dozens upon dozens upon dozens of companies that due pharmaceuticals. What we look at is pretty narrowly the combination of particular products for particular end uses. We go so narrow as to determine whether or not they're the same mechanism of action. What we've also found through our investigations is that while the combination of

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a brand and the first generic company can affect prices, because when a generic comes in it lowers the price, [so] that when the second generic comes in the brand sort of becomes somewhat irrelevant to the competition, and you can have a market that just consists of the two generic products, and so the merger of two generics can be anticompetitive even if the brand is still out there. And that's true of the third, and the fourth, and the fifth generic. There's been a lot of empirical research that says at least up to four or five generics, the entry of each new one actually decreases price, and that's the reason that we're worried about the combination of both brand-brand, brand-generic, and generic-generic. This has been an area of constant enforcement. In the past decade we've probably done several dozen consents, which have led to the divestiture of hundreds of products. We're seeing particularly large deals now, I think, because of the incentives with the tax inversion laws, and so we're seeing the really large transactions such as the Pfizer, Allergan; the Teva, Allergan; the Mylan, Perrigo; Teva, Mylan spat much of which was caused by the inversion tax laws. So we think we will continue to see these. For the most part these transactions end up being allowed to proceed with divestitures when we require divestitures, we require pretty fulsome divestitures. We want to make sure that everything that the buyer needs to continue to manufacture, sell, and develop the product are part of the package. We typically require that there be a monitor. It's chosen by the companies involved. We approve the monitor. They pay for the monitor, but the monitor reports directly to us not to them to ensure that the commitments that they've made are carried out. They're usually specialists in the area. We don't use just in pharmaceuticals, but they've been particularly prevalent in pharmaceuticals. We always require an upfront buyer. We want to know who they buyer is going to be, and we want to make sure that they have the capabilities to continue. We're currently undertaking a remedy study to determine whether all of our consents are effective and including that is a substantial component that's going to look at the pharma area consents. One other area that I want to mention is high drug prices. We get asked a lot what can the FTC do about high prescription-drug prices. Again a couple of things to note. We are not a regulatory body. We cannot simply put a cap on prices even that was a good idea, which I think there's a lot of questions about whether or not that would be workable, and whether or not it might reduce innovation. There'd have to be a lot of thought about that. That is not something we can do. We can only bring actions under the antitrust laws. And so it is not illegal to have a monopoly. If you developed the better mousetrap, if you developed patent rights to that, you get a monopoly. Simply exercising that monopoly by charging a high price is not against the antitrust laws. Now if you use that monopoly and do something that is exclusionary, for instance, you entered into the agreement with all of the only suppliers for a particular pharmaceutical ingredient, that might be an active monopolization. If you enter into an illegal agreement, a price fixing agreement, an exclusive dealing agreement. Again, that might be illegal. Certainly our reverse-patent settlement pay for delay cases are an example of an agreement between competitors that may lead to higher prices that are anticompetitive, but sometimes the high drug prices--and we look at them often--simply come about because a new owner had a different strategy and decided to increase the prices as much as it could and by itself, if the companies didn't have competing products and it's literally just a change of ownership and a different philosophy, that is not typically something that we can do anything about because it is not an antitrust violation, but we do look every time we see this to see why it is that the prices have increased in the hopes that there might

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be something that we could do. I think that's sort of an overview of some of the key things that we're doing, and I'll turn it over to our next speaker.

Marilyn Serafini: Great. Thanks. Let's switch over to this side to Andrea.

Andrea Murino: Thank you so much, Marilyn, and thank you so much for having me here today. It's a real pleasure. I am in private practice, although I have spent my entire career doing antitrust, and I listen very intently any time Debbie speaks because it's her advice that I end up having to consider and give back to my clients. So this is just as informative for me as it is for all of you hearing her thoughts. That said I think I have a slightly different take on some of her comments, so I'm going to talk. I'll talk about insurance markets; I'll talk about provider and hospital consolidation and then lastly just get onto the topic of pharma as well. In terms of insurance markets, I'm not involved in any of these transactions, but the thing in which I'm most interested in seeing, how DOJ undertakes this investigation, is their concept of a national market and their concept of leverage. Bill Baer who is in charge of the Antitrust Division, a former partner of Debbie, somebody very well known to the antitrust community has given speeches not about healthcare but about other kinds of industries where he's noted his concerns about what is leverage, what is having national power. Although healthcare antitrust analysis has some very distinct and discreet aspects that are completely different from other kinds of industries, I think it's important to remember that that's his view, that's his policy. If that's his vent, then I think that you can expect that to carry over, at least a little bit, into his review of the insurance markets and into what DOJ is doing. As I think about those two pending, very large insurance mergers, the things that occur to me is that these are very well counseled, very sophisticated entities; and that the analysis and the investigation are likely to be very heavy on economics and very heavy on what we might consider natural experiments, so that is, they're going to try to convince DOJ that they believe this is what will happen if these mergers are allowed to go through. Now merger enforcement is predictive, entirely, in nature. You look at what the statute is. It's absolutely prospective. And so the private-party economists are going to have the challenge of convincing the government that they believe prices, quality, all of the things antitrust concerns itself with will be prices will be reduced but quality will not be reduced. So I assume this investigation is proceeding as a very data-heavy exercise. The other thing of which I think you see a lot in the press, the CEOs and the other leaders of these organizations are talking about how there's not much geographic overlap. In certain regions they don't even compete against each other. That could very well be true. But again going back to sort of this view of national markets, you saw it in AT&T, T-Mobile several years ago when the DOJ challenged it. Again, that's not a healthcare deal, but I think it's still illustrative. There the DOJ said we think that we should not be reducing the number of national providers, even though, on a regional level, you may have had additional choices. You saw it very recently just last week when the FTC challenged the Staples, Office Depot deal. You saw it earlier this year when the FTC challenged the Cisco, U.S. Foods transaction. The concept of a national market and having national power, I think, is going to be, again, another challenge for these insurers to have to overcome. Then you move to the remedy. Obviously, Debbie described in pharma markets how remedies are very viable, very much a live solution to antitrust overlaps. The difficulty here is to whom will these insurance companies divest the covered lives. You have unprecedented consolidation. You

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know. Basically four of the big five are involved in these deals. And so who is going to be able to step into the shoes of the lost competitive entity and restore that competitive balance? I think it's going to be very interesting to see the way in which this investigation unfolds and what DOJ decides to do. I make no predictions about which way it will come out. What I can tell you is that if the deal gets cleared, there will be some very robust remedies attached to it on a very regional level, and if the deal gets challenged, it's very likely to be because of this national leverage problem. On the issue of provider and hospital mergers, again, my bias is to try and figure out a way to get my clients' deals through the FTC and the DOJ. And so I very much need to know, again keep my finger on the pulse of what it is that both the FTC and DOJ are valuing. The one thing that I have heard probably every time Debbie has said it is that there is not tension between the Accountable Care Act, and the antitrust laws. The difficulty is when I talk with my clients, some of whom are very small, and they say we don't have a choice, there's no way for us to be able to accomplish get the benefits of collaboration without the full-on merger. That may be unique to the quirky set of clients on behalf of whom I happen to work, it may be symptomatic of something larger, but I do think there's a tension between the ACA, which values collaboration, and the antitrust laws, which sometimes think that collaboration can lead to improper consolidation. That's just a challenge that's there. I think it's something you'll continue to see, and I think that that's why you do have many in the healthcare side on the provider side. You do see a lot of these challenges actually moving along into court. Over the past maybe ten years, there's a lot of deals that get abandoned, but I think you see that, on a very consistent basis, the FTC is going into court. Debbie mentioned the Hershey case they just filed, Hershey, Pennsylvania. There's also a case in Huntington, West Virginia that's ongoing. Those are very interesting and I think you'll continue to see that tension play out between the ACA and the antitrust laws. Now the thing I think that I absolutely tell all of my clients is, if you are going to be interested in doing any kind of consolidation, the remedy must be structural. I think this is a bright-line rule that I can actually-- Very little of what I tell my clients I can say with 100-percent confidence, but this is one area where I tell them, if you're preparing to go forward, a structural remedy is going to be absolutely necessary, and it's for all of the reasons that you heard earlier. Because [regarding] these conduct remedies where you just try and regulate someone's behavior, as opposed to fundamentally altering the backbone of the economics behind a transaction, they just aren't as effective, and [because] the economics and the data and the academic studies have born that out. So you really need to be on the lookout for that. Now an interesting quirk here is that very occasionally and with some increasing regularity, you see state attorneys generals who are willing to allow these transactions to go through with conduct remedies, whereas you have federal enforcers who may not sure that view. The West Virginia case I mentioned, which is Cabell--I think it's pronounced Cabell--and St. Mary's in Huntington. There the attorney general actually signed an agreement blessing the transaction. The parties agreed to many of the same kinds of conduct remedies Debbie described earlier, and the FTC there chose to challenge it even in the face of that attorney general approving the deal. Now from my perspective, and I've been doing this a while, but not forever, that's unusual. Usually you see great unity between what the FTC and the state attorneys generals do and same thing on the DOJ side. You look at any of the complaints that they bring, and the first page will often take you, just the caption on the first page, two or three pages because they have all of the names of the state attorneys general, so very interesting to see the FTC depart there. Another interesting development, which is now about a year old, was in

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Massachusetts. The Boston area healthcare market, which is obviously a preeminent research center, a big focal point in the world of medical research. Partners, which is the entity that owns all of the hospitals you've heard of up there, Brigham and Women's, Mass General, tried to buy Southside Hospital and Hallmark Health System. There again the Massachusetts attorney general came up with the consent decree that focused on conduct remedies. The group of private parties, and I was involved in this representing the private parties, decided to challenge the attorney general's consent agreement. Ultimately before a state court judge, the state court judge refused to enter the consent decree and said that what the conduct remedies would do would [be to] basically put a band aid on a gushing wound. So there are some interesting dynamics at play in healthcare markets you don't always see in other industries. What I tell my clients is that when you're thinking about moving forward with one of these deals the very first thing we have to do is [to] look at what is going to happen to quality, what does the economic evidence say? Where some other transactions pop up on my desk, we kind of get started from there. They'll sign the agreement. We'll move forward. I think in these provider and hospital deals, you really need to be prepared to do a lot of work on the front end because this is such an active enforcement environment that what you would hate to see is for the parties to invest time, resources, money, and then ultimately find themselves in the midst of a challenge, so it is incredibly important to start working early. On the pharma side I actually think that I agree completely, and my experience is consistent with everything that Debbie said. I think there's been very good consistency at the FTC over the past 20 years in terms of how they look at pharma mergers. I think because of that consistency, there's real predictability. And so I do also do work on behalf of pharma clients usually smaller ones that are being acquired by some of these bigger one. There too I think you can draw some fairly bright lines about what's going to be permissible and what's not going to be permissible. As long as a remedy is available to a competitor that will be able to step into the shoes immediately of the entity that's lost. I think the FTC generally believes that pharma divestitures can be very successful, and so I would expect to see things to continue at the same rigor, same pace as what you're seeing now, as long as you keep that number of pharma competitors at a sufficiently high level. I think certainly right now there are plenty of very large players and plenty of mid and small players who really can keep the competitive dynamics at the point where they need to be.

Marilyn Serafini: Great. Thank you, Andrea. Let's turn now to George for the consumer perspective.

George Slover: A good way to start thinking about the consumer perspective is that consumers want meaningful choice. When we have options companies are spurred to compete for our interest and our loyalty. That leads to better quality and better affordability. We don't necessarily want the most choices, we want the best choices, but that depends on keeping the marketplace open for creating meaningful choice, not just choice being available today or tomorrow or the next year, but over the long term keeping the market open to choice. That's how we get new thinking and best choices in the future. For consumers to get that meaningful choice, there needs to be enough competition at every level of the supply chain, so that everyone has meaningful choice. The antitrust laws properly focus on us, consumers, but we're affected by what happens in the rest of the marketplace. The supply chain in healthcare is a bit different. There's the additional complicating factor that most consumers encounter,

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[which is that] the cost of healthcare is filtered through their insurance company. That's not as unique to healthcare as some suggest, but it's important and it affects the whole picture. Both the insurers and the providers claim to be in the consumer's corner and each says we need to be strong to protect you. The providers say we want to bring our best professional judgment to bear on giving you the care that you need, and we can't have insurance companies interfering with our professional judgments, and insurers say that they have no restraint on what they charge except[ing] the restraints we put on them. We're the ones who bring cost down. Both are right to a point, but if either of them gets too much leverage over the other, antitrust law is called market power, then consumer choice gets restricted and quality, value, and innovation all suffer. So what we need is competition and the meaningful choice it translates into on levels. Providers need enough insurers who provide access to patients, and insurers need enough providers who provide healthcare, and each needs to have alternatives, somewhere else to go, so that neither can dictate terms. If a hospital network or group medical practice or drug maker or medical device manufacturer is powerful enough that an insurer can't afford not to contract with it, it can jack up its prices, and if an insurer is powerful enough that a hospital network or group-medical practice or drug or device maker can't afford not to contract with it, it can force prices down so far that quality of care is jeopardized and innovation. We want doctors, hospitals, clinics, drug and device makers motivated to look for ways to lower prices without cutting corners on quality of care and other aspects of service that consumers value. That's the difference between providers wanting to trim costs to compete as one aspect of their efforts versus being forced to cut service to the bone in hopes to survive. It's the difference between responding to incentives that flow from competition versus knuckling under to a market dictator. Similarly we want insurers motivated to look for the best provider networks without being forced to contract with a network charging exorbitant rates just because it can in order to give policy holders access to the healthcare they need. The merging companies in healthcare or in any industry aren't necessarily aiming to reduce competition. Getting bigger and stronger can be a natural response to pursuing business opportunities in a changing marketplace. Changes in technology and in the marketplace and in consumer choices and in the law create opportunities and also uncertainties and companies react by looking to make sure they are positioned to move ahead successfully. Part of that is making sure you have reliable sources for the input and partners you need to provide the products and services that consumers want to buy and that you have reliable and effective ways to reach your consumers, and it can help to be big enough, so that you know suppliers and partners and purchasers will see you as reliable yourself. We get that, and so do the antitrust laws. Similarly, it's okay to get ahead of your competitors, so that you're the preferable choice if that spurs you to make your products as high quality and as low cost as you can, because that's also good for consumers. But if it spurs you to look for ways to limit competition you have to worry about that can be harmful. Smoking-gun memos or board presentations that vow to crush the competition can be colorful evidence, but the focus in a merger investigation is not on the intent but on the likely effect. The vast majority of mergers and integrations don't approach the levels of market concentration that threaten competition and consumer choice, but when they do approach those levels, they need to be looked at carefully. And when they cross the line, they need to be fixed or stopped. Figuring out where that line is and how close it is to being crossed can require extensive investigation and analysis, which is why we're thankful we have the Federal Trade Commission and the Antitrust Division. Companies

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seeking to justify a merger often have a checklist. They say the merger will create cost-saving efficiencies or synergies. They say other companies will enter the market and maintain the existing level of competition, and they say that if there's a concern in this or that specific local area or product or service offering, that can be fixed by selling off, divesting, just that one part of one or the other merging company to some other company who will take it over. All of these justifications have their shortcomings and caveats and need to be carefully examined. I think enough has already been said about the conduct remedies and trying to enforce that kind of promise. I won't go into that, but for these three that I did mention the efficiencies aren't even relevant until the merger takes market concentration past the threshold of concern and there's an antitrust issue in the first place, but once you are beyond that threshold the efficiencies have to be enough to actually prevent any net harm to consumers. For the longer term, they have to prove that the drive to innovate is not going to be compromised. It's not a question of a balancing test that you're going to allow some harm to competition as a tradeoff for some other supposed benefit. Remember that competition inherently involves duplication, so if you're talking about the efficiencies as being, well now there's two accounting departments or two distribution systems, and now we'll only have to pay for one, and so we're going to save a lot of money, you don't have competition unless you have duplication in all of those aspects, and so you can provide that meaningful choice. An argument for eliminating those kinds of costs is really an argument for allowing an monopoly, so we don't want to go there. The other question about the efficiencies if they're like synergies we can get the best of both companies and all of their knowledge and expertise. You don't always have to acquire an entire company to get that expertise. You can hire, not acquire. That's often a way to better preserve the competition. The so-called efficiencies have to be dependent on the merger, and not obtainable some other way that safer for competition. The promise of other companies ready to enter the market and compete either on their own with the help of a divestiture handoff, also needs a reality check. If these companies are ready and willing to compete, why aren't they doing so already? And how do we know that they are up to the challenge and in for the long haul? Now that's something that, as Debbie says, the Federal Trade Commission looks at carefully and assures itself that is going to be the case, but it's always going to be the role of the dice with new entry. You just never know for sure. Often they don't work out, and often the most effective competitors are the ones that are already competing. Furthermore, we don't want concentration allowed to increase right up to the very brink of where the harm to competition is obvious and immediate, then there's no margin for error or for all too foreseeable elements beyond the control of the antitrust laws or anyone else. What if one of the current key players you're depending on later decides to downsize or close shop. The antitrust laws don't force someone to work, and they don't force the company to stay in business. It's also important to look not just at a snapshot at where competition is happening now and [at] what current competition a merger would immediately eliminate but also to look over the next hill at what the merger means for future competition. A consummated merger can't be easily unwound to restore lost competition. The antitrust laws recognize the importance of taking potential competition and market uncertainties into account. The Clayton act is written to prohibit mergers that may substantially lessen competition or tend to create a monopoly, which gives plenty of latitude for taking the longer view. We're encouraging the Justice Department to take a careful look at the pending Anthem-Cigna and Aetna-Humana health-insurance mergers, which combine the largest four health

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insurance companies spanning numerous product sectors, I should say four of the largest five health insurance companies spanning numerous market sectors in numerous states and local areas. They are already in various degrees of direct competition with each other and are in prime position to expand further and into new territories. They would seem to already be as big as they need to be to make a go of it on their own without joining forces with their most able competitors. Early this year we encouraged the FTC to take a hard look at the proposed Teva-Mylan merger, a hostile takeover that would have combined the two largest generic drug makers in their vast generic and specialty drug portfolios. Teva abandoned its takeover efforts in the face of FTC concern. The healthcare marketplace is complex in how it operated and how it motivates providers, insurers and consumers. Regulatory framework has developed over many years and is still evolving to work within that and shape that complex environment and to help safeguard consumers, help keep costs under control, and help make a full range of healthcare products and services available. Even the best regulatory framework works better where competition within appropriate regulatory limits gives businesses an additional incentive to want to improve service while holding down prices and providing better value. Regulation and competition both work best when they work hand in hand.

Marilyn Serafini: Great. Thank you. We're going to open up for Q&A right now. We are video taping, by the way, this. A videotape and a transcript will appear on the AHCJ's, the Association of Healthcare Journalist's, website as well as on Health Affairs and the Alliance for Health Reform. We have a couple of roving microphones. Can someone hand Chris Flemming a microphone, please.

Chris Flemming: Hi, thank you, guys. These were great presentations.

Marilyn Serafini: Chris, if you could [-could, would], introduce yourself, please.

Chris Flemming: Sorry.

Marilyn Serafini: Even though I just named you -

Chris Flemming: Chris Flemming from Health Affairs blog. I wanted to pick up on a theme that came up in Deborah's and then in Andrea's presentations the idea, Deborah you said, that there was no conflict between antitrust and the ACA. Andrea, you seemed to suggest that some of your clients, particularly the smaller ones, felt that there was. I wonder what Deborah's reaction would be to what Andrea said, and then Andrea, your reaction to Deborah's point that she made that there are ways short of full-scale merger to achieve the kinds of ACA goals, coordinated care, better quality that providers can take that will not be as harmful to competition.

Deborah Feinstein: Sure. Thanks. A couple of points. First just the empirical. There are hundreds of ACOs. ACOs are all collaborations among different folks. Sometimes they involve hospitals, sometimes they involve hospitals and physicians. They span the universe. There are hundreds of ACOs. How many of them have been challenged by the antitrust authorities? Right, zero, not one. That suggest that there are in fact ways for folks to collaborate, so that's sort of point one is that folks are finding a way to do it that do not run afoul of the antitrust laws. I think that's really important. The second thing is to talk

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about the distinction between collaboration even among competitors and something that leads to increased consolidation. The example I always use, and it might be showing my age, but I remember as a kid the "Incredible Edible Egg" campaign. Right? Remember that? Remember that, the advertisement. It's sort of like the "Got Milk" campaign, right? This was a group of competitors. The egg manufacturers all got together and said let's spend some money to promote the health benefits of eggs; that eggs are okay to eat. That was a situation where they collaborated on delivering a message to consumers. They did not simultaneously fix the price of eggs, as far as we know. That's the difference between collaboration and consolidation, and I think it's important to bear in mind. We often hear things like well, to do population health management; you really need data on a larger population than maybe that's covered by one hospital. Well, you can do that. There's nothing in the antitrust laws that prevents all the hospitals in an area from saying, you know what, it would be great if we all got on the same IT system, so that we can share information with the physicians in the area. It's okay if we sit down and have our quality experts sit down and go what's your rate of methicillin-resistant staphylococcus aureus (MRSA)? We're trying to figure out if the rate of MRSA is something endemic to the city and the population that we're in or something that we're doing badly as a hospital or need to be doing better at. You can share that stuff without, at the same time, having to set the prices together or negotiating together with payers. So there are lots of things that you can do that are collaborative even with your competitor, even with the hospital next door that do not involve the kind of consolidation and increased leverage against payers that would increase the price of healthcare.

Andrea Murino: I don't necessarily disagree with anything you just heard. I mean for some the use of ACOs has proven incredibly valuable and very viable. You see that around the country, and lots of these are springing up. I think you'll continue to see it, but for other entities their business reality is such that they can't do these high-touch areas of collaboration and get the efficiencies they need to bring costs down without having that complete unity of interest and without being able to go and negotiate singularly with payers. I think the background that's interesting to me here is that-- I haven't talked too much about how the payers interact with the providers, but for many of the clients I counsel, their greatest fear are those yearly or every-other-year negotiations they have with the big payers because those payers say to them well, your reimbursement rates are going down 10 percent no matter what. Then for the providers to have to make adjustments and to be able to do the things that they want to do to keep the quality of care and to keep their entities functioning in the way that they want while they're being paid less. It's a real challenge. Debbie is absolutely correct, and I give this advice all the time. There are tons of things you can do short of a full-on merger, short of sitting and negotiating with these payers, which is the third rail, frankly, in these provider deals but it's hard, and it's really hard for these businesses whose boots-on-the-ground reality makes it especially challenging.

Chris Flemming: I have one quick follow up. I was just sort of intrigued because people often make the distinction, the combination is often presented as a way to increase quality, and then the other side will say no, no, it's a way to increase power and increase payment. You seemed just now to make the case that, in fact, you can't divide those two because if you don't have the market power to negotiate effectively with the payers and get better payment you don't have the resources to increase the quality.

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So should regulators and law-enforcement agencies be looking more favorably on combinations that are party designed to have more market power to negotiate with the payers.

Andrea Murino: No. That's not what I was trying to suggest. For me the quality argument is largely separate, and to be candid most hospitals, most providers around the country are pretty good on quality, and so I would never rest my defense on being able to say well, we're going to see a dramatic increase in quality here. That's not what I was trying to suggest.

Deborah Feinstein: If I could make one or two more points, which are the health insurers care about this stuff as much as anybody else. We routinely hear from them that a particular merger is completely fine. An example of that was we looked at a merger of a large academic medical center that was filled to the gills, and it was combining with a small local provider some miles away, I think, but clearly in the same geographic market. The plan was, you know what, I'm going to take the kind of routine primary care sort of hospital things and move it to this hospital, which has excess capacity, so that I can keep the beds opened for tertiary and quaternary care and that sort of thing. We talked to the insurers, and the insurers said yeah, you know what; this is not going to be a problem for us. In fact it's going to reduce costs for us. The insurers have a good sense of, do we think that this is going to increase prices or decrease prices? Do we think that this collaboration is beneficial? If they see something that is going to reduce their cost--improved quality reduced cost, right. You get people in and out of the hospital. You have fewer readmissions. So the interests can often be quite aligned, and so we do look at the facts of this. I would not that so far the courts have agreed with that. The best example of that is the case in Idaho with St. Luke's where the judge basically said you know look, I get what they're doing, and I completely agree with what George said. This is not about bad intent. We sometimes see bad documents, but often we find that the hospitals, in fact, want to do this for the right reasons. It's just that we don't think it's necessary or sufficient to achieve the goals, and the judge in the St. Luke's case agreed with us that while he had every belief that they were trying to do the right thing with the combination of these physician practice groups that in fact there were other ways to achieve it, there was evidence that they were already working on many of these things even without the merger and therefore could accomplish them. He basically found that he didn't think the ACO conflicted and that he wasn't prepared to do a little healthcare experiment instead of following the antitrust laws that have been around for 100 years and, I think, have served us quite well.

George Slover: I would just add briefly that in those negotiations you were referring to we want the providers to have to negotiate with the insurers, but we also want the insurers to have to negotiate with the providers. And so we want each of them to have effective alternatives, so that no one can really lay down a take-it-or-leave-it. We're concerned about this spiral where the providers are saying the insurers are too powerful, we need to get powerful too; and the insurers are saying the providers are getting more powerful, we need to get more powerful too. You end up with what has been long referred to in antitrust circles as a Sumo wrestler situation where one says there's a Sumo wrestler over there, put us in to do battle for you against that one, and they end up usually finding that it's in their best interest to accommodate each other in some way. Then the people on the outside end up suffering from that.

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Joyce Frieden: Hi, Joyce Frieden from MedPage Today. I was interested, Ms. Feinstein. You said that you did challenge some physician-practice mergers, and so I wondered if you could talk a little bit more about what triggers interest from the FTC in that area, and what you might be looking for because you said what you haven't done is challenge the hospitals trying to buy the physicians practices.

Deborah Feinstein: Sure. The case that we brought is the St. Luke's case in Nampa, Idaho, and it combined the two largest physician practice groups in Idaho. People sometimes refer to that as a hospital physician merger because St. Luke's was a hospital that had a physician group. What we challenged was the horizontal combination between the two physician groups, not the vertical part of the transaction, which I'll get to in a minute. We can hear about it all sorts of ways. Most of these are under the Hart-Scott reporting requirement. They're not \$70 million-plus transactions. We can often hear about things from the state AG, we can hear about it from the press, and we look at the facts, and decide whether or not there's a high enough concentration. If the payers are saying it will change the bargaining dynamics, that's something that we might have a concern about and St. Luke's was a case we brought. The vertical transaction where we might be interested with a hospital joining a physician group, take the most extreme example, which is that you have a dominate hospital in an area, one with 80-percent market share just to give a hypothetical, and it acquires every single cardiologist in the city, every single cardiologist within a 50-mile radius say. Now you've got another hospital, it's got not cardiologists, it's got nobody to refer cardiology patients to it. Suddenly it's foreclosed, and it's not going to be able to compete to provide cardiac services. That would allow the hospital, which may have an average of 80 percent suddenly to have 100 percent in a particular market and [to] exclude all competition. On the other hand there are price-reducing effects from vertical transactions that a well-known effect is that you eliminate the double marginalization. Simply put, if I've got two people, they each need to make money. If I've got one person, they can figure out overall what the margin is, so there are benefits to vertical transactions, which is why neither federal agency has actually gone to court to challenge any vertical transaction in any vertical industry in decades. There have been many settlements in vertical transactions. I've worked on a number of them. An easy example of that is Pepsi and Coke both bought their bottlers downstream, and the FTC entered into consent decrees to deal with some of the problematic vertical aspects while allowing them to go through because they did see the benefits. To that one of the things that we would look at is entry. It's one thing to enter with the new hospital, right. It's time consuming, it's expensive, there can be certificate-of-need (CON) laws that make it particularly problematic, your competitor can challenge whether or not there's a need for another hospital. CON laws exists in the healthcare area, but in what other world does a competitor get to weigh in on whether or not you get to open a business. It's a bit unusual and bit problematic for the antitrust enforcers, but that doesn't exist with respect to physician practices, and it may be quite easy for entry to occur. We have looked at examples where we have looked at physicians combinations particularly in urban areas, particularly near lots of medical schools where we say, you know what, the combination of these two physician-practice groups won't be a problem because it would be easy for someone to bring in new physicians of that particular type to be able to remedy any foreclosure concerns or to remedy any horizontal concerns, so it's very, very, very much a fact-specific issue depending on the type of physician group that you're talking about, depending on the geographic area, depending on hospitals

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and all sorts of things. Again, it's something we're alert to but something we've not yet brought a case on.

Jill Wexler: Jill Wexler with Pharmaceutical Executive magazine. While nobody did specifically talk about the tax-inversion incentives to pharmaceutical industry mergers, I'm just wondering, the financial benefits of such deals if you see evidence that they might be driving mergers activity that other wouldn't make sense or wouldn't be beneficial because of these financial incentives that they raise other problems, or conversely, that they're driving highly beneficial mergers involving smaller companies that can greatly benefit. That wouldn't take place without such financial incentives.

Deborah Feinstein: I'm not in the board room for these companies. I really can't comment on what's driving them to the mergers. I mean I think that there's a lot of speculation that a number of these are pushed by inversion, but we haven't seen it. Ultimately, the reason, unless it's an anticompetitive reason, a transaction comes about is not moment to us because we're looking at the effects of transaction.

Andrea Murino: If a client came to me and said we really want to do this because of the inversion benefits, I would say it's neither here nor there, we need to look at what the antitrust outcomes will be.

Bob Rowe: Bob Rowe [PH] freelance. There's a trend I see emerging of providers particularly larger ones doing their own self-insurance, more like on the Kaiser model but going from care into the insurance side of that. How is that going to affect the consumer? In some ways I can see advantages of savings--in some ways, and certainly clarity in that you know what you're buying when you buy an insurance policy. You're buying certain sets of providers and things, so how is that going to sort out.

George Slover: I think if it gives consumers more choices, that's good. I don't think there's anything inherently wrong about that kind of a vertical integration as long as it doesn't foreclose options in the way Debbie was just talking about, insurance companies that can't get providers anymore because the providers are all doing their own insurance. That would have to be looked at separately. It might be just a change in the way that healthcare is delivered, and if that ultimately takes over, that's not necessarily bad for consumers as long as there's enough choice in the supply lines, so that consumers have choices.

Marilyn Serafini: I saw a question down here.

Sarah Karlin: Hi, I'm Sarah Karlin with Politico. In terms of pharmaceutical mergers, you talked a lot about divestitures, but how does FTC think about the future competition that's lost and the innovation that doesn't happen or even in the generic drug space the future competition that's lost in that space especially as more and more consolidation occurs?

Deborah Feinstein: That's a good question. We do look and especially in the pharmaceutical area, at future competition, and that's because it's easier to look at in the pharmaceutical area because there's a very clear process for getting clearance. You have to go through the FDA pipeline, and so we are in regular contact with the FDA when we're looking at transactions to say okay, who's filed for approval for

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this kind of product, and who's in the queue to develop a generic for this kind of product. So our consents routinely talk about-- If you were to search the word FTC complaint and future, you would see a lot of markets where we talk about divestitures occurring because it would eliminate competition that would happen in a couple of years, and so a huge number of our transactions look at that. To date we have found that there are enough different companies that tend to innovate just generally that we have not worried about kind of a more global innovation concern, but it's something that we would be alert to if the number of pharmaceutical companies got smaller. What we've found is that innovation comes from a number of places, small companies, large companies, medium companies, and there's still a huge amount of innovation, so we have tended to look at it sort of product-by-product to see what the pipeline looks like to determine whether or not we have particular problems, but we're alert to the larger issue as well. [Pause from 01:00:09 to 01:00:16]

Male: From looking at complaints from government courts and agencies and court decisions and studies we can get a pretty good idea of what's going on or what is happening in the specific sectors. But when we have this discussion we're talking in general about mergers of doctors, hospitals, insurance companies, pharmaceutical companies, do you have any sort of cross cutting reflections about the larger changes and how they may or may not be considered and antitrust enforcement, in other words, anything besides just sector-specific analysis?

Deborah Feinstein: For the most part when people have come to bring their mergers to us, it is really much pretty specific to the facts of that merger. We do hear of some of these broader landscape issues such as the need to move towards collaboration, the need to move towards risk-based contracting, we hear a lot about population-health management, but the analysis that we use in every case is really pretty much driven by the guidelines and the questions we ask with respect to those things, are they necessary, are they sufficient. In other words, are these-- The first question we ask as Andrea mentioned is, is this anticompetitive, and George said this too, you don't even get to the efficiencies analysis until you've decided that there's a problem. I think many, many, many transactions are probably driven by these broader ACA goals. We don't have to have that discussion if the transaction isn't problematic. There are hundreds of hospital mergers every year. We investigate a handful, a couple of dozen that we'll actually look at with some degree of significance beyond looking at the initial filings are realizing the hospitals are 200 miles apart and they don't compete. Then it's an increasingly small funnel to where we're actually challenging them. It's in those handful that we actually have to have the conversation about are the efficiencies merger specific. The very fact that we clear dozens and dozens of transactions and challenge only a handful suggest to me that to the extent that these broader things are going on, we're doing a pretty good job of accommodating that-- I shouldn't say that. That's not the way I mean to say this. It means that these broader things really aren't effecting most transactions in terms of the antitrust analysis that we look at because a lot of them are getting cleared, so a lot of people are able to do the kinds of transactions they want without the antitrust problems, and it's really only a handful that are problematic, and in those, as I said, we've gone through the analysis and determined that they're still problematic.

Rich Daily: Hi, Rich Daly with Healthcare Financial Management magazine. I just wanted to follow up. It's a little bit more of sort of a zoomed in question than Roberts. One of the issues that are frequently raised by hospitals looking at mergers and acquisitions and an issue that comes up in accountable care organizations that you were talking about is how to keep the patients that they are responsible for within their system of care. It's a big problem in ACOs and it's a big problem outside with dealing with private payers who have these managed care systems what have you, and there's an incentive to improve the care for this patient, but the patient keep leaving your system. Are there any approaches that you've found? I mean you talked about other payment systems that are effective short of mergers and acquisitions. Are there any approaches that you could point to that are effective in terms of retaining those patients that providers could look into instead?

Deborah Feinstein: Yes. It's a good question. It's really not something at which the antitrust agency has looked. I mean we're more focused on the question of is it necessary for these two entities to combine, so they can address the concern that you're worried about, and the question we would ask there is are there any competitive aspects and how does that balance against the possibility that if they combined they would be able to do more risk-based contracting. There we would talk to the insurers among other places to try to get a view on that. If the insurers say, yeah, that would be really helpful, we think that, combining, they could reduce the costs because they would be able more well engage in risk-based contracting and we think that that would be a good thing, that would be meaningful to us. If, on the other hand the insurance companies say, look, I understand that maybe the motivation, but all it's going to end up doing is increasing their price to us when they jointly negotiate, that would tend to concern us.

Marilyn Serafini: We've talked about what goes into making these kinds of decisions. George brought up an interesting question or statement. He said that these deals or this activity can't be easily unwound. I'm wondering if we could talk just a little bit about what kind of recourse there is if the promised benefits don't come to fruition and maybe it appears that there is some detriment from the activity. Is there any kind of recourse? Is it possible to unbundle a merger? Has it ever been done? Are there penalties, sanctions?

Deborah Feinstein: Again, going to the question of we're a law enforcement agency, so not sanctions unless they violated a consent decree, if they've entered into a consent decree and violated it, we can get civil penalties. It's why we have a Hart-Scott-Rodino Act, which requires pre-notification of large transactions, so that we can take a look at them and challenge them before the combination occurs. The best example in the hospital area of a combination that occurred was the Evanston/Northshore-Highland transaction in the Chicago suburb some years ago. The transaction was not challenged when it was it additionally occurred. The prices went up dramatically. The FTC challenged it after the fact, and got a remedy. The problem was that the companies had been so intertwined by then and had a really, I think, somewhat successful cardiac program that would have gotten sort of torn apart if the two hospitals had been split up. And so the remedy was that the hospitals would each separately negotiate if the payers wanted to. No payer took advantage of it probably because it's hard thing to figure out how it's going to work out at the end of the day. They both had the same CEO, and having clear division is

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challenging, and for whatever reason, the benefits of competition really didn't come about after that challenge, which is why we are so disappointed when we lose. A good example of a time we lost a hospital merger and ultimately were unable to achieve any remedy is with the Phoebe Putney-Palmyra case down in Georgia. We did challenge the transaction when we first learned about it before it was closed. The district court decided that we were not entitled to relief because the transaction was immunized by the State Action Doctrine because one of the hospitals was basically a state-run, state-owned entity, and the State Action Doctrine says that if the state immunizes competition, the federal government can't do anything about it. We didn't think that the State Action Doctrine applied, but the hospitals were allowed to merge. It went up to the Eleventh Circuit. The Eleventh Circuit said, wow, this is really anticompetitive, this is a problematic deal, but I think the State Action Doctrine applies. We then went to the Supreme Court, and the Supreme Court said in a 9-0 decision that the State Action Doctrine doesn't apply. The FTC absolutely has jurisdiction to look at this, but by then the hospitals had merged. We tried to get a divestiture, but because of complicated CON laws it was unclear. It didn't not appear that we were ever going to be able to separate the hospitals and have one of them sold to another party, so we couldn't get any remedy whatsoever, highly problematic. I mean really troubling to all of us at the commission who went through this, which is why we try so very hard to go after it the first time. We are technically allowed to go after a transaction at any time even after its close even if we have looked it originally. I think the odds that we'd go after a transaction that we'd investigated seriously and cleared--it has not happened in recent time. I can't predict whether it would happen in the future. I do think that it's why we try so hard to get it right, and why we're always going to err on the side of consumers as opposed to the promises that somebody has about why it's going to end up being a good transaction.

George Slover: Something that Debbie just alluded to and you had referenced in my statement, once it's done everybody makes their adjustments. People who worked for one entity or the other are either brought into the new entity or they are let go and they go off to look for work elsewhere, suppliers, customers make their adjustments. So you really don't have the contents of the two companies left in order to be able to make a clean break between them again. It's often referred to with the metaphor of trying to unscramble eggs. You just can't. There's one company there, and it's too late. That's why you have to do it before the merger happens.

Marilyn Serafini: Given this reality, do you have everything that you need? Do you have all of the legal tools that you need to be able to conduct a rigorous preapproval process or do you need anything from the policy makers, anything more?

Deborah Feinstein: Look. I think the antitrust laws have served us very well for over 100 years. I think that we're able to look at transactions. It's a challenge in terms of-- I don't think any government agency will tell you it always has as many resources as it would like, but I think we do a very good job with what we have. I think we're able to look at a lot, and I think we're pretty confident that we're looking at the transactions that really need to be looked at, challenging the ones that are really problematic, and letting those that are not problematic go through as quickly and as efficiently as possible.

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Marilyn Serafini: Let's wrap up here, last question.

Male: [Unintelligible] [01:11:35] Congressional Quarterly. I just had a question regarding the certificate-of-need laws. How much does that factor into your analysis when you're blocking a merger, a state certification, like, whether you can effectively do it, and how much that's going to hamper future competition?

Deborah Feinstein: A couple of things to say on certificate-of-need laws. We look at in virtually every transaction to see whether they exist because it answers the question of whether or not entry is likely to occur. We often here that entry may occur-- In the hospital merger situation, if there's actually a hospital being built, that may convince us, and we have seen situations where there are new hospitals coming in, and so the snapshot at which we're looking at this particular moment in time does not reflect what it's going to look like in a year and we may decide if you ignore the future entry, the transaction might be problematic, but given that other people are building hospitals, we're not concerned. On the other hand if those plans of people are hampered by certificate-of-need laws, we may be more skeptical that the entry will in fact occur that a hospital says it wants to do because of that. We'll look at that in the context of whether or not we think entry is likely. We have. When asked we'll weigh in on certificate-of-need laws. We have an office of policy and planning and they are frequently invited by legislators to provide views on different legislation whether it is Certificate of Public Advantage (COPA) or CON laws or other legislation that affects healthcare provider such as the amount of certification that advanced practice registered nurses need, that sort of thing. There's a lot of that on our website because we make all of this public. Whenever a state asks us to weigh in on legislation or if any of the federal agencies ask us to weigh in on particular things. There's a lot in healthcare area that we've been asked to weigh in on. It's all up on our website, so we do look at these sorts of things pretty routinely.

Marilyn Serafini: Fantastic. I would like for you to do one last thing for me, and that is inside of your packet you have a smaller piece of paper that's at the front. It's a blue evaluation form. We would love to hear what you have to say, not just because we want to hear what you have to say, but we're going to be doing these kinds of events once every couple of months, and they're for you, we want to hit the subjects that you want to hit, we want to bring in the speakers you would like to hear from. Please, tell us very specifically if you have a thought about what subject is pressing, you want to hear more about it, and what speaker. If you could [would] take a minute and fill out the evaluation that would be great. I'd like to thank you all for getting up very early on a Tuesday morning. Again, I'd like to thank Health Affairs for their partnership, and also the JKTG Foundation for support of these briefings. [Applause] [Pause from 01:14:38 to End of Audio]