

July 21, 2014

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

Re: Commonwealth of Massachusetts v. Partners Healthcare System, Inc., South Shore Health and Educational Corp., and Hallmark Health Corp., Superior Court Civil Action No. 14-2033-BLS
CC: Massachusetts Health Policy Commission

Dear Judge Sanders:

We, the undersigned, submit to you this comment in our capacity as academic economists with expertise in the subjects of antitrust, competition policy, and health economics. We are concerned that the consent judgment in the above-referenced matter will not fully address the substantial alleged anticompetitive effects of the acquisitions proposed by Partners Healthcare Systems, Inc. (“Partners”). We urge you to reconsider your support of the proposed settlement and to file for injunctive relief to ensure the transactions cannot be consummated until and unless a full trial on the merits can be held. Our review of the public documents issued by the Massachusetts Health Policy Commission, together with our collective understanding of healthcare organizations and markets (underpinned by extensive academic research, cited below), leads us to believe that the evidence would show that these acquisitions are not in the public interest. Moreover, we do not believe that the proposed restrictions on Partners’ conduct included in the consent judgment will offset the consumer harm that is likely to arise from the acquisitions of South Shore and Hallmark hospitals and their physician affiliates. Below, we provide three distinct arguments underlying our conclusions.

1. There is scant empirical evidence that horizontal or vertical integration among healthcare providers of this scale leads to efficiencies.

The proposed settlement permits several acquisitions with horizontal as well as non-horizontal (“vertical”) overlaps. We challenge the implicit conclusion by the Attorney General that these transactions are likely to generate merger-specific, verifiable benefits to consumers.

In its response to the Health Policy Commission’s Cost and Market Impact Review of the South Shore and Harbor Associates acquisitions, Partners claimed the deal would “yield economic and operational efficiencies, all of which will, in turn, result in the delivery of high quality, cost effective health care to all patients served in the South Shore and contribute to moderating the

rate of growth in health care expenditures for the benefit of patients and employers.”¹ Unfortunately, systematic evidence from hundreds of hospital mergers around the nation provides little empirical support for these assertions.

A 2006 survey article authored by two prominent health and antitrust economists and sponsored by the Robert Wood Johnson Foundation concluded that *hospital mergers yield modest cost savings at best*, and only when hospitals combine operations (as opposed to sharing a corporate parent).² The authors also find that consolidation generally leads to significantly higher prices, and to lower, rather than higher, quality of care. A 2012 update to the 2006 survey reviewed subsequent research and affirmed the prior findings.³ In other words, hospital mergers have consistently failed to generate the benefits promised by their proponents.

There are important non-horizontal components to these transactions, as Partners will acquire several physician groups and clinics affiliated with South Shore and the other hospitals. We are hopeful that such affiliations among various healthcare providers can generate savings and quality improvements, but there is no convincing evidence to date that combining physicians and hospitals under common ownership tends to result in cost savings. In a lengthy review of the literature, Burns, Goldsmith, and Sen (2013) conclude that “Research on the effect of integration on physician productivity and hospital profitability has produced *mixed results*.”⁴ A recent study found that increases in the market share of hospitals that own physician practices are associated with increases in area prices and spending.⁵

The stated objectives of organizations formed through hospital-physician partnerships have much in common with a key initiative of the Affordable Care Act, the Accountable Care Organization (ACO). Hence the early performance of ACOs is probative. The Centers for Medicare and Medicaid Services recently reported that slightly less than half of ACOs participating in the Medicare Shared Savings Program achieved savings relative to the CMS benchmark – about what one would expect from a random sample of healthcare delivery organizations.⁶ However, ACO sponsors presumably expected better-than-average savings given the significant fixed and ongoing investments required to form and operate these novel and heavily-regulated entities.

¹ Partners HealthCare, Brigham and Women’s Hospital, and South Shore Hospital’s Response to the Health Policy Commission’s Preliminary CMIR Report dated December 18, 2013. Submitted to the Health Policy Commission on January 17, 2014. <http://www.connectwithpartners.org/wp-content/uploads/2014/01/PHS-BWH-SSH-CMIR-Response.pdf>

² William B. Vogt and Robert J. Town, “How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?” *The Synthesis Project*, no. 9 (2006): 11, available at <http://www.rwjf.org/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html>.

³ Martin Gaynor and Robert J. Town, “The Impact of Hospital Consolidation—Update,” *The Synthesis Project*, 2012, available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

⁴ Lawton Robert Burns, Jeff Goldsmith, and Aditi Sen, “Horizontal and Vertical Integration of Physicians: A Tale of Two Tails,” *Advances in Health Care Management* 15, 2013, 39-117.

⁵ Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, “Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending,” *Health Affairs* May 2014 vol. 33 no. 5 756-763.

⁶ CMS reported that 54 of 114 ACOs participating in MSSP in 2012 “had lower expenditures than projected. Of these, 29 achieved savings sufficiently large to trigger shared savings. <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-30.html>.

We do not intend to suggest that ACOs or their analogues for non-Medicare populations are not promising mechanisms for improved care delivery (both in terms of cost and quality). Rather, we observe that the success of ACOs is yet unknown, and permitting combinations that are extremely difficult to unwind if they prove unsuccessful requires a significant leap of faith on three dimensions: (1) clinical care coordination can be successful; (2) the benefits of clinical care coordination cannot be achieved through joint ventures or contracts; (3) the benefits exceed the likely anticompetitive effects.

2. The parties' background and arguments do not warrant exceptional treatment

No court has yet to permit an otherwise illegal merger to proceed on the grounds that efficiencies sufficiently offset alleged harm.⁷ Notably, the courts require “proof of extraordinary efficiencies” in circumstances where market concentration is high.⁸ In our view, neither Partners’ historical record nor its post-acquisition plans appear sufficiently compelling to meet this standard.

While Partners’ planned investments in the South Shore might not occur absent the proposed acquisitions, it is not clear that net benefits to consumers will be positive. Partners has not suggested that the acquisitions are intended to generate financial losses, hence it is plausible to assume that the investments must be repaid over time through higher charges to payers (or, equivalently, lower pass-through of cost savings). Partners plans to invest \$200 million to support its new investments in the South Shore.⁹ If realized efficiencies exceed this figure, there is potential for net consumer benefits. Yet Partners’ claimed efficiencies – which HPC’s experts have deemed significantly inflated – amount to only \$158.6 million over an eight-year period.^{10, 11} And, as noted earlier, systematic evidence from prior mergers suggests that savings are unlikely.

Partners’ track record also fails to inspire confidence that this new set of acquisitions will generate the hoped-for efficiencies. Since its inception in 1994, Partners has pursued a strategy of expansion and integration. Currently, Partners includes 8 general acute care hospitals and contracts on behalf of several others. Its physician group, Partners Community Healthcare, Inc. (PCHI), comprises more than 5,500 physicians.¹² As a result of a 2012 acquisition, Partners also owns a health plan.¹³ In spite of two decades of expansion and integration, Partners Healthcare is consistently identified as having *higher prices and higher medical expenses than other, less*

⁷ *FTC v. ProMedica Health Sys.*, No. 3:11 cv 47, 2011 WL 1219281, at *57 (N.D. Ohio, Mar. 29, 2011)

⁸ “High market concentration levels require proof of extraordinary efficiencies, . . . and courts generally have found inadequate proof of efficiencies to sustain a rebuttal of the government’s case,” *United States v. H&R Block, Inc.*, 833 F. Supp. 2d 36, 89 (D.D.C. 2011).

⁹ Massachusetts Health Policy Commission, “Review of Partners Healthcare System’s Proposed Acquisitions of South Shore Hospital and Harbor Medical Associates,” HPC-CMIR-2013-1 and HPC-CMIR-2013-2, February 19, 2014, at 6.

¹⁰ “Why our Partnership with South Shore Hospital Will Improve Care and Reduce Costs,” 1/17/2014 press release. This estimate does not include potential savings to the federal Medicare program, but only a small fraction of Medicare savings accrue to Massachusetts residents. However, the HPC CMIRs note the risk of higher costs to Medicare because hospital-affiliated physicians may bill for facility fees in addition to professional charges for office-based care.

¹¹ We refrain from remarking on the efficiencies and investments detailed for the Hallmark transaction, as the CMIR has yet to be finalized and Partners has not issued a response as of this writing.

¹² Massachusetts Health Policy Commission, “Review of Partners Healthcare System’s Proposed Acquisition of Hallmark Health Corporation,” HPC-CMIR-2013-4, July 2, 2014, at 7.

¹³ <https://www.nhp.org/whoware/Pages/Partners-Healthcare.aspx>.

*integrated, systems.*¹⁴ Moreover, several reports issued by Massachusetts state agencies, including the Office of the Attorney General, have concluded that high prices are not well-correlated with higher quality of care. These studies have also raised significant concerns about adverse impacts of current and future consolidation on local healthcare spending.¹⁵

3. *The proposed agreement does too little to curb the exercise of market power alleged to arise from the acquisitions of South Shore Hospital, Harbor Associates and Hallmark Health System.*

In most cases, antitrust enforcers favor structural remedies – e.g., blocking or dissolving mergers – for a variety of reasons well-described in a recent speech by Deborah Feinsein, the Director of the Bureau of Competition at the Federal Trade Commission.¹⁶ Perhaps the most important of these reasons is that regulators can only guess at the “but for” world and attempt to design conduct requirements that seem likeliest to produce that world. Such endeavors are 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.¹⁷ These conditions do not characterize healthcare markets of today. Nevertheless, the Attorney General has stated that the restrictions in the consent judgment would accomplish more than successfully blocking this set of acquisitions.¹⁸ Economic theory and evidence suggest otherwise.

First, the requirement that Partners offer payers the right to engage in “component contracting,” whereby payers may pick and choose which components of the Partners system they wish to include in their various insurance products, does not eliminate the unilateral incentive for each component to raise price following a merger.¹⁹ Ordinarily, firms are reluctant to raise price because they may lose customers to rivals. But if two erstwhile competitors share a corporate parent, then when one raises its price, some of its customers shift their business to the other firm. This keeps the revenues “in the family”, which blunts any disincentive to raise prices. Thus, a

¹⁴ For example, the Massachusetts Center for Health Information and Analysis recently reported the following: (1) Partners had “acute hospital price levels in 2012 that were higher than the network median price across all payers’ networks”; (2) “Physician groups that were associated with Partners and Atrius Health had relative price levels that were significantly higher than the network median price levels across most payers in 2011”; (3) “Partners was the only physician group system examined that had a health status adjusted TME [Total Medical Expense] above the network average physician group TME in the top three payers’ networks.” Center for Health Information and Analysis, “Annual Report on the Massachusetts Health Care Market” August 2013, at 29.

¹⁵ For a summary of the 16 reports issued between 2008 and 2013, see <http://www.mahp.com/assets/pdfs/MAHP-cost-drivers-in-the-cwealth.pdf>.

¹⁶ Deborah L. Feinsein, “Antitrust Enforcement in Health Care: Proscription, Not Prescription,” June 18, 2014, at 14-15. Available at <http://www.ftc.gov/public-statements/2014/06/antitrust-enforcement-health-care-proscription-not-prescription>

¹⁷ Ken Heyer, “Optimal Remedies for Anticompetitive Mergers,” 2012, *Antitrust* 26(2): 26-31.

¹⁸ “While a lawsuit could have blocked Partners’ expansion to South Shore Hospital, it also would have maintained the unacceptable status quo in the health care market. Today’s resolution goes well beyond that by reducing the negotiating power of Partners, limiting its ability to acquire physicians, and controlling costs across its entire network,” June 24, 2014, “AG Final Resolution with Partners Would Alter Provider’s Negotiating Power, Restrict Growth and Health Costs,” available at <http://www.mass.gov/ago/news-and-updates/press-releases/2014/2014-06-24-partners-settlement.html>

¹⁹ In years 1-7 of the agreement, the four components are: Academic Medical Center Contracting Component, Community Contracting Component, South Shore Contracting Component, and Hallmark Health Contracting Component. In years 8-10, the South Shore and Hallmark Health components will be merged with the Community Contracting Component. <http://www.mass.gov/ago/docs/press/2014/partners-settlement-062414.pdf> at 17-18.

merger of rivals will result in prices above the levels that would prevail if the rivals were truly independent. This is true even in the absence of explicit price coordination among the co-owned former rivals.

Indeed, the Evanston Northwestern-Highland Park hospital merger in the northern suburbs of Chicago in 2000 provides a case in point. Shortly after the merger, inpatient prices charged to commercial payers increased by nearly 50%, far exceeding price increases among various control groups in the Chicago area.²⁰ Moreover, extensive empirical analysis shows that quality did not improve relative to other area hospitals.²¹ In light of this evidence, the merger was deemed anticompetitive by an administrative law judge in 2005, a determination that was affirmed on appeal to the full Commission in 2007.²² Concluding that “divesting Highland Park after seven years of integration would be a complex, lengthy, and expensive process,” the Commission ordered the parent entity (Evanston Northwestern Healthcare) to establish a separate and independent contract negotiating team for Highland Park Hospital. Apparently no insurer has yet availed itself of this option, suggesting that payers recognize that the benefits of separate negotiation (which subsumes component contracting) are minimal. To our knowledge, prices have not reverted back to competitive levels, despite the supposed return of competitive pricing incentives. The FTC has since distanced itself from this remedy.²³ A recent simulation of such a remedy in a different setting – a proposed hospital acquisition in Northern Virginia – also shows that separate bargaining would have done little to mitigate post-merger price increases had the FTC and Virginia Attorney General not successfully blocked the transaction.²⁴

Second, the price and total medical expenditure (TME) growth caps imposed by the consent judgment will only bind if (a) prices and spending growth would otherwise increase; and (b) prices and spending can be easily calculated and monitored. Healthcare inflation and spending growth are no longer foregone conclusions. Total U.S. healthcare spending actually declined between Q42013 and Q12014, notwithstanding a substantial increase in the insured population. There are many ongoing initiatives to “bend the cost curve,” so this may not prove to be a one-time event. To take but one example, the 2011 shift by Medicare to bundled payment for dialysis treatments led to a 20 percent reduction in the use of expensive biologic drugs over the course of a single year, and an additional 39 percent reduction the subsequent year.²⁵ 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. We also note that the TME cap may be raised if

²⁰ Deborah Haas-Wilson and Christopher Garmon, “Hospital Mergers and Competitive Effects: Two Retrospective Analysis,” *International Journal of the Economics of Business*, 2011, 18(1): 17-32.

²¹ Patrick S. Romano and David J. Balan, “A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare,” *International Journal of the Economics of Business*, 2011, 18(1): 45-64.

²² In the Matter of Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc., No. 9315, August 6, 2007, available at www.ftc.gov/os/adjpro/d9315/070806opinion.pdf.

²³ “The Commission did accept a conduct remedy in its challenge to the combination of Evanston and Highland Park hospitals.... We have repeatedly rejected this sort of conduct remedy since.” Deborah Feinstein, “Antitrust Enforcement in Healthcare: Proscription, not Prescription,” June 19, 2014, at footnote 43.

²⁴ Gautam Gowrisankaran, Aviv Nevo, and Robert Town, “Mergers When Prices Are Negotiated: Evidence from the Hospital Industry,” Accepted, *American Economic Review*, June 2014. For additional details on the transaction in question, see <http://www.ftc.gov/enforcement/cases-proceedings/061-0166/inova-health-systems-foundation-prince-william-health-system>.

²⁵ 2013 Atlas of CKD & ESRD, U.S. Renal Data System, available at http://www.usrds.org/2013/pdf/v2_ch11_13.pdf

non-Partners hospitals exceed the HPC's benchmarks, and moreover that it pertains only to the segment of Partners' patients enrolled in a "Risk Arrangement." According to the most recent data available (from 2012), only 11% of Partners' commercial business falls in this category.²⁶

Even if the caps were to bind, implementation and monitoring will be exceedingly difficult. There is widespread agreement that price is extremely hard to measure in the healthcare sector. In addition, and as the dialysis example illustrates, payment modalities are evolving away from fee for service and toward more sophisticated approaches such as bundling. Even the apparently straightforward TME is challenging to measure, as it must be adjusted for patients' health risk and changes in health plan benefit design. And as many have noted, price and spending caps do not address quality of the services provided, which could be reduced in order to maintain desired margins.

Third, there are no protections in place after the agreement expires. If the acquisitions are indeed anticompetitive, and if the restrictions imposed by the consent judgment bind, when they expire the residents of the Commonwealth will face the full extent of the market power of a system strengthened by the Attorney General's decision to drop its investigation into Partners' historical contracting practices and to permit the new series of acquisitions to proceed unchallenged. There are few well-documented analyses of conduct by hospitals following the expiration of similar agreements, as remedies of this form are rare. However, the limited evidence available is not encouraging.

For example, in 1997 New York State's Attorney General agreed to drop its opposition to the merger of Long Island Jewish Medical Center and North Shore Health System in exchange for a series of post-merger commitments, including a 2-year price-growth cap. In 2000, hospital executives reported significant improvements in reimbursement rates due to their stronger negotiating position.²⁷

Another example is the "Community Commitment" required by the judge who denied the FTC's 1996 request for an injunction to bar the merger of Butterworth Health Corporation and Blodgett Memorial Medical Center in Grand Rapids, Michigan.²⁸ The Commitment, entered as a court order, included a price freeze for 3 years, followed by a price growth cap set at the Consumer Price Index (CPI) for an additional 4 years. Immediately following the expiration of the price cap

²⁶ Public Comment by the Massachusetts Health Policy Commission in re Commonwealth of Massachusetts v. Partners Healthcare System, Inc., South Shore Health and Educational Corp., and Hallmark Health Corp., Superior Court Civil Action No. 14-2033-BLS, <http://www.mass.gov/anf/docs/hpc/hpc-submission-into-court-authorized-public-comment-period.pdf>

²⁷ "After Merger's Bumpy Start, North Shore-L.I.J. is Clicking," *New York Times*, December 17, 2000. <http://www.nytimes.com/2000/12/17/nyregion/after-merger-s-bumpy-start-north-shore-lij-is-clicking.html?src=pm&pagewanted=1>

²⁸ David Balto and Meleah Geertsma, "Why Hospital Merger Antitrust Enforcement Remains Necessary: A Retrospective on the Butterworth Merger," *Journal of Health Law*, 2011, 34(2): 129-165.

in 2004, the parent system raised prices 12 percent.²⁹ In recent years, price increases have far exceeded CPI, including 8 percent price increases in each of 2010 and 2011.³⁰

In closing, we emphasize that there is no longer any meaningful debate in the academic community about whether provider competition is beneficial to consumers. In contrast, there is significant evidence that efficiencies do not necessarily or generally follow from provider mergers. Partners' 20-year track record of integration paired with high prices and high medical costs casts serious doubt on its assertions that the proposed acquisitions would yield substantial efficiencies, let alone of the magnitude necessary to outweigh the alleged anticompetitive effects.

We urge the court and the Attorney General not to be unduly swayed by submissions from community members and organizations in support of this judgment. Most hospital mergers – particularly among non-profit organizations – draw substantial support from the affected communities due to strong community ties. But the harmful impact of these mergers on prices and insurance premiums generally affects a broader group of stakeholders, many of whom lack the incentive or resources to voice their objections. In addition, they do so at the risk of alienating powerful healthcare providers who may subsequently retaliate with impunity.

The court should be given the opportunity to weigh the evidence concerning whether the series of acquisitions permitted by the consent judgment will substantially lessen competition, per Section 7 of the Clayton Act and the Massachusetts Consumer Protection Act, M.G.L. c. 93 A.

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²⁹ "Spectrum Hikes Charges 12 Percent," *Grand Rapids Business Journal*, June 4, 2004, available at <http://www.grbj.com/articles/63939>

³⁰ "Spectrum Health Plans Another Significant Rate Hike at Grand Rapids Hospitals," June 7, 2011, [mlive.com](http://www.mlive.com)., available at http://www.mlive.com/business/west-michigan/index.ssf/2011/06/spectrum_health_plans_8_perccen.html

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