ABSTRACT The growing concentration of physician markets throughout the United States has been raising antitrust concerns, yet the Department of Justice and the Federal Trade Commission have challenged only a small number of mergers and acquisitions in this field. Using proprietary claims data from states collectively containing more than 12 percent of the US population, we found that 22 percent of physician markets were highly concentrated in 2013, according to federal merger guidelines. Most of the increases in physician practice size and market concentration resulted from numerous small transactions, rather than a few large transactions. Among highly concentrated markets that had increases large enough to raise antitrust concerns, only 28 percent experienced any individual acquisition that would have been presumed to be anticompetitive under federal merger guidelines. Furthermore, most acquisitions were below the dollar thresholds that would have required the parties to report the transaction to antitrust authorities. Under present mechanisms, federal authorities have only limited ability to counteract consolidation in most US physician markets.

The decline of small physician practices and the growth of very large practices in the United States have been documented by several studies. For example, the share of physicians practicing in groups of fifty or more increased from 30.9 percent in 2009 to 35.6 percent in 2011, while between June 2013 and December 2015 the share of primary care physicians practicing in groups of one or two fell by 5.7 percentage points and the share in groups of five hundred or more rose by 4.5 percentage points. Other research has found that prices are higher in more concentrated physician markets than in less concentrated ones, which suggests that the trend toward larger physician practices should be of concern to policy makers and antitrust agencies alike.

In the United States, antitrust concerns are within the jurisdiction of the Department of Justice (DOJ) and Federal Trade Commission (FTC). Our study confirmed that the trends in physician practice concentration are occurring but also documents that there is little these agencies can do about them. This is because the formation of most large physician groups resulted from piecemeal acquisitions of small group practices and the hiring of new physicians, rather than from mergers or acquisitions involving independent large group practices (we use the word acquisition to include both mergers and acquisitions). This phenomenon may limit antitrust scrutiny for three reasons: The agencies do not systematically collect information on small acquisitions; each individual acquisition of a small group or the hiring of an individual physician is unlikely to lead to a substantial change in market concentration; and the agencies lack the resources to investigate more than a tiny fraction of all acquisitions.
Background On Antitrust

While the agencies jointly enforce federal antitrust laws, the FTC currently handles most cases involving health care providers. States also have a role in antitrust enforcement. To provide guidance to merging firms and to inform judicial proceedings, the agencies jointly publish the Horizontal Merger Guidelines (last updated in 2010). 9

According to these guidelines, the first step in merger analysis is to define the market. At the risk of oversimplification, competition from providers outside of a well-defined market does not substantively constrain the behavior of providers within the market. When defining markets, it is important to account for both products and geography. On the product side, each major medical specialty is considered to be a defensible component of a well-defined market. For example, it is unlikely that obstetricians would constrain the pricing of cardiologists.

Defining geographic boundaries is far more challenging. In the past decade the courts have accepted geographic boundaries for health care providers that are no larger than metropolitan areas and often are much smaller. What these markets have in common is that “outflows” are low (that is, relatively few local residents travel outside of the market for care). When outflows are low, insurers must include local providers if they are to offer viable networks, and competition from distant providers will not constrain the prices of local providers as the latter jockey to be included in insurer networks. 10 The courts usually look for the smallest boundaries that satisfy the geographic market criteria, because larger areas may understake the true extent of provider market power. 11

The next step in merger analysis is usually a structural analysis of market concentration. The Horizontal Merger Guidelines recommend using the Herfindahl-Hirschman Index (HHI) to identify potentially problematic mergers. The HHI equals the sum of squared market shares and ranges from 0 (an infinite number of many small firms) to 10,000 (a single monopolist). According to the guidelines, a market is highly concentrated if the HHI is above 2,500, which can equate to a market with four equal-size firms or a market in which one firm has a 50 percent share and many other firms have small shares. A market is moderately concentrated if the HHI is 1,500–2,500. Markets with an HHI of less than 1,500 are unconcentrated.

Two metrics are used in the Horizontal Merger Guidelines to flag potentially problematic mergers: the HHI after the transaction and the change in the HHI. 9 Mergers that result in both an HHI of greater than 2,500 and a change in HHI of greater than 200 are presumptively anticompetitive. Mergers that result in either a postmerger HHI of less than 1,000 or a change in HHI of less than 100 are “unlikely to have adverse competitive effects.” Intermediate mergers “potentially raise significant competitive concerns.”

For example, consider a market where one firm has a 40 percent share, another has a 10 percent share, and all of the other firms are very small. The HHI in this market is slightly above 1,700, which is moderately concentrated. If the largest firm acquires the second largest firm, the HHI becomes slightly above 2,500 and the market becomes highly concentrated. With a change in HHI of 800, the acquisition is presumptively anticompetitive.

The DOJ and FTC are more likely to challenge acquisitions that are presumptively anticompetitive than those that are not. Nevertheless, they do not challenge all presumptively anticompetitive deals. Rather, they consider many other factors, such as the extent to which the merging parties are particularly close competitors, the ease of entry into the market by competitors, and the potential for efficiencies that would be passed along to consumers should the merger proceed. 12,13

There are also two practical reasons why the agencies do not challenge all presumptively anticompetitive deals. First, the agencies have limited resources. 14,15 Second, they can challenge only those deals of which they are aware. Rules established by the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (Section 7A of the Clayton Act) require firms to disclose their intent to engage in acquisitions of certain targets exceeding a threshold value, currently $78.2 million. 8 Nearly all physician acquisitions fail to exceed this threshold and therefore are exempt from the requirement to notify the agencies of the proposed action. While other stakeholders—such as insurers and competing health care providers—sometimes alert the agencies to potentially problematic deals, the threshold does make it difficult for them to remain apprised of all but the largest acquisitions.

Study Data and Methods

DATA We reviewed administrative claims data for the period 2007–13 from a data provider. Our data use agreement precludes us from revealing the identity of the data provider, the identity of the insurer or insurers that the data are from, or the specific states that the data cover. We are able to disclose the following: The data are from one or more insurers that conduct business in at least several states. These states are geographically dispersed and collectively contain more than...
12 percent of the US population. The average resident in these states was slightly older than the average American and had a slightly lower average household income. A population-weighted majority of the states sampled was present for the entire study period of 2007–13, but because of incomplete data, some states entered this sample as late as 2010. The enrollees were present broadly across these states. Physicians were reimbursed almost exclusively by fee-for-service. Enrollees had almost unfettered choice of what physicians they could visit. We estimate that 89 percent of the physicians in these states who accepted some private insurance were in network for the one or more of the insurers (for details of our analysis, see online Appendix 6). For the varied services provided in different geographic regions over multiple years, the average physician (including both primary care and specialist physicians) was reimbursed $40,000 annually, while the average primary care physician received $25,000 annually. Overall, this suggests that we were able to meaningfully track the provision of medical care by physicians in the markets used in this study.

We analyzed changes in the concentration of physician markets. We first defined the product and geographic markets in which physicians competed. We followed the standard approach explained above, and we demarcated product markets based on physician specialty.

To facilitate analyses of the large number of geographic markets in our data, we adopted an algorithmic approach to market definition that we describe below and in more detail in Appendix 2.

We identified individual physicians using their unique National Provider Identifiers (NPIs). We placed physicians into organizations using the main tax identification number under which the physicians billed. Because large organizations sometimes bill under more than one number, we aggregated related numbers using information from the SK&A physician database and the American Hospital Association Annual Survey. For details of our methodology for assigning physicians to organizations, see Appendix 1.

We defined market share as the share of each physician practice in each market for each year of our study period. These market shares are defined based upon output, which we determined by the amount that Medicare would have reimbursed each physician had all services been provided in an office setting. We measured market shares using output, rather than the actual amount that each physician billed, because the latter can be affected by the physician’s market power, by whether the physician practices in an office or outpatient hospital setting, and by billing conventions that depend on whether the practice is owned by a hospital. Output essentially measures physicians’ market share based upon their volume of services rather than commercial revenue.

**Methods** Before defining the markets we used in this study, we imposed two sampling restrictions. First, we restricted the analysis of market concentration to the nine largest specialties in our data: primary care, surgery, diagnostic radiology, obstetrics/gynecology, pediatrics, dermatology, gastroenterology, cardiology, and otolaryngology. These nine specialties accounted for roughly 75 percent of physician output. Second, we restricted our sample of claims to those for enrollees living within Metropolitan Statistical Areas. We imposed these two restrictions because rural areas and small specialties have fewer patients and physicians than nonrural areas and large specialties, respectively. As a result, rural areas and small specialties will appear relatively concentrated and will have more changes in market structure driven by sampling error. This restriction also greatly reduced our computational burden.

We followed an outflow-based procedure to define geographic market, which is described in detail in Appendix 2. Generally speaking, we selected a number of dispersed and densely populated ZIP codes within each metropolitan area to serve as initially defined geographic markets. We then added adjacent ZIP codes to enlarge these markets until the outflows were below 20 percent. This procedure is akin to one used by Samuel Kleiner and coauthors. As shown in Appendix 2, we obtained similar results if we instead defined markets as Dartmouth Atlas hospital service areas or metropolitan areas, or used outflow cutoffs of 10 percent or 25 percent. Ultimately, we had 1,117 markets (specialty–geographic area pairs) in our analysis. We constructed several measures of the size of physician groups, market concentration, and the reasons for changes in both of these over time. We were particularly interested in assessing whether increases in concentration resulted from large groups’ acquiring other large groups, because this would be the only source of growth likely to attract antitrust scrutiny.

Our analysis proceeded in three steps. First, we determined the HHIs for each of our markets in 2013. We also determined the percentages of markets that were unconcentrated, moderately concentrated, or highly concentrated, and whether the largest provider had a market share of less than 30 percent, 30–50 percent, or more than 50 percent. While the Horizontal Merger Guidelines do not specify these thresholds, the
agencies have indicated that accountable care organizations (ACOs) with less than a 30 percent market share in common service lines are in an “antitrust safety zone.” In contrast, the agencies advise ACOs with a market share above 50 percent to avoid specific forms of restrictive conduct, such as antisteering provisions, exclusive contracting with member providers, and restricting payers’ ability to disseminate cost and quality information.

Second, we categorized physician groups based on their initial size, and we documented the reasons that group sizes changed over time. Our main interest was in growth through acquisition. We classified acquisitions based on the number of physicians in the acquired group. Groups can also grow by hiring physicians who had not previously been in the data. A physician might not have been in the data because he or she was hired directly out of residency or from a state outside the sample. It is also possible that a physician might not have appeared in the data because he or she didn’t treat any enrollees in the data. Thus, changes in which physicians enrollees see can also cause group sizes to appear to grow or shrink. We aggregated these changes not related to acquisitions into an “all other reasons” category.

Third and finally, we decomposed the sources of changes in market HHI s over time. In particular, we restricted this analysis to markets that were highly concentrated in 2013. For each of those markets, we calculated an overall change in HHI (that is, the difference in the market’s HHI between the first year the market was in our data and 2013). We then categorized markets based on whether there was a specific acquisition large enough to have been presumed anticompetitive according to the Horizontal Merger Guidelines. For such acquisitions, we next examined whether the deal was so large that antitrust authorities should have received premerger notification under the Hart-Scott-Rodino Antitrust Improvements Act. Further details on our methodology for defining acquisitions and calculating changes in HHI are included in Appendix 3.16

LIMITATIONS

Our study had several limitations. First, while our market definitions were consistent with the principles in the Horizontal Merger Guidelines, they were calculated using an algorithm that necessarily ignored details that would arise during an actual antitrust case—such as whether the merging parties were particularly close substitutes for each other within the market. Similarly, while the concentration thresholds we used were useful heuristics, they need not serve as bright lines in the decision making of antitrust authorities.

A second limitation is that while our data provider or providers had a substantial presence in the markets studied, we did not have claims data from other insurers within these markets. To the extent that the utilization patterns of enrollees in our data provider or providers are not representative of the overall commercial insurance market, our market shares and HHIs might not reflect overall shares and HHIs. Nearly all of the enrollees in our data were in broad-network preferred provider organization products, which suggests that restrictive networks should not have distorted our market structure measures. Still, some changes in measured shares and HHIs may be the result of sampling error, rather than actual changes in market concentration.

A third limitation is with the representativeness of the markets that we considered. Our main conclusion is that some physician markets have become highly concentrated, but because of the piecemeal nature of the consolidation, antitrust authorities face impediments to preventing it. While the exact extent of concentration in our data is not likely to be identical to that of the United States as a whole, the overarching lessons are likely to be externally valid. We discuss external validity in more detail in Appendix 4.16 Of particular relevance, we note that the changes in practice size that we document in Appendix Exhibit A4E16 closely mirror Pete Welch and coauthors’ findings for the entire United States.1

This both bolsters the relevance of our sample and confirms some of our key empirical findings. Furthermore, a number of other studies have documented high and growing levels of concentration in physician marketplaces.4-6,18 The gaps between our conclusions and these general empirical findings are small.

A fourth limitation is that our results may be affected by the fact that different markets entered our sample in different years. We examined the sensitivity of our findings to the inclusion of markets that entered the sample after 2007, as well as variations in some of our results by physician specialty; the results of these sensitivity analyses appear in Appendix 5.16

Finally, we defined groups using aggregations of tax identification numbers. This definition likely worked well for determining the size of groups and measuring market concentration. However, it likely overstated the number of new groups that were formed and the number of old groups that exited a market, because physician groups may change their tax identification number for billing purposes. Nonetheless, such relabeling of groups would affect only measurements of churn, not those of market concentration.
Study Results

Twenty-two percent of the physician markets were highly concentrated in 2013, and an additional 21 percent were moderately concentrated (Exhibit 1). Not surprisingly, market concentration and the market share of the largest provider tended to move together. For example, 64 percent of the highly concentrated markets had a single physician group with a market share of more than 50 percent. If these large groups maintained their shares, then these markets would remain highly concentrated regardless of the shares of the smaller groups.

Physician groups that began with eleven or more physicians grew larger during the study period, whereas those with ten or fewer physicians shrank (Exhibit 2). The growth percentage was greater, on average, for groups that were larger to begin with. For example, at the upper extreme, groups with 101 or more physicians grew by about one-third over the study period.

Our examination of the sizes of acquired groups revealed that the growth of large physician groups resembles “whale eats krill,” rather than “shark eats shark.” Roughly half of the growth of the groups that initially had more than a hundred physicians involved acquisitions of groups of ten or fewer physicians (Exhibit 3). An additional one-third of the growth came from adding new physicians without an acquisition, which is consistent with other reports that newly minted physicians increasingly prefer large practices.20 By contrast, the acquisition of groups of eleven or more physicians accounted for only 15 percent of the growth of the largest groups.

Overall, the bulk of the growth of the largest groups resulted from either hiring new physicians or acquiring very small groups. Hiring new physicians is likely to fall outside of the purview of the antitrust laws, and smaller acquisitions typically will have correspondingly small effects on market shares and HHIs and are unlikely to require Hart-Scott-Rodino filings. Either way, the predominant channels that large physician groups continue to use to grow make it likely that their growth will avoid antitrust scrutiny.

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concentrated in 2013. We considered the extent to which concentration was driven by an acquisition that could have been presumed to be anticompetitive, as compared with an accumulation of small acquisitions and hirings that, individually, would not be presumed anticompetitive.

Among markets with a cumulative change in HHI of more than 200, only 28 percent had an acquisition that would have been presumed anticompetitive; these are shown in red in Exhibit 4. We then sought to determine whether antitrust authorities would have been likely to be notified of these transactions in those markets—notification that is required if the target value exceeds $78.2 million. Data on the valuations of acquired groups were not available, but one example—St. Luke’s Health System’s thwarted acquisition of Saltzer Medical Group—suggests that a valuation of that magnitude could require a group size of a hundred primary care physicians or fifty specialists.21–24

As is clear from a comparison of these headcount thresholds with the distribution of acquired group sizes in Exhibit 3, an exceedingly small share of acquisitions involved meaningful numbers of physicians relative to the Hart-Scott-Rodino threshold. For example, fewer than 10 percent of the presumptively anticompetitive acquisitions involved even ten physicians, let alone fifty or a hundred.

**Implications**

Although physician practice consolidation is leading to worrisome levels of concentration in many markets, the current methods used by federal antitrust agencies would often fail to identify any single acquisition warranting investigation. The DOJ and FTC are hampered by two related factors: Most acquisitions are too small to trigger Hart-Scott-Rodino notifications and are also too small to be presumptively anticompetitive under the Horizontal Merger Guidelines.

Even if the agencies were notified of problematic mergers, resource limitations would force them to judiciously choose which merger cases to investigate and challenge. The FTC has recently pursued several cases in physician markets,

**EXHIBIT 3**

Physician practice sizes and changes in practice size by 2013, by reason for change

<table>
<thead>
<tr>
<th>Initial practice size</th>
<th>Net change caused by:</th>
<th>Acquisition, by size of acquired practices</th>
<th>Physician arrivals and departures</th>
<th>Average change in practice size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1-2</td>
<td>0.06</td>
<td>−0.26</td>
<td>−0.20</td>
</tr>
<tr>
<td>2</td>
<td>3-10</td>
<td>0.21</td>
<td>−0.54</td>
<td>−0.31</td>
</tr>
<tr>
<td>3-10</td>
<td>11-50</td>
<td>0.62</td>
<td>−1.23</td>
<td>−0.45</td>
</tr>
<tr>
<td>11-50</td>
<td>51-100</td>
<td>3.84</td>
<td>−4.40</td>
<td>1.27</td>
</tr>
<tr>
<td>51-100</td>
<td>101+ or more</td>
<td>12.38</td>
<td>−13.02</td>
<td>10.52</td>
</tr>
<tr>
<td>101+ or more</td>
<td></td>
<td>30.05</td>
<td>30.14</td>
<td>84.19</td>
</tr>
</tbody>
</table>

*Source:* Authors’ analysis of proprietary claims data for 2007–13. *Notes:* Definitions of practices and practice sizes are given in the Notes to Exhibit 2. The exhibit shows data only for groups present in the data for the first year of our study period for the state in which the group practiced.

**EXHIBIT 4**

Cumulative changes in HHI in physician practice markets that were highly concentrated in 2013

*Source:* Authors’ analysis of proprietary claims data for various years from 2007 to 2013. *Notes:* Market concentration is defined based on the Herfindahl-Hirschman Index (HHI), as explained in the text. Each bar represents one market with a 2013 HHI of more than 2,500, and the bars are ordered based on the cumulative change in HHI beginning in the first year for which data were obtained. The height of the bar indicates the cumulative change in HHI for the market. These changes could be caused by acquisitions, changes in market shares of individual physicians, and the entry and exit of individual physicians. Mergers that result in both an HHI of more than 2,500 and a change in HHI of more than 200 are presumptively anticompetitive. Those markets in which a presumptively anticompetitive merger occurred are shown in red.
such as the St. Luke’s–Saltzer case,21,22 the acquisition of cardiology practices by Renown Health,25 and Providence Health and Services’ plans to acquire two cardiology practices in Spokane, Washington.26 While the FTC litigated the St. Luke’s–Saltzer case, the agency can also preclude or mitigate competitive harm without a costly trial. The Renown Health case involved a consent decree between the FTC and Renown Health to address competitive concerns. Such decrees are relatively common and can be pursued by federal or state agencies. In the Providence Health and Services case, Providence abandoned the acquisitions after the FTC and the Washington State attorney general concluded that the deal was likely to be anticompetitive.

A number of steps could be taken to slow the formation of powerful physician groups in highly concentrated markets. The agencies could set lower Hart-Scott-Rodino thresholds for physician practice acquisitions—a change that could be accompanied by simplified reporting requirements so as not to make acquisitions too burdensome. At the same time, the agencies could establish more liberal bright-line thresholds, such as the 30–50 percent market shares in the ACO guidelines. By doing this, the agencies could better target their resources and also give medical groups greater certainty about the enforcement environment. Finally, states could work in concert with or instead of federal agencies.21,27,28

Unlike federal agencies, states are not bound by Hart-Scott-Rodino requirements and have superior local information, giving them unique opportunities to identify powerful physician groups.

These steps are unlikely to fully address the broader problems: that there may be hundreds of concentrated physician markets, that most large physician groups grow through piecemeal acquisitions, and that the combined resources of state and federal antitrust agencies are not sufficient to identify or challenge even a modest percentage of deals.

The piecemeal nature of physician practice consolidation also raises important questions about whether the manner in which consolidation occurs affects outcomes of policy interest. For example, piecemeal consolidation and a large acquisition that have the same effect on HHIs could have very different effects on scale efficiencies, quality, market power, and the manner in which bargaining over the prices of services takes place. Understanding how different types of consolidation affect these outcomes of interest is an important topic for future research.

The authors thank Zuhad Hai for excellent research assistance.

NOTES

5. Sun E, Baker LC. Concentration in orthopedic markets was associated with a 7 percent increase in physician fees for total knee replacements. Health Aff (Millwood). 2015;34(6):916–21.
7. Different types of consolidation (that is, large mergers versus piecemeal acquisition) may vary in how they affect prices or quality. In particular, acquisitions affect both market power and scale economies. Indeed, Naomi Hausman and Kurt Lavetti present evidence that suggests that scale economies and market power are likely both important factors in explaining the effect of consolidation on physician prices (see Note 3).
11. As noted in the Horizontal Merger Guidelines, “where analysis suggests alternative and reasonably plausible candidate markets, and where the resulting market shares lead to very
For efficiencies to be considered, they must be specific to a particular merger. The agencies may also approve an acquisition that would otherwise lessen competition if the target is failing and an alternative buyer is not available, as in the case of CentraCare Health’s acquisition of the St. Cloud Medical Group (see Note 12).

In its 2017 budget justification, the Federal Trade Commission stated that “resource constraints remain the most significant challenge to the bureau,” and the agency specifically referred to “the rising costs of critical expert witness resources” as one of the two leading challenges faced by the agency (see Note 14, p. 79).

When calculating practice sizes, we included physicians in specialties beyond the nine listed that we considered for the market concentration analysis.

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