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Provider Mergers: The Need for Early Antitrust Advice [Ober|Kaler]

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Given the Federal Trade Commission's (FTC's) aggressive antitrust enforcement program attacking provider mergers in hospital, physician, and other markets, it's become extremely important for those considering a merger to seek early legal advice if there's any possibility of antitrust concern. Once the parties have delved into serious discussions and negotiations and the transaction has become public, it may be too late. Counsel can provide advice about a number of early-arising issues that easily can affect the ultimate success or failure of the transaction, such as whether the transaction is likely to generate an investigation or subsequent challenge. Some of these issues are:

1. Hart-Scott-Rodino (HSR) pre-merger reportability. Section 7A of the Clayton Act requires that parties to certain relatively large mergers report such mergers to both the FTC and Antitrust Division of the Department of Justice before consummating them. Potential civil penalties for failure to comply with HSR requirements can be draconian—up to $40,000 per day for the period of the violation.

The HSR statute and the regulations implementing the reporting requirements are complicated. Briefly stated, the transaction is reportable if, roughly speaking, its value exceeds $312.6 million. The transaction is not reportable if its value is less than $78.2 million. At values in between, whether the transaction is reportable depends on the size of the parties to the transaction. Also, certain transactions appear to constitute mergers but, based on their structure, are treated as joint ventures under HSR regulations and, as such, are not reportable. If the transaction *is* reportable, determining when to provide the required notice requires some degree of strategizing, on which counsel can advise.

Importantly, that a transaction is not reportable doesn't mean it's not likely to come to the attention of the antitrust agencies and thereby generate an investigation. In addition to HSR reporting, the agencies learn of provider-merger transactions through numerous other means, such as trade publications, newspapers, and complaints from those believing it will adversely affect them, such as health plans.

2. Single-entity status. For most provider affiliations or mergers, it's important to structure the transaction so it results in a single entity instead of a joint venture. In the latter case, the parties remain separate entities for antitrust analysis, so their post-transaction actions result from “agreements” subject to Section 1 of the Sherman Act, which prevents agreements that unreasonably restrain competition. For example, if providers negotiate health plan contracts together, a horizontal price-fixing agreement results, potentially subject to per se unlawfulness. But if those providers become a single entity through the transaction, their post-transaction activities don't result from horizontal agreements but rather from unilateral action.

So-called “virtual mergers,” e.g., joint operating agreements and loosely affiliated physician limited liability companies, can raise this issue. Unless one entity absolutely controls the other, determining whether the transaction results in a single entity can be difficult. It typically depends on the degree to which the parties have centralized their operations and, conversely, the degree to which the two parties retain autonomy or control over their own facilities and operations. There is no black-letter line, and counsel must consider a number of factors to make an educated judgment and advise the parties whether their proposal likely meets the test, and then, if it doesn't, suggest ways it can be tweaked to minimize any risk.

3. The degree of service and geographic overlap between the parties. If the services the parties provide and the geographic area in which they provide them overlap, the merger is horizontal, and this, by itself, raises at least some initial suspicion. Horizontal mergers, or those between competitors, are a primary concern of the antitrust laws. The parties typically can roughly determine the degree of overlap, if any, themselves. If there is overlap, the parties would be wise to obtain antitrust advice.

But the parties need not be competitors for an antitrust issue to arise. For example, hospital acquisitions of physician practices can raise vertical antitrust issues if the acquisition forecloses other hospitals from a significant percentage of physician referrals, substantially weakening their competitive viability vis a vis the acquiring hospital. And if the hospital already employs physicians in the same specialty as those it's acquiring, the merger is horizontal, which adds a significant amount of risk.

Finally, but of lesser concern at present, is the situation in which there is little or no overlap between the parties but they operate in adjacent or nearby markets—so-called “cross-market” mergers. There, in limited circumstances, it may be necessary for health plans to construct competitively viable networks that include hospitals in both markets, so that the merger may increase the bargaining leverage of the merged providers even though they aren't competitors in the usual sense. The theories of how this might occur are not well-developed, but the FTC has expressed concern about cross-market mergers based on complaints from health plans that they result in greater provider bargaining leverage.

4. An early “eyeball” assessment of the merger's antitrust ramifications. An antitrust attorney, sometimes with aid from a consulting health care antitrust economist, should be able to provide an early rough assessment of the transaction's likely antitrust ramifications. Indeed, one job for the attorney is to advise about the need for economist help.

The analysis requires, first, defining the product and geographic markets (the “relevant market”) in which the transaction would most directly affect competition. Typically, definition of the product market is not difficult, but definition of the geographic market can be and has been the major issue in a number of both early and recent hospital-merger decisions. That analysis can be quite complicated. Roughly speaking, the relevant market includes the smallest number of competing providers that, acting jointly, would be able to profitably raise price because health plans would lack adequate good substitutes to which they could turn if they excluded those providers from their networks. Defining relevant markets is a job for the attorney and economist.

The Antitrust Division/FTC *Merger Guidelines* focus on two potential types of potential anticompetitive effects from mergers—so-called “unilateral effects” and “coordinated effects.”

Unilateral effects result when the loss of direct competition between the merging providers permits them, by themselves, to profitably raise price. Whether unilateral effects are likely depends greatly on the degree of substitutability between the merging providers in the eyes of health plans and patients compared to their substitutability with other providers in the area. If, for example, the merging providers are very good substitutes for one another (say, the first and second choices of a significant percentage of area patients) and other providers in the area are only distant substitutes, health plans may be forced to contract with the merged provider, acceding to its higher reimbursement demands, to avoid a significant loss of enrollees and thus of profits.

The degree of the merging providers' substitutability for each other can be ascertained by estimating the “diversion ratios” between them—i.e., the percentage of one party's patients that would divert to the other party, as opposed to choosing other area providers, if the first weren't available. The higher the diversion ratios, the more substitutable the parties are for each another and the greater the danger of unilateral effects. Another danger sign is the post-merger market share of the merged provider. A very rough guideline is that

concern begins to arise at market shares greater than 35 percent. Most provider mergers have focused on this unilateral-effects type of potential harm, but some have raised the next type as well.

Coordinated effects can occur when the merger results in a significantly more concentrated market—i.e., when the resulting number of competitors in the market is quite small. This facilitates potential price increases by all the providers in the market, not just the merging providers, because tacit collusion among those providers—i.e., collusion without actual agreement—becomes more feasible. The market may become an oligopoly, characterized by interdependent or follow-the-leader pricing decisions; if one raises its prices, the others will follow. The key variables in assessing this danger are the post-merger level of market concentration as measured by the Herfindahl-Hirschman Index (HHI) (calculated by adding the market shares of the merging providers, squaring the market shares of all providers with shares in the market, and summing the squares), and the increase in the HHI resulting from the merger (calculated by multiplying the merging providers' market shares by each other and that product by two). The *Merger Guidelines* (and many courts) provide a rebuttable presumption that the merger is unlawful if the post-merger HHI exceeds 2,500 (dropping the decimal point) and the HHI increase is greater than 200.

It's often possible to determine, early-on before the parties spend substantial time and effort, either that the merger will raise no problem at all or that it's clearly a non-starter. If the latter is the case, the parties should be informed. The frequent difficulty is that many horizontal mergers are in the middle and will require more detailed examination, including information about relevant variables about which little will be known at this stage, for example, efficiencies from the transaction.

5. Advice about pre-consummation coordinated activities. Until the transaction actually consummates, the parties remain separate competitors for purposes of the antitrust laws and must behave as such. Thus, agreements adversely affecting competition between them during this interim period can raise serious problems under Section 1 of the Sherman Act, which prohibits agreements unreasonably restraining competition. Examples include one of the parties beginning to control the activities of the other, jointly negotiating contracts with health plans, agreements not to compete for business from particular health plans, and agreements not to compete in providing particular services. The parties, in general, can agree on activities they will implement or not implement after the transaction closes.

A related problem can arise when the transaction is reportable under the HSR pre-merger notification requirements, which prevent the transaction from closing until cleared by the enforcement agencies. If one party begins to control the operations of the other—that is, “jumps the gun”—the agencies interpret this, in effect, as merging prior to clearance. This violates Section 7A of the Clayton Act and can result in substantial civil penalties; and if it adversely affects competition between the parties, it may violate Section 1 of the Sherman Act as well.

6. Advice about discussions, the exchange of documents, and due diligence. The parties will have many, many discussions in planning the transaction and determining whether to proceed. They need to be somewhat careful about what they discuss, however. Again, they are separate entities and competitors until the transaction closes, and must behave as such. Thus, particularly sensitive competitive information should not be discussed and competitively sensitive documents should not be exchanged until late in the process. Every law firm engaging in antitrust merger work has boilerplate guidance discussing these subjects that can be tailored to the particular parties and transaction. That guidance, however, can't cover every situation that may arise, and counsel should be available to answer questions about specific information the parties may wish to exchange.

At the head of the list of subjects not to discuss is the parties' reimbursement from health plans. Other competitively sensitive subjects include the parties' competitive strategies if the transaction ultimately does not

close. To be sure, final decisions of whether to do the transaction may depend on some of these types of information; merging parties are not required to buy a "pig in a poke," and the agencies have taken a relatively lenient position on the types of information that can be exchanged if it's actually needed for rational decision making about the transaction. But all else being equal, if these types of information need to be reviewed, they should be exchanged relatively late in the process—after clearance by the agencies if the transaction is reportable and when it appears that the transaction will, indeed, go forth and close unless the information is a deal-killer. The parties may be able to exchange the information earlier if certain safeguards are put in place to control access and use of the information.

7. Advice about creation of "hot documents." A "hot document" is one that substantially advances a party's case. In the case of mergers, hot documents include those indicating that a purpose for the transaction, its likely effect if consummated, or its actual effect if already consummated, is anticompetitive. For example, a pre-closing document may state that a purpose for the transaction is to increase the parties' bargaining leverage with health plans and thus their reimbursement; a consultant's report or a CEO's report to the board may recommend the transaction because it will have that effect; or if the transaction was consummated several years prior, the CEO may report to the board that the transaction permitted the providers to obtain significantly higher reimbursement.

These types of hot documents have played a major role in almost every recent hospital merger case. They are a major source of evidence and can be suicidal in both an investigation and litigation. Indeed, if increasing reimbursement is the primary motivation for the transaction and the parties anticipate that effect, the parties should think seriously about doing the deal in the first place because the chances are decent that the transaction will encounter antitrust problems at some stage down the road. Internal documents should emphasize the benefits of the transaction to patients and health plans—cost reductions and passage of the benefits of those reductions on to consumers; quality, access, and innovation improvements; and other consumer benefits. Indeed, one of counsel's first jobs should be to review all documents the parties have created to examine any bad (and hopefully, good) documents that later may be produced to the enforcers.

8. Starting the efficiencies analysis early. Although FTC complaints, briefs, and even some court decisions state that efficiencies from a transaction have never saved an otherwise unlawful merger, the *Merger Guidelines* and court decisions say that efficiencies should be weighed against the transaction's effect on the merged entity's market power in determining whether the merger is lawful. But one problem is that the parties often wait until relatively late in the process to carefully examine efficiencies so that the work may be half-baked or shoddy, uncertain, and speculative. Moreover, if the serious efficiencies work begins only after the transaction is under investigation so the parties can raise an efficiencies argument, the agencies and courts have suggested its credibility is open to question.

It's difficult to understand how the parties can reach a final decision whether to do the transaction without first completing a serious and detailed efficiencies study. But in too many provider mergers, there seems to be merely an assumption that efficiencies will magically appear and thus that the transaction is a good thing for consumers. Instead and early on, the parties need to develop, usually with help from a consultant, a detailed integration plan explaining exactly how their organizations will be combined, how the efficiencies will be achieved, what the efficiency results will be, and why. Then, to the extent possible, the efficiencies should be quantified in dollar and sense terms. Quantification of other types of efficiencies is impossible, but their benefits can be explained as well as how they will be achieved.

The case law suggests that the five major shortcomings of efficiencies claims have been that (1) the work was started too late or was not finished; (2) the claimed efficiencies could be achieved by means other than a merger; (3) the efficiencies plans were speculative and not certain; (4) the parties' information was not sufficient for the agency to verify the efficiencies; and (5) the parties overstated the efficiencies to the agency.

In one litigated case, the efficiencies work presented to the court lost credibility because the claimed efficiencies far exceeded those presented to the board of directors earlier.

The hope is always that proof of efficiencies won't be necessary because the transaction isn't likely to result in market power. But if an early assessment of the transaction suggests otherwise, it's important to start the analysis early and have it ready when an agency investigates.

9. Generating stakeholder support for the transaction. It goes without saying that the more opposition there is to the transaction, the more likely that it will be investigated and challenged. First, opponents may complain to one of the enforcement agencies, generating an investigation. Second, depending on their reasons for their opposition, opponents may provide the agency with witnesses and its case with credibility.

In the context of provider mergers, the most important of these stakeholders are health plans and self-insured employers. They pay the bill and are the parties most directly injured if the transaction would increase provider prices, and the agencies always seek their input about the transaction through telephone interviews, in-person meetings, affidavits, or testimony. Their support or opposition can go far in making or breaking a case, so it's important to show health plans and self-employed employers that the merger will provide them and their stakeholders—health-plan members and employees—with significant benefits. The parties should create a presentation and meet with area health plans and employers, preferably prior to the filing of any HSR notification or public announcement of the transaction. Often, an important part of the presentation will focus on the efficiencies from the transaction—another reason that efficiencies work should begin early in the discussions about a transaction.

Several merging parties have attempted to placate health plans, state attorneys general, and the FTC through agreements with the plans or state attorneys general constraining the parties' post-merger competitive behavior, such as freezing rates or limiting price increases for a fixed number of years. These conduct remedies won't satisfy the FTC (or recently, most state attorneys general) for a number of reasons, especially because after the term of the agreement, the merged provider is free to exercise whatever market power, if any, the transaction provided it. Interestingly, one court did rely to some extent on this type of agreement in refusing to preliminarily enjoin a hospital merger (in a case now on appeal), but it will not stave off a challenge by the FTC.

Other stakeholder support is important as well, including favorable reaction from medical staff members, employees, community groups and coalitions, local and state politicians, and state health-regulatory personnel. They, too, need to be told and convinced why the merger will not adversely affect them.

Ober | Kaler's Comments

The bottom line is that if the merging parties are competitors, it's wise to bring in antitrust counsel at an early stage of the discussions to advise on issues that could have a major effect on the transaction later. Once an agency has opened an investigation, the train may have left the station.