# PUBLICATION

## The FTC's Three Current Hospital Merger Challenges: Will the FTC Ever Lose? [Ober|Kaler]

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**Beginning with the Federal Trade Commission's 2007 decision in *Evanston Northwestern Healthcare Corp.*, holding that a hospital merger in the North Chicago suburbs violated the antitrust laws, the FTC has experienced unprecedented success in challenging hospital mergers—indeed, it's undefeated.**

And this streak resulted after eight straight government losses between the mid-1990s and 2001 and then a long hiatus in hospital-merger enforcement. The *Evanston Northwestern* decision was a game-changer in hospital-merger analysis, introducing more sophisticated analysis, including complex econometric evidence and economic theories not employed in previous hospital-merger cases.

Look what's happened since then. In 2008, the Inova Health Foundation abandoned its proposed acquisition of Prince William Medical Center in northern Virginia after the Commission filed a motion for preliminary injunction to block the transaction. Reading Health System, in 2012, abandoned its proposed acquisition of the Surgical Institute of Reading in light of an FTC challenge. In 2013, Capella Healthcare abandoned its proposed acquisition of Mercy Hot Springs in Arkansas when informed the FTC would sue to block it. In matters that went to trial, the Northern District of Illinois, in 2012, blocked OSF Healthcare's proposed acquisition of St. Anthony Medical Center in Rockford, Illinois. And in perhaps the best known case, the Sixth Circuit, in 2014, affirmed the FTC's decision that ProMedica's acquisition of St. Luke's Hospital in Toledo, Ohio, violated Section 7 of the Clayton Act. Simply put, since the *Evanston Northwestern* decision, the FTC has yet to lose; a fact that, rightly or wrongly, has likely deterred numerous other transactions based on more conservative legal advice resulting from that decision.

At present, the FTC has three outstanding challenges—hospital mergers in Huntington, West Virginia; Harrisburg, Pennsylvania; and another in the north Chicago suburbs involving the same system that was the focus of the 2007 decision. The parties in all these challenges, notwithstanding the problematic nature of the transactions (at least based on FTC allegations) have, at least thus far, decided to fight. And each of the cases has some interesting twists.

## The Cabell Huntington Hospital/St. Mary's Medical Center Transaction

Cabell Huntington Hospital with 303 beds and St. Mary's Medical Center with 393 are the only general acute-care hospitals in Huntington, a city of approximately 49,000 residents and home to the Marshall University "Thundering Herd." After determining to proceed with a merger and apparently recognizing that the transaction would raise antitrust concern, the hospitals, in July 2015, entered into an Assurance of Voluntary Compliance with the Attorney General of West Virginia to obtain that office's support. Basically a conduct remedy meant to prevent the merging hospitals from exercising market power, the key provision of the Assurance would prevent the merged hospitals from "increase[ing] hospital rates beyond benchmark rates established by the West Virginia Health Care Authority" (WVHCA), a state rate-reviewing authority that approves the list prices of West Virginia hospitals. (A bill presently before the governor for signature would withdraw that authority.)

Negotiating a conduct remedy with the state attorney general that would permit the merger, but under delineated constraints, has been a common tactic in many hospital-merger investigations. Often, if agreement could be reached with the state attorney general, the FTC would yield to the state's desire and leave the parties alone. But not this time. Determining that the constraints in the Assurance were inadequate to replace competition between the hospitals, the Commission filed an administrative complaint on November 6, 2015, alleging that the transaction would violate both Section 5 of the FTC Act as an unfair method of competition and Section 7 of the Clayton Act as an unlawful acquisition. The Commission typically would also file a motion in federal court for a preliminary injunction to prevent the parties from merging until the FTC's own administrative process could determine its lawfulness. In this case, however, the parties could not merge absent a certificate of need from the state and, given St. Mary's status as a Catholic facility, approval by the Vatican, neither of which had occurred. Thus, there was nothing to enjoin.

The FTC's administrative complaint defines one alleged relevant product market in the usual FTC fashion in hospital-merger cases: "general acute care services sold and provided to commercial health plans and their members" offered by both hospitals—the "GAC" market. A second alleged product market is "outpatient surgical services sold to commercial health plans and their members." The alleged relevant geographic market for both product markets is the "Four-County Huntington Area."

According to the FTC, the hospitals, post-merger, would have a 75.4 percent share of the GAC market. The transaction would allegedly increase the Herfindahl-Hirschman Index (HHI) in that market by 2,825 to 5,824. The Department of Justice/Federal Trade Commission *Horizontal Merger Guidelines* provide that a merger is rebuttably presumed unlawful, i.e., the government proves a prima facie case, if the post-merger HHI exceeds 2,500, and the HHI increase from the merger exceeds 200, so the complaint alleges a very strong prima facie case. This shifts the burden to the hospitals to show that the statistics provide an inaccurate indicator of the merger's likely effect. The *Merger Guidelines* include no post-merger market-share number resulting in a prima facie case, but a 53-year-old U.S. Supreme Court decision suggests that a share greater than 30 percent is sufficient, and the FTC, as well as some courts, continue to cite to that figure. A 75 percent share is certainly troublesome. The complaint provides no share or concentration figures (or much of any other information) about the alleged outpatient product market.

Additionally, the Commission alleged that the two hospitals are each other's closest and most direct competitor. This is a key variable in determining whether the merger will provide the merging hospitals, by themselves or unilaterally, with the ability to exercise market power because it can suggest that other area hospitals are not adequate substitutes to which health plans could turn to contract if the merged hospitals attempted to raise price. In effect, the merged hospital becomes a "must have" facility in the eyes of health plans and thus can negotiate better reimbursement than either facility could separately.

Thus, that the hospitals entered into the Assurance of Voluntary Compliance with the attorney general is understandable. Likely, they hoped that would keep the FTC at bay. But the FTC wouldn't buy into the deal. Most important, it noted that the agreement would apply only to the hospitals' "benchmark rates established by the [WVHCA]," which are *list* prices or charges, not *negotiated* prices with health plans, that the agreement would last only seven years and then the hospitals could negotiate their highest possible rates, and that the agreement would not protect the current quality competition between the hospitals.

But then the West Virginia legislature jumped into the picture, passing a bill (over the objections of the FTC explained in a letter to the state's house of delegates) that would provide the WVHCA and the state attorney general with the power to approve so-called "cooperative agreements," including certain hospital mergers in which one party is an academic medical center teaching hospital and thus (hopefully) providing them with immunity under antitrust's state-action exemption. The bill is similar to the recently enacted Tennessee and Virginia certificate-of-public-advantage legislation, enacted to provide state-action-exemption protection for a

merger of two systems with hospitals in eastern Tennessee and southwestern Virginia. The governor signed the bill, which became effective immediately, on March 18. Given this new statute, the FTC will need to determine whether to pursue the case. And in another unusual twist, the hospitals and the FTC are arguing whether the FTC administrative trial, scheduled to begin April 5, should proceed, given that the two condition precedents for the transaction—issuance of a certificate of need and Vatican approval—have yet to be met.

## The Hershey Medical Center/Pinnacle Health System Transaction

On December 14, 2016, the FTC filed an administrative complaint challenging the merger of Hershey Medical Center in Hershey and the Pinnacle Health System in Harrisburg, Pennsylvania. The Commission, joined by the Commonwealth of Pennsylvania, also filed a motion for preliminary injunction in the U.S. District Court for the Middle District of Pennsylvania. The alleged relevant product market is the same as that alleged in the *Cabell Huntington* matter—the cluster of general acute-care inpatient hospital services provided by both systems and sold to health plans and their members; the alleged relevant geographic market is the "Harrisburg Area" or the Harrisburg Metropolitan Statistical Area, consisting of four counties.

Hershey has some 551 beds (125 at a children's hospital), while three Pinnacle hospitals have a total of 662. According to the administrative complaint, the merger would combine Hershey's 26 percent market share with Pinnacle's 38 percent—a total of 64 percent. The merger would allegedly increase the HHI by over 2,000 to about 4,500—well over the level resulting in a prima facie case, thus raising a rebuttable presumption that the transaction would have adverse competitive effects.

As in the *Cabell Huntington* matter, the Commission alleged that the two systems are very close or direct competitors, suggesting that a merged system would obtain the ability to increase its prices after the merger. As evidence of this, the complaint relies on "diversion ratios," which help measure the degree of competition between two parties compared to the degree of their competition with other competitors. In the context of hospitals, diversion ratios between two hospitals measure the degree to which the patients of one, if it did not exist, would turn to the other—rather than to other competitors in the market—for services. For example, in the Hershey matter, the complaint alleges that if Hershey were unavailable, 40 percent of its patients would divert to Pinnacle, while if Pinnacle were unavailable, 30 percent of its patients would divert to Hershey. The theory is that high diversion ratios indicate that the merging hospitals are particularly good substitutes for each other while other facilities are not good substitutes for the merging hospitals in the eyes of patients and thus of health plans. Thus, while health plans could play the two good substitutes off against each other in contract negotiations absent the merger, the merger decreases the availability of a good substitute, increasing the merging hospitals' bargaining leverage in negotiations with health plans. As the complaint explains, "A merger between hospitals that are close substitutes from the perspective of health plans and their members . . . tends to produce increased bargaining leverage for the merged entity and, as a result, higher negotiated rates, because it eliminates a competitive alternative for health plans." What constitutes a sufficiently high diversion ratio to raise a problem, however, is unclear.

In addition, some health plans apparently told the Commission that the merger would significantly increase the merging systems' ability to leverage higher reimbursement. Although heavily redacted, the complaint also suggests that the systems offered one or more health plans special deals to induce their support for the transaction.

The complaint parrots the Commission's usual allegations of high entry and expansion barriers. Expecting the hospitals to raise an efficiencies argument in rebuttal to the prima facie case (which they have), the complaint alleges that "[n]o court ever has found, without being reversed, that efficiencies rescue an otherwise illegal transaction," a point that several courts have made as well. Does this mean that in the FTC's eyes, a merger's

efficiencies are never sufficient to rebut a prima facie case? If so, one wonders whether an efficiencies argument is even worth developing and presenting. Yet FTC speeches and articles emphasize the Commission's careful consideration of transaction efficiencies in determining whether to challenge a merger and the *Merger Guidelines* state that efficiencies are the primary benefit from mergers. But assuming that, in some situations, efficiencies can trump a prima facie case, the FTC's complaint adds that those claimed by Hershey and Pinnacle "are overstated, speculative, unverifiable, not merger specific, or result from an anticompetitive reduction in output, quality, or services, and are largely non-cognizable" and, even if that were not true, "insufficient to offset the substantial competitive harm the merger is likely to cause." Wow, could they have any other shortcomings?

A hearing in federal court on the preliminary injunction motion is scheduled to begin on April 11. The FTC administrative hearing is scheduled to begin on May 17. Given their view that the preliminary injunction hearing may moot the need for the administrative trial, the hospitals have moved the FTC administrative law judge to stay commencement of the latter. They argue that when federal courts deny the FTC requests for preliminary injunctions, the FTC usually does not proceed to an administrative trial; and that if the preliminary injunction is granted, the hospitals "intend to walk away from the challenged combination barring extraordinary circumstances." Commission staff opposes the motion and, as of this writing, no decision has issued.

## The Advocate Health Care Network/NorthShore University Health System Transaction

Finally, on December 18, 2015, the FTC filed an administrative complaint challenging the merger of the Advocate Health Care Network and NorthShore University HealthSystem in the North Chicago suburbs. On December 21, the FTC and the State of Illinois filed a motion for preliminary injunction to block the transaction in the U.S. District Court for the Northern District of Illinois.

Both these systems have significant previous experience with the FTC. In 2006, the Advocate PHO entered into a consent order with the Commission based on a complaint alleging that the network was unlawfully fixing prices by negotiating fees for its member physicians with health plans. NorthShore, prior to a name change, was the Evanston Northwestern Healthcare Corporation, the subject of the Commission's 2007 hospital-merger decision.

The alleged relevant product market is the usual inpatient general acute-care services offered by both systems sold to commercial insurers and their members, excluding certain tertiary and quaternary services, psychiatric care, substance abuse, and rehabilitation services. The alleged relevant geographic market is the "North Shore Area" in northern Cook County and southern Lake County, Illinois, north of downtown Chicago. Advocate has two hospitals in the market—with 638 and 273 beds—while NorthShore has four with 354, 173, 125, and 149 beds. The merger would allegedly combine NorthShore's 35 percent share and Advocate's 20 percent into a post-share of 55 percent. The HHI would increase by 1,423 to 3,517, well above the level necessary for a prima facie case.

In addition, the systems allegedly are "close, if not each other's closest, competitors in the North Shore area," although there are five other hospitals in the relevant market, and the diversion ratio from NorthShore to Advocate was only about 20 percent and that from Advocate to NorthShore was between 20 percent and 25 percent. Health plans, however, allegedly do not view the other five hospitals as adequate substitutes for those merging, and thus the FTC claims the merger would increase the merged hospital's bargaining leverage.

Entry barriers allegedly are high, particularly because of Illinois' certificate-of-need requirements. As usual, the complaint rejects the parties' efficiencies claims because they are "not substantiated, not merger-specific, and not nearly of the magnitude necessary to justify the [t]ransaction in light of its potential to harm competition."

As in the *Hershey/Pinnacle* matter, the hospitals have moved to stay the FTC administrative trial, scheduled to begin on May 24, 2016. The preliminary injunction hearing is scheduled to commence on April 6, and, as in *Hershey/Pinnacle*, the hospitals argue that the result in that hearing is likely to negate the need for the FTC administrative hearing. They note that if the preliminary injunction is granted, they "would undoubtedly . . . reevaluate proceeding . . . and likely abandon the transaction." That motion is outstanding.

## Ober|Kaler's Comments

There is no end to these mergers and challenges in sight. A recent *Modern Healthcare* survey notes that 79 percent of a group of some 84 national health care leaders believe that "[t]he pace of consolidation among healthcare players will continue or accelerate" and 72 percent believe that "[g]overnment scrutiny of healthcare deals will grow . . . no matter who wins" the fall presidential election. It seems clear that mergers in one healthcare industry spur mergers in others. At present, the Antitrust Division is carefully considering the Anthem/Cigna and Aetna/Humana health plan mergers, recently described by the head of the Antitrust Division as "game changer[s]" and "transformational mergers in a number of markets." Proponents of these mergers indicate that one purpose is to offset the power of hospitals resulting from hospital mergers. And as anyone representing them knows, providers point to consolidation in health plan markets as a reason for hospital and physician mergers. Both sides have raised an "Affordable-Care-Act-made-me-do-it" defense, but that argument falls on deaf ears at the Commission and, so far, in the courts. Basically an efficiencies argument, the Commission's belief is that mergers are rarely necessary to accomplish Affordable Care Act goals—that, for example, they can be sustained unilaterally or through contractual arrangements and joint ventures and thus that the benefits are not merger-specific. In any event, all signs suggest that the antitrust enforcement agencies may be quite busy with health care-sector mergers for some years to come.