PUBLICATION

Anatomy of a Provider Antitrust Merger Challenge (Part 5) [Ober|Kaler]

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This is the fifth in a six-part series discussing the Federal Trade Commission's challenges to provider mergers. Following the initial Introduction and Background (Part 1), the series discusses The Need for Early Legal Advice (Part 2), The Investigatory Process (Part 3), Analyzing the Merger's Likely Effect on Competition (Part 4), and Rebutting the Prima Facie Case (Part 5), then offers a Conclusion (Part 6) to summate the factors that must be considered in an informed approach to provider mergers.

The series is based on Mr. Miles' presentation at the American Health Law Association Physicians and Hospitals Law Institute on February 2 and 3, 2015.

Part 5: Rebutting the Prima Facie Case

If the government proves a prima facie case and thus a rebuttable presumption that a merger is unlawful, the burden of going forward shifts to the merging parties to rebut the government's case by showing that post-merger market share, post-merger market concentration, and/or the high degree of substitutability between the merging parties provide an inaccurate indicator of the merger's likely effect on competition. What variables should the merging parties examine and seek to prove?

Generally speaking, rebuttal factors fall into four categories: that (1) the government defined the relevant market incorrectly and thus miscalculated market share and market concentration figures; (2) increased output by new providers entering the market or expansion of output by providers already in the market ("incumbent providers") would equal or exceed the decrease in output by the merged providers attempting to exercise market power; (3) efficiencies from the merger would offset any anticompetitive effects from the merger; and (4) one of the merging providers is so competitively weak that it would either quickly exit the market altogether or become such an insignificant competitive force that its current market share substantially overstates its future ability to constrain the power of other providers in the market. Providers have raised other defenses as well—arguing, for example, that the merging parties are nonprofit entities with no incentive to engage in anticompetitive behavior1 or, since passage of the Affordable Care Act, that health reform and its encouragement of more integrated and coordinated care justified the parties' merger— but those defenses have been rejected summarily

Low entry barriers

If the attempt by the merging providers to raise prices post-merger would quickly induce new providers to enter the market or induce incumbent providers to expand their output to the extent that it replaced the output lost as a result of the higher price, the merger would have no anticompetitive price effects.2 Merging parties in different industries frequently argue that entry or expansion barriers are sufficiently low that they would be unable to raise prices for any significant period of time. The merging providers bear the burden of persuasion on the defense; the federal agencies' *Horizontal Merger Guidelines3* set forth the evidentiary burdens they must meet.

The *Merger Guidelines* explain that "[t]he prospect of entry . . . will alleviate concerns about adverse competitive effects only if such entry will deter or counteract any competitive effects of concern so the merger will not substantially harm customers." The key variables are the entry's *timeliness*, *likelihood*, and *sufficiency*.

The *Guidelines* provide no specific time period in which entry must occur to be timely. Some decisions (and the agencies' previous *Merger Guidelines*) suggest a two-year period. The current *Guidelines* state, rather unhelpfully, that "entry must be rapid enough to make unprofitable overall the actions causing [anticompetitive] effects."4 The threshold for proving the requisite entry is "high."5

Entry is "likely" if it would be profitable for the entering providers. A provider (or any firm) considering entry because of supracompetitive prices resulting from a merger must consider that entry will drive prices down. So if entry is sufficient to counteract the adverse price effects of the merger, it must be profitable for new entrants at the pre-merger price. And for entry to be "sufficient" under the *Guidelines*, the resulting increase in output must counteract the effect of the likely price increase.

In the case of hospital mergers, low-entry or -expansion barrier arguments are normally non-starters, particularly in states with certificate-of-need laws.6 The entering hospital would have to be planned, licensed, built, and offer substantial competition to the merging hospitals within a two- to three-year period—a very unlikely scenario. The situation may be somewhat different if the competitive problem results from only a single type of hospital service, such as obstetrics, because the introduction or expansion of a single service may be less onerous, expensive, and time-consuming than entry by a new hospital. But merging hospitals rarely make a low-barrier argument, and no hospital-merger decision suggests that entry would counteract the likely anticompetitive effects of the merger.

The situation also may be different in the case of physician-practice mergers because entry would seem much easier. For example, in a 1997 decision discussing a hospital's acquisition of a second physician practice, the court found "low entry barriers to the primary care market" because of unsatisfied demand for primary-care services in the area, testimony from physicians that more primary-care physicians were needed, strong recruitment of primary-care doctors by the city's hospitals, opportunities for new primary-care physicians in the city, recent successes in recruiting new physicians, and testimony that "a primary care physician can build a successful practice in two to three years."7 On the other hand, in the more recent *St. Alphonsus* decision, the court concluded that it "cannot find that entry of competitor[] [primary-care physicians] is likely to mitigate the anticompetitive effects of the Acquisition."8 The court found that newly minted physicians preferred more urban environments over the area in question or to become hospitalists or specialists. Evidence indicated that it was "difficult to recruit family doctors to" the area and that St. Alphonsus had failed to recruit any PCPs to the area within the two years before the merger. Similarly, the FTC's complaint in *OSF*, which challenged the combination of the merging hospitals' employed physicians as well as the merger of the hospitals, alleged substantial entry barriers into the PCP market because most physicians were employees of the hospitals, fewer and fewer PCPs wanted to practice independently, and there had been little entry by PCPs into the area in recent years.9 The entry-barrier and expansion question is fact-specific, but expect the agencies to allege significant entry and expansion barriers.

Efficiencies

Although the Ninth Circuit expressed skepticism about the relevance of efficiencies in its recent *St. Alphonsus* decision,10 the efficiencies effects from a merger can offset its anticompetitive effects. The concept, however, is somewhat amorphous in antitrust analysis. Strictly construed, *efficiencies* encompasses effects from a merger that lower cost or resource usage for a given level of output—economies of scale as a prime example. Given that as a theoretical matter, a profit-maximizing firm sets its price at the point where its marginal cost equals its marginal revenue, a decrease in its variable costs resulting from a merger will mean a lower profit-maximizing price.11

But typically, *efficiencies* is defined more broadly to include almost any effect from the transaction that benefits patients or health plans making the merged firm a more effective competitor—lower costs and prices, higher quality, improved access, new services, and the like—at least to the extent that the benefit improves the firm's

competitive position. Competition, after all, is multi-dimensional. In selecting among competing providers, health plans and particularly patients consider not only price but also non-price factors such as quality.12 It is not the nominal price but the "quality-adjusted price" that drives competition. Indeed, in the second stage of provider competition, the model applied by the agencies and courts today, where health-plan network providers compete for patients, the focus of competition is on non-price factors.13 As a result, non-price improvements resulting from the merger should be and are considered efficiencies, although admittedly, non-price benefits such as quality are notoriously difficult to quantify empirically and balance against structural concerns the merger may raise. But the *Merger Guidelines* state that "a primary benefit of mergers . . . is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in . . . improved quality, enhanced service, or new products."14 Thus, the agencies, in provider mergers, give potential quality improvements serious consideration as a rebuttal factor.15

While the agencies and courts consider efficiencies as a rebuttal factor, the merging providers' burden in proving that they save the day is extremely stringent. Under the *Merger Guidelines*, the bottom line is that they must be "of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market."16 And before any efficiency even counts in favor of the transaction, it must be "merger-specific," "verifiable," and not result in a reduction of output. The claimed efficiency is merger specific if it is "unlikely to be accomplished in the absence of . . . the proposed merger."17 In practice, the agencies and courts have read this to mean that an efficiency is not merger-specific if it *could* be achieved by some reasonable means absent the merger, not that it *would* not be achieved absent the merger—for example, if it could be achieved by some arrangement between the parties, such as a joint venture or contractual arrangement, short of merger.

The most burdensome requirement is that of verifiability. The *Merger Guidelines* provide that for each claimed efficiency, the parties must provide information sufficient for the agency to verify the likelihood of its achievement, its magnitude, how it will be achieved, when it will be achieved, the costs of achieving it, why it is merger-specific, and how it will further competition. Only net efficiencies count—i.e., the excess of the efficiency's cost-saving or benefit over the cost of achieving it. This burden is substantial, requiring reams and reams of documentation. And some, including an FTC Commissioner, have argued that the government's burden and the parties' burden seem asymmetric in that the government must show only a "reasonable probability" of anticompetitive effects, while the defendants' must prove efficiencies almost to a certainty.18 Finally, but not surprisingly, the stronger the government's prima facie case, the greater the efficiencies must be:19 "High market concentration levels require proof of extraordinary efficiencies."20

To be sure, the skepticism of the agencies and courts is understandable. Efficiencies are easy to claim but much more difficult to prove, and the agencies cannot turn their backs on an otherwise anticompetitive merger simply because the parties present, for example, preliminary, poorly developed, half-baked, or pie-in-the-sky plans for post-merger integration and efficiencies, or claimed efficiencies that the parties could easily achievable unilaterally or through a joint arrangement less restrictive of competition.

Merging providers assert efficiencies claims as a rebuttal factor in almost every provider merger investigation and challenge. None yet have overcome a prima facie case. Merging hospitals have cited numerous types of efficiencies, including capital-cost savings from capital projects the merger makes unnecessary, savings from consolidation of administrative and operational functions, savings from consolidation of service lines, sharing of best practices, establishment of centers of excellence, better ability to recruit physicians, creation of graduate education programs, sharing of medical staffs, development of new service lines, improved EMR and EHR systems, ability to serve larger geographic areas, generation of critical masses to facilitate risk acceptance, improvement in coordination of services, and improved on-call service.

In the 2007 *Evanston* decision and subsequent provider-merger decisions, however, the agencies and courts have universally rejected the merging parties' efficiencies claims based primarily on lack of merger-specificity or verifiability. In *Evanston*, for example, the FTC noted that "the quality improvements . . . are not properly credited as benefits . . . because [the acquired hospital] could, and likely would, have made similar improvements without a merger" and that "in many instances, [Evanston] produced little verifiable evidence that the changes it made . . . improved quality of care."21 Interestingly, although the FTC held that the merger violated Section 7, its quality improvements convinced the agency not to order divestiture, which would have abrogated those improvements.22

The efficiency claims in *OSF* exhibited the same problems and others. In the "other" category, the hospitals claimed that the merger would save capital costs because a patient tower needed by one of the hospitals to increase its capacity would not be built. But the CFO of that hospital testified that "'I don't know if I want to imply that if the merger doesn't go through, we would have to build a bed tower," and there was other testimony showing that "no specific plans have been made on how or when any of these service lines would be consolidated to achieve the claimed efficiencies."23 Numerous other efficiencies, according to the court, even if achieved, would not be merger-specific, including the sharing of best-practices, creation of centers of excellence, recruitment of specialists, and development of a residency program.

One of the important lessons from the *OSF* case is that merging parties, if they believe an efficiencies argument might be necessary to save the merger, cannot wait until they see how serious the investigation is before they begin serious and detailed planning and decision making about the hospitals' post-merger integration and efficiency benefits. By then, the train has left the station: a "we may do this or we may do that" argument is a non-starter with both the agencies and courts, and an efficiency study begun only once the parties see an investigation will ensue or after the decision to complete the transaction lacks credibility.

The efficiencies argument in the *ProMedica* hospital-merger case exhibited some of the same sorts of weaknesses as those in OSF. In a preliminary injunction hearing, the district court found the claims speculative and, in effect, the work of the parties' counsel and consultants. The efficiencies report was described as an "initial plan"; one of the parties testified that "if we don't find those efficiencies, we will find other efficiencies"; and testimony was that the "estimates . . . are preliminary and subject to further analysis," and based on "gut feeling." About one claimed efficiency, a party's representative stated, "I don't believe this claim."24 In subsequent proceedings in the case, the parties appeared to drop their efficiencies claims.25

In the latest decision, *St. Alphonsus*, which challenged a hospital's acquisition of a large physician group, the Ninth Circuit appeared to hold, amazingly, that quality improvements resulting from a merger fail even to count as an efficiency or benefit in support of the transaction. The defendants claimed that the merger would improve patient care by generating tight integration between the hospital and the acquired physicians, and thus a greater probability of coordinated patient care, including development of highly sophisticated electronic records systems and a better ability to engage in risk-contracting. The district court had suggested that this type of benefit, if merger-specific, would count in favor of the merger but that it could be accomplished unilaterally or by relationships short of merger. The Ninth Circuit agreed but went further, stating:

It is not enough to show that the merger would allow St. Luke's to better serve patients. The Clayton Act focuses on competition, and the claimed efficiencies therefore must show that the prediction of anticompetitive effects from the prima facie case is inaccurate. . . . [T]he [district court] did not find that the merger would increase competition or decrease prices. Quite to the contrary, the court, even while noting the likely beneficial effect of the merger on patient care, held that reimbursement rates for PCP services likely would increase.26

While the exact meaning of this statement is not clear, the court seems to say that quality improvements (and perhaps all non-price benefits) resulting from a merger are irrelevant in the antitrust analysis—that, to count,

efficiency benefits must reduce costs and thus the merging parties' profit-maximizing price. Or the court might have been saying that quality improvements might count, but that the parties must prove a specific cause-and-effect connection between the improvements and the merging hospitals' competitive position—that health plans and patients would actually choose the merged hospital because of the quality improvements.

If the former, the court is clearly incorrect. The agencies and courts, as noted before, do consider quality and other non-price factors in determining a merger's effect on competition. If the latter, it would seem that just as the agencies and courts assume that price affects demand, they should assume that quality and other non-price factors do so as well. Efficiency claims based on quality improvements, admittedly, are particularly difficult to investigate, evaluate, and balance given the different and amorphous methodologies for identifying and measuring quality improvement, data problems, determining how to value improvements, and then balancing them against likely price increases.27 But they are an important procompetitive reason for many provider mergers.

The agencies examine efficiencies claims with a fine-tooth comb, considering numerous factors.28 Both agencies have financial analysts and a stable of outside experts on whom they call to review efficiency claims. They typically seem to find and testify that most claimed efficiencies lack merger-specificity, are speculative, or fail the verification requirements. Relatedly, the efficiency claims presented to the agency should match those provided the parties' decision makers, if any, when deciding to do the deal. In one case, for example, the claimed efficiencies savings provided the agency and court far exceeded the amount provided to the firms' boards earlier when they were deciding whether to pursue the transaction.29 This adversely affects the study's (and possibly the parties' and counsel's) credibility.

In assessing efficiencies claims, the agency will look at the prior acquisitions by the acquiring party to determine if those transactions generated efficiencies, including examining whether the firm followed through and actually implemented any efficiencies plan. If not, they question how the transaction under review is any different, why the previous transaction failed to generate efficiencies, and why the party expects any different result in this transaction.

The bottom line is that there may be situations in which the efficiencies from a transaction, including quality improvements, will trump a prima facie case. The defendant's burden is heavy, however, and success is rare. Indeed, the courts in both *ProMedica* and *OSF* stated that in no case has an efficiencies argument saved an otherwise unlawful merger.30 If a transaction will result in a merged firm with a large market share or a highly concentrated market, or is between significant providers who are each other's best substitutes in the eyes of health plans and patients, the efficiencies story should be developed early and in substantial detail. Typically this involves coordination between the merging parties and their consultants to first develop a highly detailed plan of integration and then, where possible, a quantification of the efficiencies the transaction will generate.

Failing or flailing firm

The ailing financial status of one of the merging hospitals, depending on the depth of its problems and likely effect on its future competitive strength, might support either a “failing company defense,” or a “flailing company” or “weakened competitor” rebuttal argument. The former is an absolute, dispositive, affirmative defense regardless of the strength of the government's case—that but for the acquisition, the failing company and its assets would, in fairly quick order, exit the market. In that situation, and if no other partner, whose acquisition of the firm would be less restrictive of competition, would retain those assets in the market, little or no harm to competition results from the merger.

The requirements for sustaining the defense, however, are stringent. The *Merger Guidelines* explain that the proponent must prove that “(1) the allegedly failing firm would be unable to meet its financial obligations in the near future; (2) it would not be able to reorganize successfully under Chapter 11 of the Bankruptcy Act; and (3)

it has made unsuccessful good-faith efforts to elicit reasonable alternative offers . . . that pose a less severe danger to competition than does the proposed merger."31 As to the first requirement, the parties must show, in effect, that the hospital is insolvent, has no net worth, or is unable to meet its debts as they become due. The third requirement mandates an extensive and unsuccessful search for an alternative purchaser. The defense has been successful in only one hospital-merger case,32 although there are several instances in which the acquired hospital's financial condition convinced the FTC not to pursue a challenge. The burden of persuasion, of course, is on the defendants.

The one hospital-merger decision in which the defense was successful is C*alifornia v. Sutter Health System*, involving Sutter Health's acquisition of Summit Medical Center in Oakland.33 The defendants showed that Summit had some $8.9 million in overdue bills and was a "cash-on-delivery" customer with its vendors; was unable to meet its bond covenant restrictions; had a negative net worth; and could not obtain a "clean" letter from its auditors. It had shopped itself for three years with help from an investment banker and obtained offers from Sutter and Tenet. As Summit's financial condition worsened, Tenet's interest waned, finally to the extent that, according to the court, it "is not sufficient to elevate Tenet to the status of a viable alternative purchaser."34

If the ailing hospital is not insolvent, but clearly heading in that direction, the weakened competitor or "flailing company" rebuttal argument may be viable, but it, too, is difficult to sustain. And, unlike the failing-company defense, it is not a dispositive affirmative defense; rather, it is merely one factor that can rebut a prima facie case To the extent the provider is spiraling downward financially (and presumably competitively) its current market share may significantly overstate its future competitive strength.35 In making this assessment, the agencies "rel[y] on documents, interviews with payors, and evidence of a hospital's financial struggles such as staff layoffs, closed service lines, declining inpatient admissions and outpatient procedures, declining revenues and increased losses, compromised (or potentially compromised) quality, or downgraded credit scores from the rating agencies." In addition, the agencies "want to see what efforts a hospital has made to turn around its financial condition before deciding to merge with a competitor."36

But the burden the defendants must meet, at least in the eyes of some courts, is stringent: that within a reasonable period of time, the ailing provider's market share would fall to the point at which the rebuttable presumption of unlawfulness would disappear,37 for example, that the HHI would decrease to below 2,500. Attempting to meet this burden is, to say the least, quite speculative. Thus, in the *ProMedica* case, the defendants would need to prove that, in a relatively short period of time (no one knows how short), the acquired hospital's share would fall from 11.5 percent to less than 2 percent.38 This seems too strict a requirement; the threshold should be the point (or share) at which that hospital would lose its role as a significant competitive factor in the market. In any event, in concentrated hospital markets under this strict requirement, the flailing company argument will rarely succeed. And finally, as in the case of the failing company defense, the parties must show that the ailing hospital unsuccessfully sought an alternative purchaser whose acquisition of it would have less restrictive effects on competition.

As the above suggests, courts have not viewed the flailing company argument with favor. Several courts, in provider-merger decisions and those involving other industries, have stated that the weakened-competitor argument is the weakest rebuttal argument of all.39 The Sixth Circuit, in *ProMedica*, described it as "the Hail-Mary pass of presumably doomed mergers—in this case thrown from ProMedica's own end zone."40

Health Reform and the Affordable Care Act

Finally, a number of merging hospitals have cited health reform and the Affordable Care Act (ACA) to justify their transaction.41 The argument, which is in part an efficiencies argument and in part a "the government made me do it" argument, has been uniformly rejected The basic argument is that, in a number of ways, the ACA contemplates and prompts provider mergers by emphasizing provider integration and coordination in the

provision of care to lower costs and improve quality. And certainly there is much truth to the argument that the Act does induce, if not mandate, increased coordination of care through integration.42

Nothing in the ACA, however, suggests that firms integrate or coordinate in ways that generate market power, whether through total or partial integration. The ACA contains no express antitrust exemption; nor does it provide the basis for any argument for "implied repeal" of the antitrust laws—an irreconcilable conflict between the antitrust laws and the ACA and the need for repeal of the antitrust laws to the extent necessary for the Act to work as Congress envisioned.43 In enacting the ACA, Congress envisioned programs that would stem or decrease the cost of health care and increase its quality. Difficult to see is how permitting provider mergers or other forms of integration *that result in market power* furthers the congressional goal of lower health-care costs. Economic theory and a fair volume of empirical work strongly suggest that combinations resulting in market power have the opposite effect. The evidence of impact on quality is more mixed, but several studies suggest, at best, neutral effects.

The ACA, per se, should have no relevance in the antitrust analysis of provider mergers. But if the merging parties can show that the merger will result in lower costs or improved quality—that it will generate substantial efficiencies—and that those efficiencies, or the levels of those efficiencies, cannot be achieved absent the merger, those effects should count in favor of the merger in the balancing analysis, regardless of whether they were induced by the ACA or other reasons. The source of the impetus is not important; what matters is the effect.

The FTC, not surprisingly, rejects that argument of "tension" between the ACA and the antitrust laws and that the Act provides any type of "defense" to an otherwise unlawful merger. What case law there is thus far suggests the same. FTC Commissioner Julie Brill, for example, argues that while the ACA does "encourage integration of health care delivery," it "neither requires nor encourages providers to merge or consolidate" and that there are other, less restrictive means of coordinating care such as the formation of joint ventures or contractual relationships. She argues that the ACA depends on competition, through, for example, competition among health plans on insurance exchanges and competition among providers through formation of accountable care organizations.44

In *St. Alphonsus*, the district court explained that while "the Acquisition was intended by [the parties] to improve patient outcomes" and "[t]he Court believes that it would have that effect," "there are other ways to achieve the same effect that do not run afoul of the antitrust laws and do not run such a risk of increased costs."45 The evidence there failed to support the defendants' theory that the hospital's acquisition of the physician practice in question was necessary to create a core of employed physicians to make the transition to integrated care: "While employing physicians is one way to put together a unified and committed team of physicians, it is not the only way. The same efficiencies have been demonstrated with groups of independent physicians."46 And the court went on to explain that the merger was not necessary for the creation of an efficient shared electronic records system but rather that the physician practice could obtain access to the system through a cooperative arrangement short of merger. In other words, these claimed efficiencies were not merger specific.47

As a matter of both business-organization theory and logic, it would seem that efficiencies would be greater, as would the probability of achieving them, from a merger than from a looser form of affiliation, such as a joint venture or contractual arrangement. There was, however, contrary evidence from an expert in the *St. Alphonsus* case, and whether the marginal benefit from merger over another type of arrangement would be significant is questionable.

The bottom line: There is no inherent tension between the ACA and the antitrust laws justifying otherwise anticompetitive mergers. Parties claiming efficiencies based incentives or mandates of the Affordable Care Act

must show that comparable benefits cannot be achieved by arrangements short of a full merger. The defense, if any, is an “efficiencies defense,” not an “ACA defense.”

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1 *See Evanston Northwestern Healthcare Corp*., 2007-2 Trade Cas. (CCH) ¶ 75,814 at 108,600 (FTC 2007) (*Evanston*) (noting that “ENH does not devote much time to this argument, and we need not either”).

2 E.g., *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 987 (D.C. Cir. 1990) (“The existence and significance of barriers to entry are frequently, of course, a crucial consideration in a rebuttal analysis. In the absence of significant barriers, a company probably cannot maintain supracompetitive prices for any length of time.”).

3 U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* § 9 (2010) (*Merger Guidelines*or *Guidelines*).

4 *Id*.

5 E.g., *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 430 n.10 (5th Cir. 2008) (noting that “there is a high threshold applied to assertions as to whether a company can be considered a potential entry for antitrust purposes” and that the defendants “must provide evidence that the likelihood of entry reaches a threshold ranging from 'reasonable probability' to 'certainty'”).

6 *See*, e.g., *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1219 (11th Cir. 1991).

7 *HTI Health Servs. Inc. v. Quorum Health Group, Inc*., 960 F. Supp. 1104, 1133-35 (S.D. Miss. 1997).

8 *St. Alphonsus Medical Center-Nampa v. St. Luke's Health Sys., Ltd.*, 2014-2 Trade Cas. (CCH) ¶ 78,667 at 129,259 (D. Idaho 2014) (*St. Alphonsus (Dist. Ct.)*).

9 Complaint for Temporary Restraining Order and Preliminary Injunction, *FTC v. OSF Healthcare Sys*., No. 11-cv-50344 (N.D. Ill., filed Nov. 18, 2011), at 25.

10 *St. Alphonsus Med. Ctr.-Nampa v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 790 (9th Cir. 2015) (*St. Alphonsus (9th Cir.)*) (“We remain skeptical about the efficiencies defense in general and about its scope in particular.”).

11 *See generally* Oliver E. Williamson, *Economies as an Antitrust Defense*, 125 U. PA. L. REV. 699 (1977).

12 *See Evanston*, 2007-2 Trade Cas. (CCH) at 108,598 (“Quality is one dimension on which firms compete, and differences in prices may reflect differences in quality.”).

13 For an explanation and discussion of the model, see Gregory Vistnes, *Hospital Mergers and Two-Stage Competition*, 67 Antitrust L.J. 671 (2000).

14 *Merger Guidelines* § 10.

15 *See generally* Jeffrey H. Perry & Richard H. Cunningham, *Effective Defenses of Hospital Mergers in Concentrated Markets*, Antitrust (Spring 2013) at 43; Katherine A. Ambrogi, *Clinical Quality Analysis in Merger Enforcement: Lessens from FTC v. OSF Healthcare*, AHLA Antitrust Healthcare Chronicle (Sept. 2012) at 2.

16 *Merger Guidelines* § 10.

17 *Id*.

18 *See* Dissenting Statement of Commissioner Joshua D. Wright, Ardagh Group S.A., Dkt. No. 9356 (FTC June 18, 2014).

19 *Merger Guidelines* § 10 ("The greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies, and the more they must be passed through to customers." Accordingly, "[e]fficiencies almost never justify a merger to monopoly or near-monopoly.").

20 *United States v. H&R Block, Inc.*, 833 F. Supp. 2d 36, 89 (D.D.C. 2011).

21 *Evanston*, 2007-2 Trade Cas. (CCH) at 108,599.

22 *Id*. at 108,603 ("while the improvements do not vindicate the merger . . ., they are relevant to determining whether divestiture is appropriate because divestiture may reduce or eliminate the resulting benefits for a material period of time.).

23 *FTC v OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1091 (N.D. Ill. 2012) (*OSF*).

24 *FTC v. ProMedica Health Sys., Inc.*, 2011-1 Trade Cas. (CCH) ¶ 77,395 at 120,086 (N.D. Ohio 2011) (*ProMedica (Dist. Ct.)*).

25 *See FTC v. ProMedica Health Sys, Inc.*, 749 F.3d 559, 571 (6th Cir. 2014) (*ProMedica (6th Cir)*) ("But ProMedica did not even attempt to argue before the Commission, and does not attempt to argue here, that this merger would benefit consumers.").

26 *St. Alphonsus (9th Cir.)*, 778 F.3d at 791.

27 *See generally* Deborah L. Feinstein, Director, Bureau of Competition, FTC, "Antitrust Enforcement in Healthcare: Proscription, Not Prescription," Prepared Remarks Before the Fifth National Accountable Care Organization Summit-Washington, D.C. (June 19, 2014), at 11 (Feinstein) (noting that compared with determining cost-reduction efficiencies, "it is more difficult to determine how best to balance a possible price increase on the one hand and a quality improvement on the other hand. To date, however, that is not something we have found necessary to do").

28 *See id.*:

In assessing quality arguments, we examine a variety of evidence. We look at the comparative quality of the hospitals merging. If the acquired hospital already has strong quality measurements comparable to those of the acquiring hospital, we may question the ability of the acquiring hospital
to improve those metrics. If the acquiring hospital has made prior acquisitions, we will want to see whether those mergers resulted in quality improvements. The parties must explain more than just the processes and practices that the acquiring hospital system can transfer to an additional hospital; they need to address the specifics of how those processes and practices will benefit patients through improved care. In addition, we also want to understand why the acquired hospital could not improve its quality without a merger with this particular acquirer.

29 *See FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1089 (D.D.C. 1997).

30 *ProMedica (Dist. Ct.)*, 2011-1 Trade Cas. (CCH) at 120,099; OSF, 852 F. Supp. 2d at 1089.

31 *Merger Guidelines* § 11.

32 *See California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001).

33 *Id*. In discussing the requirements of the failing-company defense, the court explained that "[t]he most important factor . . . in determining whether a firm faces the 'grave possibility of business failure' is whether the firm is insolvent or on the brink of insolvency either in the bankruptcy sense, that the firm has no net worth, or in the equity sense, that the firm is unable to meet its debts as they come due." 130 F. Supp. 2d at 1133

34 130 F. Supp. 2d at 1136. Perhaps worth noting is that the court would have found the merger lawful regardless of the failing-company defense based on plaintiff's failure to define the relevant market correctly.

35 The argument is based on the Supreme Court's 1974 in *United States v. General Dynamics Corp*., 415 U.S. 486 (1974), which held that, in rebuttal, courts should consider factors indicating that a firm's current market share may overstate its ability to compete to compete in the future. This financial or competitive-strength variable can work both ways. If the hospital is gaining strength, its current market share may understate its future effect in the market.

36 Deborah L. Feinstein, Director, Bureau of Competition, FTC, "Antitrust Enforcement in Health Care: Proscription, Not Prescription," Prepared Remarks Before the Fifth National Accountable Care Organization Summit—Washington, D.C. (June 19, 2014).

37 *See*, e.g., *ProMedica (6th Cir.)*, 749 F.3d at 572 ("Courts 'credit such a defense only in rare cases when the [acquiring firm] makes a substantial showing that the acquired firm's weakness, which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level that would undermine the government's prima facie case.'").

38 *See ProMedica (Dist. Ct.)*, 2011-1 Trade Cas. (CCH) at 120,100..

39 E.g., *Evanston*, 2007-2 Trade Cas. (CCH) at 108,597 ("courts have generally cautioned . . . that '[f]inancial weakness, while perhaps relevant in some cases, is probably the weakest ground of all for justifying a merger,' and 'certainly cannot be the primary justification' for permitting one.").

40 *ProMedica (6th Cir.)*, 749 F.3d at 572.

41 *See St. Alphonsus (Dist. Ct.)*, 2014-1 Trade Cas. (CCH) at 129,256 through -58; *ProMedica (Dist. Ct.)*, 2011-1 Trade Cas. (CCH) at 120,089 through -90.

42 *See generally* Christopher M. Pope, *How the Affordable Care Act Fuels Health Care Market Consolidation*, Heritage Found. Backgrounder, Aug. 1, 2014; Toby G. Singer, *Antitrust Implications of the Affordable Care Act*, 6 J. HEALTH & LIFE SCIENCES L. 57 (2013).

43 *See generally Credit Suisse Secs. (USA) v. Billing*, 551 U.S. 264 (2007); *Gordon v. N.Y. Stock Exch.*, 422 U.S. 659 (1975).

44 Julie Brill, Commissioner, FTC, "Competition in Health Care Markets," Prepared Remarks before the 2014 Hal Bates Antitrust Conference (June 9, 2014); see also "Questions for Federal Trade Commission Bureau of

Competition Director Debbie Feinstein," AHLA Antitrust Practice Group Spotlight, Sept. 30, 2014 (arguing that the antitrust laws are entirely consistent with the goals of the ACA and explaining her rationale).

45 *St. Alphonsus (Dist. Ct.)*, 2014-1 Trade Cas. (CCH) at 129,261.

46 *Id*. at 129,257.

47 In *OSF*, the defendants argued that the merger was necessary to meet the challenge of health care reform. The court did not discuss the argument in any depth, noting only that the argument was "inherently difficult to evaluate" but appeared contradicted by the fact that financial projections indicated that both merging systems expected to remain profitable. *OSF*, 852 F. Supp. 2d at 1095. As in*St. Alphonsus*, the court did note that the parties should be commended for their goal of improving patient care, but explained that it was "unable to declare that these goals would be realized with, and only with, the proposed merger." *Id*. at 1094.

It appears that the defendants in the *ProMedica* argued that, as a result of health-reform, the merger was necessary for the creation of a viable ACO. The court rejected the argument on several grounds: that (1) at the time, health reform was in flux and the nature and form of ACOs was unclear; (2) the acquired hospital was in a favorable position to implement some reform measures (e.g., an EMR system) itself; (3) that the benefits from ACOs could be achieved by arrangements other than merger; (4) that the acquired hospital remaining independent would likely result in its participating in multiple ACOs; and (5) that the acquired hospital itself stated that it was in good position for the transitions health reform would require. *ProMedica* (Dist. Ct.)), 2011-1 Trade Cas. (CCH) at 120,089-90.