The Trump Administration and Antitrust Challenges to Hospital Mergers

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Mergers of health care industry competitors, whether between hospitals, physicians, pharmaceutical manufacturers, health insurers, or others, have been rich antitrust targets for the Obama Administration. Nowhere has this been more true than in the hospital industry, where the Federal Trade Commission (FTC or Commission) began a winning streak shortly before Obama's 2008 election that has yet to end.[1]

Beginning with the FTC's 2007 decision in *Evanston Northwestern Healthcare Corporation*,[2] the FTC has won five major litigated hospital merger challenges.[3] Perhaps as important, several hospitals contemplating mergers abandoned their transactions in light of threatened or actual challenge.[4] Several other transactions were cleared only after

1 Two challenges were arguably unsuccessful, not because of the transactions' likely effect on competition but because, in one case, of the impossibility of divestiture given the state's certificate-of-need laws. *See* Statement of the Federal Trade Commission in the Matter of Phoebe Putney Health System, Inc. et al. Docket No. 9348 (Mar. 31, 2015), *available at* www.ftc.gov/system/files/documents/public_statements/634181/150331phoebeputneycommstmt.pdf; and in the other case, because the state enacted a statute arguably providing the transaction with state-action exemption protection. *See* Statement of the Federal Trade Commission In the Matter of Cabell Huntington Hospital, Inc., Docket No. 9366 (July 6, 2016), *available at* www.ftc.gov/system/files/documents/public_statements/969783/160706cabellcommstmt.pdf.

2 In the Matter of Evanston Nw. Healthcare Corp., 144 F.T.C. 1, 381 (2007), *available at* www.ftc.gov/system/files/documents/commission_decision_volumes/volume-144/vol144.pdf.

3 In addition to *Evanston Northwestern Healthcare*, *see* FTC v. Advocate Health Care Network, 841 F.3d 460 (7th Cir., Oct. 31, 2016); FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327 (3d. Cir. 2016); ProMedica Health Sys. v. FTC, 749 F.3d 559 (6th Cir. 2014); FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069 (N.D. Ill. 2012).

4 *See*, *e.g.*, In the Matter of Reading Health Sys., No. 9353 (FTC Dec. 12, 2012) (Order Dismissing Complaint in light of transaction abandonment), *available at* www.ftc.gov/sites/default/files/documents/cases/2012/12/121207readingsircmpt.pdf.

agreements to divest.[5] The most recently litigated challenges both focused on delineation of the geographic market; the hospitals won at the district court level, where courts refused to grant the FTC preliminary injunctions—only to lose on appeal. In *Hershey Medical Center*, the Third Circuit ordered the district court to grant the injunction. In *Advocate Health Care*, the Seventh Circuit remanded the case for further consideration by the district court. Hospitals and their counsel must be wondering whether the FTC will ever lose a hospital merger case.

The aggressiveness of the Obama Administration in antitrust matters surprised no one. Mr. Obama had stated during his campaign that he intended to "reinvigorate" antitrust enforcement, and he followed through. The election of Donald Trump raises the question whether the Trump Administration FTC will view hospital mergers more hospitably than the Obama Administration has. The question can't be answered conclusively, but there are some reasons to believe that, at least at the margins, the answer is yes.

The Republican Platform is silent about antitrust, and Mr. Trump has issued no position papers addressing it. He has, in off-the-cuff remarks, indicated concern about industry concentration generally, voicing opposition to the proposed AT&T/Time Warner merger as an example and accusing Amazon of constituting a monopoly engaging in anticompetitive behavior.[6]

Suggesting a less aggressive approach, however, is his appointment of Joshua Wright as the transition guru in charge of antitrust.[7] Mr. Wright, a

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5 *See*, *e.g.*, In the Matter of Community Health Sys, Inc., No. C-4427 (FTC Apr. 11, 2014) (Decision and Order requiring hospital divestitures), *available at* www.ftc.gov/system/files/documents/cases/140415chshmado.pdf.

6 *See* Brian Stelter, *Donald Trump Rips Into Possible AT&T-Time Warner Deal*, CNN Money (Oct. 22, 2016 4:05 PM), http://money.cnn.com/2016/10/22/media/donald-trump-att-time-warner/; Ryan Knutson, *Trump Says He Would Block AT&T-Time Warner Deal*, Wall St. J. (Oct. 22, 2016 2:50 PM), www.wsj.com/articles/trump-says-he-would-block-at-t-time-warner-deal-1477162214.

7 *See* Leah Nylen, *Former FTC Commissioner Wright to Lead Trump Transition on Antitrust*, mlex Market Insight, Nov. 14, 2016, http://mlexmarketinsight.com/editors-picks/former-ftc-commissioner-wright-lead-trump-transition-antitrust/.

Ph.D. in economics, is a Republican, a law professor at the Antonin Scalia Law School of George Mason University, and an FTC Commissioner from 2013 to 2015. He was the most conservative of the five commissioners, dissenting from the Commission's decisions to challenge several mergers, and he is a strong believer of a strictly economic approach in analyzing antitrust issues. Mr. Wright will be heavily involved in choosing new FTC commissioners, as well as the Chairperson. Mr. Trump will likely appoint two Republicans, and possibly also a conservative Democrat or Independent. (No more than three comissioners may be of the same political party.)

What would that composition say about the Commission's likely aggressiveness in challenging hospital mergers? The best bet is that the Commission will turn slightly to the right, but any change in enforcement likely would be marginal. Antitrust enforcement historically has enjoyed bipartisan support with relatively little difference in enforcement philosophy. A review of Obama Administration FTC hospital merger challenges reveals nothing radical or outside mainstream antitrust analysis. The merging hospitals subject to those challenges were almost all close competitors or very good substitutes for each other, triggering concern that they could increase prices themselves post-merger—that the mergers would result in what the agencies' *Horizontal Merger Guidelines* refer to as anticompetitive "unilateral effects."[8] In each challenge, the merging hospitals' post-merger market shares would have been extremely high, another danger signal. There seem to be, however, several areas of merger analysis that a Trump FTC might carefully examine. Two are the presumptive unlawfulness in "unilateral effects" cases based on the merger's effect on market concentration, and the analysis of efficiencies in rebutting a presumption of unlawfulness.

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8 U.S. Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines § 6 (2010), *available at* www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf [hereinafter Merger Guidelines].

Mergers between competitors primarily raise concerns about the likelihood of unilateral effects and/or coordinated effects. Unilateral effects occur when the merging firms raise prices regardless of the pricing behavior of other competitors, resulting from the loss of competition between the merging parties.[9] Coordinated effects occur when the merger results in a market sufficiently concentrated that it performs as an oligopoly—that the merged firms and their competitors raise their prices by engaging in interdependent competitive decision making through tacit agreement or conscious parallelism (but without an actual agreement that would violate Section 1 of the Sherman Act).[10] The theory is that the fewer the competitors, the easier and more likely it is that coordinated decision making will result. Thus far, every hospital merger challenge has relied primarily on concern about likely unilateral effects.[11]

Under the *Merger Guidelines*, a rebuttable presumption of likely anticompetitive effect (and thus unlawfulness) arises if a market's post-merger concentration level and the increase in concentration resulting exceed certain thresholds.[12] Based primarily on a 1963 Supreme Court opinion, the same is true if the merging parties' post-merger market share exceeds a certain level—30 percent.[13] The Trump Administration's approach to antitrust enforcement in health care, however, may rely less on this rebuttable presumption of unlawfulness because post-merger market concentration and the degree to which the merger increases that level provide little, if any, help in predicting the merger's effect on unilateral price increases.

Market concentration and the increase in concentration from the merger are obviously relevant—indeed the most important variables—in

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9 *Id*. § 6.
10 *Id*. § 7 ("Coordinated interaction involves conduct by multiple firms that is profitable for each of them only as the result of the accommodating reactions of the others.").
11 One challenge did involve both. *See* FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1086–88 (N.D. Ill. 2012) (discussing coordinated effects).
12 Merger Guidelines § 5.3.
13 United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 364 (1963).

predicting whether a merger will result in *coordinated* effects. They predict little, however, about the merger's likely generation of *unilateral* effects. A post-merger market can be highly concentrated and yet the merging parties lack the ability to unilaterally raise prices. Indeed, the *Merger Guidelines* suggest this,[14] as do the agencies' *Commentary on the Horizontal Merger Guidelines*,[15] and leading commentators.[16] What is important is not concentration, but the degree of substitutability between the merging parties as opposed to their substitutability with other actual or potential competitors.[17] For example, assume a significant number of patients consider hospitals A and B very good substitutes—perhaps their first and second choices—but do not consider hospitals C, D, and E good alternatives. Health plans can threaten to exclude A and include B (or vice versa) if one of them demands what the plans consider excessive reimbursement. If A and B merge, however, this is not possible; the plans must either pay the merged hospital the higher reimbursement or risk losing subscribers because the other hospitals are unacceptable substitutes in their eyes.

Notwithstanding the irrelevance of market concentration in unilateral effects challenges to hospital mergers, up until now the agencies have continued to argue and the courts have continued to accept that

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14 Merger Guidelines § 6.1 ("The Agencies rely much more on the value of diverted sales than on the level of the HHI [i.e., market concentration] for diagnosing unilateral price effects . . . .").

15 FTC & U.S. Dep't of Justice, Commentary on the Merger Guidelines 16 (2006), *available at* www.justice.gov/atr/file/801216/download ("Indeed, market concentration may be unimportant under a unilateral effects theory of competitive harm . . . . [T]he question in a unilateral effects analysis is whether the merged firm likely would exercise market power absent any coordinated response from rival market incumbents. The concentration of the remainder of the market often has little impact on the answer to this question.").

16 Carl Shapiro, *The 2010 Horizontal Merger Guidelines: From Hedgehog to Fox in Forty Years*, 77 Antitrust L. J. 49, 68 (2010) (noting that "HHI levels are of limited predictive value for this purpose" of assessing the potential for unilateral effects).

17 *See* Merger Guidelines § 6.1 ("Substantial unilateral price elevation post-merger for a product formerly sold by one of the merging firms normally requires that a significant fraction of the customers purchasing that product view products formerly sold by the other merging party as their next-best choice.").

sufficient post-merger market concentration and increase prove a prima facie case.[18] Although the FTC introduces other supporting evidence—party "hot documents," testimony about the merger's effect from health plans, and econometric evidence—one would hope that a Trump Administration FTC would either explain the relationship between market concentration and unilateral effects or stop relying on concentration as its case in chief. If it does, the Trump FTC might well also examine the appropriateness of any rebuttable presumption of unlawfulness in any merger challenge, ultimately requiring the Commission to prove its case of actual or likely anticompetitive effects, just as a plaintiff must do in a Section 1 Sherman Act case.

Another area where a Trump FTC might diverge from the current approach, particularly in hospital merger investigations and challenges, is the assessment of efficiencies from the transaction and the burden that merging hospitals must meet to show that a transaction's efficiencies offset its potential anticompetitive effects. The new administration should consider: Are there really situations in which the efficiencies from a transaction can offset its likely anticompetitive effects? If so, is the proof burden too stringent?

The *Merger Guidelines* provide that situations can arise in which the efficiency effects of a merger will offset its potential adverse effect on competition.[19] Commission officials have said the same in both speeches and articles.[20] And yet in complaints and briefs, the FTC emphasizes that no appellate court has ever held that an efficiencies claim rebutted a

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18 *See, e.g.*, FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 346 (3d Cir. 2016); ProMedica Health Sys. v. FTC, 749 F.3d 559, 568 (6th Cir. 2014).

19 Merger Guidelines § 10 ("The Agencies will not challenge a merger if cognizable efficiencies are of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market.").

20 *See, e.g.*, Jeffrey H. Perry & Richard H. Cunningham, *Effective Defenses of Hospital Mergers in Concentrated Markets*, 27 Antitrust 43 (2013) ("When substantiated—meaning that the evidence supports the notion that a hospital merger will improve the quality of care at the affected hospitals—such claims may well carry the day, overcoming high market concentration levels, 'hot documents,' health plan concerns about a merger, and other factors that weigh in favor of enforcement.").

prima facie case based on market concentration.[21] Hospitals and their attorneys thus wonder whether it is even worth their while to thoughtfully formulate and present a claim attempting to meet the *Merger Guidelines'* requirements for "cognizable efficiencies."[22]

A Trump Administration FTC may change this calculus, swinging the pendulum away from a disturbing possible interpretation of the Ninth Circuit's discussion of efficiencies in a successful challenge to St. Luke's Health System's acquisition of a large physician practice. There, the court held, or at least suggested, that better quality of care resulting from the merger would not constitute a cognizable efficiency because there was no evidence that it would improve competition.[23] A Trump FTC may be inclined to determine, however, that as long as competition is based in part on quality, quality improvements would inherently further competition without the necessity of direct proof of that effect. The benefits of these efficiencies, it follows, would be passed on to consumers as the *Merger Guidelines* and court decisions require.

Efficiency claims require predictions about both actions and results. Balancing efficiencies, particularly those relating to quality improvements, is difficult, and if the claimed efficiencies are not achieved, it may be difficult to "unscramble the eggs." But absent evidence of adverse effects on competition from a previously consummated merger, anticompetitive effects are predictive and speculative in any event. The

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21 *See, e.g.*, Complaint at 16, In the Matter of Penn State Hershey Med. Ctr. & PinnacleHealth Sys., No. 9368 (FTC Dec. 7, 2015), *available at* www.ftc.gov/system/files/documents/cases/151214hersheypinnaclecmpt.pdf ("No court has ever found, without being reversed, that efficiencies rescue an otherwise illegal transaction.").

22 Merger Guidelines § 10 ("Cognizable efficiencies are merger-specific efficiencies that have been verified and do not arise from anticompetitive reductions in output or service.")

23 St. Alphonsus Med. Ctr.–Nampa, Inc. v. St. Luke's Health Sys., 778 F.3d 775, 791 (9th Cir. 2015) ("It is not enough to show that the merger would allow St. Luke's to better serve patients . . . . [T]he claimed efficiencies . . . must show that the prediction of anticompetitive effects from the prima facie case is inaccurate . . . . [T]he [district court] judge did not find that the merger would increase competition or decrease prices.").

Trump FTC may want to study this problem to see if there is some middle ground to ensure that the efficiencies "defense" is not dead.

These are only two antitrust issues that may face the Trump Administration. More generally, it may be interesting to see the effect of the new administration on the Affordable Care Act and what ramifications any repeal, amendment, or replacement of the ACA might have on antitrust enforcement in the health care sector.

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