

Reproduced with permission from BNA's Health Law Reporter, 24 HLR 844, 7/2/15. Copyright © 2015 by The Bureau of National Affairs, Inc. (800-372-1033) <http://www.bna.com>

## Hospital Mergers, Affiliations and Antitrust: Why the FTC Is Nothing to Lose Sleep Over



BY MONTE DUBE AND JOHN INGRASSIA

**T**he chairwoman of the Federal Trade Commission, Edith Ramirez, has repeatedly emphasized that the FTC is watching closely when it comes to health care.<sup>1</sup> Cautionary advice from well-meaning health care consultants and lawyers likewise highlight recent high-profile government victories as confirming evidence, and industry veterans can rattle off a half-dozen deals that have cratered in the face of antitrust scrutiny.

Beware, though, of headlines spreading unwarranted paranoia about health care and antitrust.<sup>2</sup> The easy conclusion is that all proposed hospital mergers<sup>3</sup> are “guilty until proven innocent,” and face a high likeli-

hood of antitrust challenge. The easy conclusion though, does not “see the whole board.” In fact, most deals we *don't* read about on the front page are setting the stage for health care antitrust enforcement, and as the data and close analysis show, the vast majority of hospital transactions are procompetitive and don't get hung up in the antitrust review process. If health care is front and center for the FTC, it is because health care is front and center for America, and not because the agency has an agenda to thwart ACA implementation efforts or procompetitive consolidation in the health care industry.

### The Antitrust Review Process.

Once a proposed hospital merger moves from mere intentions to a written agreement, there are several ways federal and state antitrust enforcement agencies may start to take notice. Two federal antitrust agencies are charged with merger review—the FTC, which reviews most hospital mergers, and the Antitrust Division of the Department of Justice. For transactions that must be reported under the Hart-Scott-Rodino Act, the FTC and DOJ will review the written agreement and documentation (such as internal e-mails, memos, and board minutes) reflecting the parties' internal process for consideration of the potential transaction.<sup>4</sup> A signed definitive agreement is not required to begin the HSR review process and start the 30-day clock ticking. The law allows parties to get HSR review under way as soon as they have executed a nonbinding letter of intent, although most parties don't make an HSR filing that early in their process for two reasons. First, preparation and filing fees are expensive (often approaching \$100,000) and because there's always a risk that the parties—as a result of due diligence discoveries or insuperable deal term obstacles—never make it to a definitive binding contract.

Even where no HSR filing is required, the proposed transaction may come to light following issuance of a press release, or reach-outs to regulators by a concerned payer (whether a third party payer/insurer or a

<sup>1</sup> Antitrust Enforcement in Health Care—Controlling Costs, Improving Quality, N. Engl. J. Med. 2014; 371:2245-2247, Dec. 11, 2014; <http://www.nejm.org/doi/full/10.1056/NEJMp1408009>. The chairwoman voiced a similar sentiment at a conference with the FTC and the Justice Department about competition in the health care industry on Feb. 24, 2015.

<sup>2</sup> See, e.g., New York Times, F.T.C. Wary of Mergers by Hospitals, Sept. 17, 2014.

<sup>3</sup> By “merger” we mean transactions that antitrust enforcers deem “the functional equivalent of a merger,” such as outright sales, acquisitions of assets or membership interests, joint operating agreements and whole hospital joint ventures, but not clinical affiliations where there is no change of control.

*Monte Dube is a partner with Proskauer Rose LLP in Chicago with the firm's Health Care Department. He can be reached at [mdube@proskauer.com](mailto:mdube@proskauer.com). John Ingrassia is a special counsel in the firm's Washington office. He can be reached at [jingrassia@proskauer.com](mailto:jingrassia@proskauer.com).*

<sup>4</sup> Where the statutory size thresholds are met for the size of the parties and the value of the transaction (currently \$76.3 million), HSR reporting is mandatory, unless the transaction qualifies for an exemption. For instance, transactions involving one of the almost 1,000 U.S. governmental hospitals may be exempt from HSR filing requirements.

large, self-insured employer). State attorneys general also may exercise antitrust oversight along with their review of a potential merger's compliance with state nonprofit and charitable trust laws.

The HSR review process enables the FTC and DOJ to review transactions and address competitive concerns prior to their completion. In the vast majority of cases, the agencies determine within the initial 30-day waiting period that no further investigation is warranted, and the transaction is allowed to close without further inquiry.<sup>5</sup> However, where the agencies have antitrust concerns that cannot be resolved within the initial review period, the law provides for a discovery process, known colloquially as a "second request," which involves a broad-ranging document and interrogatory request that typically requires many months, and millions of dollars, to complete. Many nonprofits are unable or unwilling to incur the time and cost necessary to successfully navigate such an investigation, so for many transactions, a second request can be a de facto death sentence. For those systems, however, willing expend the resources to respond, the transaction still has a fair chance of survival, at least statistically speaking. Only a small number of transactions ultimately are subjected to the second request process, and a smaller number of those are blocked or abandoned. More commonly, transactions require modifications, such as divestitures with respect to geographic overlaps in multi-market transactions; or behavioral restrictions put in place aimed at limiting exclusivity and protecting patient choice, or protecting patients and payers from rate increases above competitive levels.

### Activity Is Up, So Enforcement Is More Visible.

Irving Levin Associates reports that hospital systems announced 100 transactions in 2014, and that those transactions involved 178 hospitals. Although the number of transactions has dipped some since the high in 2012, it is close to the 2012 high and is up substantially in the last five years.<sup>6</sup> According to the most recent FTC and DOJ joint Hart-Scott-Rodino Annual Report for fiscal year 2013,<sup>7</sup> 48 hospital transactions were reported under the HSR Act in the fiscal year ended Sept. 30, 2013. The spread between the FTC/DOJ figure (48) and the Irving Levin figure (83) likely represents transactions not subject to formal antitrust reporting based on exemptions, size, or transaction structure.

While close to half of the 48 HSR reportable hospital transactions in 2013 generated some form of preliminary or informal inquiry from federal antitrust enforcers, only five of those resulted in second requests, or full-blown investigations. This roughly 10 percent figure is consistent with other industries, and is consistent with the relative frequency of second requests in hospital acquisitions over the last five years, even as the number of HSR reported transactions continues to rise. Looked at another way, nine out of 10 hospital mergers

never receive lengthy, intensive review or challenges by the FTC. Despite public comments made by the agencies about health care and antitrust, the analytical framework remains the same and there is no reason to expect a dramatic change in the antitrust risk profile for hospital mergers in the near future.

### What Recent Investigations Tell Us.

A close look at several recent high-profile hospital transactions investigated by the FTC reveals no real surprises. Transactions that were likely to result in higher reimbursement rates and less patient choice post-merger faced the most scrutiny; transactions that did not so present—even hospital-to-hospital transactions in overlapping geographies—were not unduly scrutinized.

In 2010, ProMedica Health Systems acquired competitor St. Luke's Hospital in Maumee, Ohio, located about 10 miles from ProMedica's Toledo hospital. The FTC successfully challenged the transaction, claiming that post-consolidation market shares exceeding 50 percent likely would lead to higher costs for payers and patients. ProMedica has repeatedly and unsuccessfully appealed all the way to the Supreme Court, which in May denied ProMedica's request for review.

In 2011, the FTC blocked the merger of Phoebe Putney Memorial Hospital and Palmyra Park Hospital, claiming that the transaction was a merger to monopoly in Palmyra, Ga., and that the transaction would have allowed the combined system to raise prices for general acute-care hospital services charged to commercial payers, thus substantially harming patients and local employers and employees.

In 2012, Rockford Health System and OSF Healthcare System, two of the three hospitals in Rockford, Ill., abandoned their planned merger in the face of an FTC challenge and preliminary injunction. Following its second request investigation, the FTC sued to block the deal, alleging that once combined, the system would hold a 64 percent share of the general hospital care market and a 37 percent share of the primary-care physician services market, and would leave the third Rockford hospital as the area's only remaining competitor.

In 2012, Reading Health System, a 700-plus-bed tertiary care facility in Pennsylvania, abandoned its planned acquisition of Surgical Institute of Reading, a 15-bed physician-owned specialty surgical hospital less than five miles away, following an FTC complaint (joined by the Pennsylvania attorney general) alleging that the combination of the two providers would substantially reduce competition in the area. According to the complaint, the transaction would have substantially reduced competition with respect to inpatient and outpatient orthopedic/spine surgical and nonsurgical services, outpatient ENT surgical services and outpatient general surgical services, with respective market shares ranging from 49 percent to 71 percent.

In 2013, the proposed merger of the only two hospitals in the Hot Springs, Ark., National Park Medical Center, owned by the 12-hospital, for-profit system Capella Healthcare, and nonprofit Mercy Hot Springs, abandoned their planned consolidation in the face of likely FTC challenge. According to Richard Feinstein, then director of the FTC's Bureau of Competition, "Staff gathered testimonial, documentary, and economic expert evidence that this transaction was anti-competitive and would likely have resulted in higher

<sup>5</sup> The rules also provide a process for the parties to extend the initial 30-day waiting period by an additional 30 days to accommodate a pending initial review and avoid a full-blown investigation.

<sup>6</sup> Source: Irving Levin Associates; The Health Care Services Acquisition Report, Twenty-First Edition, 2015.

<sup>7</sup> <http://www.ftc.gov/system/files/documents/reports/36th-report-fy2013/140521hsrreport.pdf>.

prices and diminished health care service in Hot Springs.”<sup>8</sup>

Also in 2013, Community Health System’s \$7.6 billion acquisition of Health Management Associates was consummated, but subject to the divestiture of two hospitals. Both for-profit systems operate large networks of hospitals that overlap geographically in only limited areas. The FTC settlement required divestitures in Gadsden, Ala., where the parties operate the only two hospitals, and in Darlington County, S.C., where the parties operate two of only three hospitals.<sup>9</sup>

The Advocate/NorthShore transaction that was announced in September 2014 and continues the trend toward larger regional systems is now under review by the FTC. The transaction would create the largest system in Illinois with 16 hospitals, \$6.5 billion in revenue and, by some accounts, 25 percent of the hospital care market in the Chicago area with up to 40 percent in some areas. Despite large footprints in the Chicago area, the systems appear to have few overlapping service areas. The FTC issued a second request at the end of March 2015 and is reviewing the transaction. It may be too soon to predict the outcome, but the transaction is noteworthy for the apparent lack of material service area overlap, so it will be closely watched. In what may have been a foreshadowing, FTC Chairwoman Ramirez said earlier in February at the Examining Health Care Competition panel, “We now also hear growing concern that provider consolidation in non-overlapping product or geographic markets may also lead to higher prices.”

Even where the feds don’t step in, the states sometimes do, especially in historically more activist states, such as New York, California, and Massachusetts. There, too, though, most transactions make it to the finish line. The New York attorney general allowed the merger of Faxton-St. Luke’s Healthcare and St. Elizabeth Medical Center, the two largest general acute care hospitals in Utica, without requiring divestitures or other structural remedies.<sup>10</sup> The settlement seeks to prohibit the combined system from exerting market power and imposing higher health care costs on patients, in part, by prohibiting exclusionary conduct. Faxton-St. Luke’s and St. Elizabeth, for instance, agreed to not require independent physicians to work exclusively at their hospitals, and also agreed to not require health plans to reimburse competing providers at the same or lower rates than the plans reimburse Faxton-St. Luke’s and St. Elizabeth. The settlement also provided for temporary rate increase protection for five years, and continued monitoring by the Attorney General’s Office for compliance.

Contrast that result with the Partners HealthCare transaction in eastern Massachusetts, which would have led to Partners HealthCare acquiring three nearby community hospitals. In a surprise move, the Suffolk Superior Court rejected a consent decree previously entered into with former Massachusetts Attorney General

MarthaCoakley after a long and grueling investigation, and which would have allowed Partners to acquire the three hospitals and add hundreds of doctors to its network, albeit with pricing restrictions in place to protect payers and patients. The transaction has since been abandoned by the parties.

## The Practical Reality.

In the few cases where proposed hospital mergers actually are challenged or fail, the common theme is some combination of very high post-merger market shares, factual evidence of likely future rate increases, absence of payer support or outright payer hostility to the deal, and absence of demonstrable efficiencies and enhanced clinical care that could not be achieved through contractual relationships short of a full merger.<sup>11</sup>

The non-headline-grabbing reality is that the overwhelming majority of hospital mergers are able to close in 30 to 60 days following the parties’ HSR submissions. This is because most transactions either are procompetitive or competitively neutral on their face, or because despite seemingly “bad facts,” the parties are able to show tangible benefits the transaction will bring. This showing requires lots of advance homework to effectively communicate the parties’ story. Key to this effort is bringing in antitrust counsel early enough to help the true picture emerge from the outset, and to anticipate and deal proactively with potential for agency concerns.

Many factual and legal bases exist upon which to defend tie-ups of even in-market close competitors. The state action defense, or state action immunity, is often employed in hospital transactions involving local governmental entities where a state policy to displace market forces can be established.<sup>12</sup> The “failing firm” defense is employed with some regularity to offset potential competitive concerns where one of the hospitals

<sup>11</sup> As recently noted by the Ninth Circuit in the *St. Luke’s* case, involving a physician practice group acquisition by a hospital system in Idaho, while likely enhanced clinical care and better patient service is a “laudable goal” of a merger, it does “not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations.” *St. Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke’s Health Sys., Ltd.*, 2015 BL 33471 (9th Cir. Feb. 10, 2015), at 29.

<sup>12</sup> Two recent Supreme Court decisions have clarified, but left largely intact, certain health care providers’ ability to shield themselves from antitrust liability under the state action doctrine. In *FTC v. Phoebe Putney Health System, Inc.*, 2013 BL 41069 (U.S. 2013), the Supreme Court held that a hospital merger involving a municipal hospital system was not automatically immune from antitrust laws under the state action doctrine. A government entity acting pursuant to a clearly articulated and affirmatively expressed state policy to displace competition can be exempt from the antitrust laws only when the anticompetitive effect was a foreseeable result of the state policy. In *N.C. State Bd. of Dental Exam’rs v. FTC*, 2015 BL 47849 (U.S. 2015), the FTC brought an action to stop the North Carolina Board of Dental Examiners, an organization of practicing dentists overseeing the practice of dentistry in the state, from attempting to prevent non-dentists from offering teeth-whitening services at reduced rates. The Supreme Court found that the board violated antitrust laws by preventing lower-cost, nonmember providers from offering discounted teeth-whitening services, and, that state boards that are not actively supervised by the state and have a controlling number of the decision makers that are active participants in the occupation the board regulates do not enjoy state action immunity.

<sup>8</sup> <http://www.ftc.gov/news-events/press-releases/2013/06/statement-ftc-competition-director-richard-feinstein-todays>.

<sup>9</sup> <http://www.ftc.gov/enforcement/cases-proceedings/131-0202/community-health-systems-health-management-associates-matter>.

<sup>10</sup> <http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-utica-hospitals-address-competitive-concerns>.



likely would be forced to shutter its doors absent the transaction.<sup>13</sup> Rate-regulated states such as Maryland and West Virginia, as well as states with CON (certificate of need) or COPA (certificate of public advantage) processes, can present additional defenses to concerns that providers will be left unchecked by market forces.<sup>14</sup> Pro-competitive benefits, such as demon-

<sup>13</sup> Scott & White Healthcare/King's Daughters Hospital, Temple, Texas, 2009. See, [http://www.ftc.gov/sites/default/files/documents/closing\\_letters/scott-white-healthcare/kings-daughters-hospital/091223scottwhitestmt.pdf](http://www.ftc.gov/sites/default/files/documents/closing_letters/scott-white-healthcare/kings-daughters-hospital/091223scottwhitestmt.pdf), "Commission staff recognized that the financial condition of King's Daughters was a significant issue in the investigation and it appeared that the poor, and deteriorating, financial condition of King's Daughters likely would have caused the hospital to close at some point in the future if it was not acquired by another hospital or health system."

<sup>14</sup> The FTC has taken a skeptical view of New York's COPA program with respect to genuinely anticompetitive transactions. In a letter addressed to the New York State Department of Health on April 22, 2015 addressing several COPAs currently under review, the agency promised "to investigate and

strable transaction-specific cost savings that will be passed on to payers and patients, and improved access and outcomes, can offset competitive concerns if presented properly. Finally, lining up early payer support for transactions before the agency comes calling is a key odds-shifting tactic that should not be overlooked.

So, what is the takeaway for hospital boards concerned about whether their deal can survive the antitrust gauntlet? Rest easy, go forth and keep working for better patient care. The FTC does not have a jaundiced view regarding truly benign hospital mergers; the real gremlins in the mix are usually not antitrust. They're the ones no agency is watching over, like shared cultural and mission compatibility and mutual trust (not antitrust), community buy-in, shared governance and control, and the host of other deal terms which, understandably, are keeping health care lawyers up at night.

challenge transactions that are anticompetitive" and to "challenge defenses based on asserted state action immunity where the state fails to provide adequate active supervision."