# PUBLICATION

## Anatomy of a Provider Antitrust Merger Challenge (Part 6) [Ober|Kaler]

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***This is the concluding installment of 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 this Conclusion 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 6: Conclusion

As previous installments of this series show, horizontal mergers between providers that are highly substitutable in the eyes of health plans and patients, when their merger would result in a high post-merger market share and a highly concentrated market, face a tough antitrust road today. Worth keeping in mind is that the HHI of a market with only four equal-size providers is 2,500, and a merger between providers with shares of only 10 percent each would increase the HHI by 200—the points at which the *Merger Guidelines* provide that the merger is prima facie unlawful. Hospital markets tend to be concentrated; premerger market shares of 40 or 50 percent are not uncommon. At the same time, application of the hypothetical-monopolist methodology for defining relevant geographic markets tends to result in relatively small markets—certainly smaller than those found in older hospital merger decisions—exacerbating market-share and market-concentration.

For example, in *ProMedica Health System v. FTC*, the parties agreed that the geographic market was limited to only the single county in which the hospitals were located,1 and the evidence suggested that the FTC could have justifiably defined an even smaller market consisting of only the southwest portion of the county. And ProMedica's share, even prior to the acquisition, was about 48 percent. So in a sense, the parties in many of these mergers begin behind the eight-ball. Add to that the fact that the government's burden in its case-in-chief is relatively low. Although it typically goes much further, the government need only present its share and concentration statistics and then rest its case. In adding to its case, the government may have found party documents expressing the parties' belief that at least one effect of the merger will be to increase the hospitals' “clout” with health plans. And in addition, the government will likely find at least one significant health plan that will testify that, indeed, the merger will have this effect.

The burden of going forward then shifts to the merging parties to show, in a unilateral-effects case, that, on balance, it is not “reasonably probable” that the merger will significantly increase the merging hospitals' market power. As a practical matter, their burden is significantly more stringent than that of the government. The defendants will typically rely on efficiencies from the transaction and, in some cases, the weakened financial status of the acquired provider. They may argue that the merger is necessary to fulfill the goals of the Affordable Care Act, but that is actually just a type of efficiencies argument—that the transaction will permit the merging providers to improve quality and access. The parties must prove that the efficiencies cannot be obtained by means of an arrangement less restrictive of competition than the merger. And seemingly they must prove the magnitude, timing, and accomplishment of attaining the efficiencies almost to a certainty. Regarding

the acquired provider's future competitive weakness, they apparently must prove that its market share during some future time period would fall to the point that the government's prima facie case based on concentration statistics would fail.

Without criticizing the outcomes in the recent provider-merger cases, some of the courts' analyses raise significant questions and concerns. First, given that the government's theory of harm in these cases has been unilateral effects, of what relevance is the HHI or market concentration—on which the government and courts have relied so heavily to raise the presumption of unlawfulness? Reliance on market share, at least to some extent, is understandable. Simply put and all else being equal, the larger the combined entity's post-merger market share, the more likely that health plans need that provider in their networks and thus the greater leverage in contract negotiations it has. Market concentration, on the other hand, is relevant in antitrust analysis simply because, all else being equal, the fewer the firms in the market, the easier it is for them to tacitly coordinate competitive decision making—the so-called "coordinated effects" concern. Thus, market concentration was relevant in the FTC's challenge to the Rockford hospital merger where coordinated effects as well as unilateral effects were alleged,2 but would not seem relevant in the *ProMedica* or *St. Alphonsus* cases because it says little or nothing about the effect on the market power of the merging parties alone. And certainly, neither *ProMedica* nor *St. Alphonsus* provides an adequate explanation of its connection to unilateral-effects analysis. All that can be said is that the outcomes in the cases would have been no different absent reliance on the mergers' effect on concentration because there was much other evidence of their likely effect on competition.

A second question is whether the standard for sustaining the weakened competitor defense is too stringent? The Sixth Circuit in *ProMedica* held, quoting a previous decision, that the argument is "'probably the weakest ground of all for justifying merger.'"3 Continuing, quoting another previous case, the court explained that the proponents must "make a substantial showing that the acquired firm's weakness, which cannot be resolved by any competitive means [e.g., turnaround? joint venture? acquisition by an acquirer whose acquisition would have a lesser or no anticompetitive effect?], would cause that firm's market share to reduce to a level that would undermine the government's prima facie case."4 The basic idea behind the weakened competitor argument is that the acquired firm's current market share overstates its future competitive importance because it is in a downward spiral that will continue into the future—but that if its share would never fall below that required for a prima facie case based on market concentration, it would remain an important competitive constraint on the acquiring provider's market power. It seems doubtful, however, that the acquired firm's share would need to fall that far (to two percent in the *ProMedica* case, for example) for it to lose its competitive significance.

The larger problems, however, are the practical problems of proving that the firm would lose its competitive significance, proving how long this would take, and determining the extent, if any, to which competition would suffer in the interim. And the apparent requirement that the acquired firm seek a partner whose acquisition of it would have less anticompetitive effect may, all else being equal, result in fewer efficiencies than an acquisition by a more direct competitor. Finally, since the rebuttable presumption under the *Merger Guidelines* arises from particular market concentration factors which seem irrelevant in a unilateral-effects case, another question is what sustains a prima facie case when unilateral effects are the only concern. Does the 30 percent post-merger market share guideline from the 1963 *Philadelphia National Bank* decision apply?5

A third concern, and perhaps the most important, is the Ninth Circuit's degree of skepticism in *St. Alphonsus* about the relevance of efficiencies in merger analysis, and most troubling of all, its suggestion, if not holding, that "[i]t is not enough to show that the merger would allow St. Luke's to better serve patients" because there was no district court finding "that the merger would increase competition or decrease prices."6 The exact meaning of this is not clear. But if the court is saying that quality or other non-price improvements from the merger benefitting patients don't count in its favor, its holding flies in the face of

the *Merger Guidelines*, speeches and comments by FTC officials,[7] case law, economics, and common sense. FTC officials should clarify that the Commission disagrees with this reading of the decision. In a recent speech, an FTC Commissioner, in commenting on the decision, lauded the court's efficiencies analysis, but stated that all it did was "reinforce[] . . . that it is not enough to assert that the acquisition might somehow lead to efficiencies, such as increased quality."[8] We can agree that the parties must do more than make assertions of efficiencies. But that's not what the court said. Rather, it said that it would not matter if the defendants had shown that the merger would have resulted in better patient care.

Finally, an "Affordable Care Act defense" will fall on deaf ears, both at the Commission and before the courts. There is no antitrust exemption in the ACA, and, more important, it and the antitrust laws seek the same goals—lower cost, higher quality, and improved access. Transactions resulting in significantly increased market power are inapposite to the goals of the ACA, as wells those of the antitrust laws. A purported ACA defense should be folded into an efficiencies argument—detailed plans explaining how and when the parties intend to increase quality through coordination resulting from the merger—benefits they cannot obtain (or cannot obtain to the same extent) from looser forms of affiliation.

There is no reason to believe that FTC challenges to provider-mergers will abate in the near future. While it is true, as the FTC continues to point out, that only a small percentage of hospital mergers are challenged, an important reason is that many are not between competitors but between systems with hospitals in widely disparate geographic markets. The situation is different when the merging hospitals (or other providers) are strong direct competitors of each other. In that situation, it is crucial, early-on when the parties begin discussions, to provide a preliminary assessment of whether the merger likely would present no problem, be in the gray zone, or constitute a non-starter.

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1 *ProMedica Health Sys. v. FTC*, 749 F.3d 559, 565 (6th Cir. 2014) (*ProMedica*).

2 *See FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1086-88 (N.D. Ill. 2012).

3 *ProMedica*, 749 F.3d at 572.

4 Id.

5 *See United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 364 (1963). ("Without attempting to specify the smallest market share which would still be considered to threaten undue concentration, we are clear that 30% presents that threat.")

6 *St. Alphonsus Med. Ctr.-Nampa v. St. Luke's Health Sys.*, 778 F.3d 775, 791 (9th Cir. 2015).

7 For example, FTC Chairwoman Edith Ramirez has noted that "[a]ntitrust takes into account both cost and quality considerations. When reviewing a hospital merger, for instance, the FTC focuses not only on whether the transaction will most likely lead to anticompetitive consequences such as higher prices or other harms, but also on whether it will raise the quality of health care services." Edith Ramirez, Perspective: Antitrust Enforcement in Health Care—Controlling Costs, Improving Quality, 371 N. Eng. J. Med. 2245, 2247 (2014).

8 Terrell McSweeny, Commissioner, FTC, Prepared Remarks Before the Dechert 2015 Annual Antitrust Spring Seminar (Apr. 28, 2015).