PUBLICATION

Anatomy of a Provider Antitrust Merger Challenge (Part 1) [Ober|Kaler]

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This is the first in a six-part series discussing the Federal Trade Commission's challenges to provider mergers. Following this Introduction and Background, 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 1: Introduction and Background

There seems to be unprecedented antitrust interest in mergers between health-care providers, particularly by the Federal Trade Commission (FTC or Commission). Why this interest? What triggers governmental interest? What are the concerns? What variables do the enforcement agencies consider when evaluating provider mergers? When are investigations and challenges likely? Isn't the government promoting and incentivizing provider consolidations through the Affordable Care Act to integrate, coordinate care, and reduce costs? Doesn't the government care about the efficiencies, including better quality, that mergers can generate, or the ability of mergers to save financially troubled providers that otherwise would fail and exit the market, leading to further market concentration and access problems? What roles should antitrust attorneys and experts play in provider mergers and when? How can attorneys advising providers considering a merger best protect them from antitrust challenge?

In light of the FTC's vigorous enforcement and extraordinary success in challenging provider mergers since 2007,1 the ability of health care attorneys, and the specialists they retain, to answer these questions is crucial. With the FTC's 2007 decision in *Evanston Northwestern Healthcare Corp*.,2 holding unlawful a hospital merger in the north Chicago suburbs, the antitrust-merger rules of the game and the antitrust environment for provider mergers changed drastically—from one of pretty much “anything goes” to one where more mergers between competing hospitals and some between other types of health care providers will draw at least an investigation if not a challenge.

This series of articles focuses on mergers among competing hospitals and, to a lesser extent, on mergers of physician practices, whether through hospital acquisition or the merger of practices without hospital involvement. Worth noting, however, is that the FTC has challenged mergers among a plethora of other types of providers as well, including imaging centers,3 ambulatory surgical centers,4 pharmaceutical manufacturers,5 and others.

First, a short history:

Hospital-merger antitrust enforcement began in the early 1980s.6 While the government did experience one loss,7 it won most of its litigated hospital-merger cases. That was true through the early 1990s.[8] Then, a strange thing happened: The Antitrust Division, FTC, and state attorneys general lost eight straight litigated cases.[9] Why? For several reasons, but the most important, by far, were the court's findings of relatively large

relevant geographic markets,[10] which, of course, resulted in less concentrated post-merger markets and lower merged-firm post-merger market shares.

From 1999 through 2004, the agencies were basically out of the hospital-merger-enforcement business. Indeed, the chairman of the FTC effectively admitted that the FTC could not win a hospital-merger case. The FTC went back to the drawing board, carefully examining the reasons for the losses and how the analysis might be tweaked to overcome the problem. At the same time, it instituted a "merger retrospective," by which it examined several consummated mergers to study their actual effects on competition with the idea of challenging one or more.[11] Just because a merger has been consummated for a long period of time, even if it was cleared under the Hart-Scott-Rodino (HSR) premerger-notification process,[12] does not mean, of course, that it can't be challenged later. There is no statute-of-limitations problem.

As a result of its retrospective study, the FTC determined that it could show that the two-hospital Evanston Northwestern Healthcare (ENH) system's acquisition of Highland Park Hospital in 2000 had resulted in ENH's significantly increasing its rates to most area health plans. In 2004, FTC complaint counsel filed an administrative complaint seeking to force Highland Park's divestiture. In 2007, although ultimately determining not to order divestiture, the full Commission, after an extensive, detailed economic analysis, agreed with its administrative law judge that the merger significantly increased ENH's market power and thus was unlawful.[13] Note that the merger had been consummated some four years before the FTC challenge and thus there was a track record on its actual effect on prices.

The *Evanston Northwestern* decision is interesting and important for a number of reasons. First, it was the FTC's first victory in a litigated hospital merger case since 1991. Second, the FTC complaint challenged the merger under two theories. One count alleged a traditional antitrust merger case, including allegations of the requisite relevant product and geographic markets. The second count, however, alleged no relevant market and claimed that econometric evidence showing actual significant price increases from the merger (i.e., direct evidence of anticompetitive effects) was itself sufficient to show the merger's unlawfulness even absent formal market definition and calculation of market concentration or the merged hospital's post-merger market share.

Third, the Commission relied very heavily on three forms of evidence for its conclusion, which then became paramount in later cases: (1) Pre-merger and post-merger documents and statements of the parties and their consultant indicating that at least one purpose for the merger was to increase ENH's bargaining power and that the transaction actually had that effect; (2) testimony from a number of health plans that, especially because of its acquisition of Highland Park, ENH was a "must have" hospital system—i.e., that health plans, to construct a competitively viable and marketable network, had to contract with ENH in light of the merger; and (3) econometric testimony from experts that, indeed, ENH had raised its prices post-merger and, based on regression analysis controlling for other possible causes of its price increases, they resulted from increased market power from the merger.

Fourth, the Commission, for the first time in a hospital-merger case, applied a relatively sophisticated "unilateral effects/differentiated products" merger analysis (discussed later). Fifth, related to that, the FTC, for the first time in a hospital-merger case, defined the relevant geographic market using the "hypothetical monopolist" framework (also discussed later), emphasizing the relationship between definition of the relevant market and the merger's effect on competition when evidence shows that the merger actually permitted the merged firm to unilaterally raise prices. Based on the fact that ENH actually did profitably increase rates significantly as result of the merger, the Commission concluded that the relevant geographic market included only the area within a triangle formed by the now-three ENH hospitals, in which they were the only hospitals. In effect, the Commission indicated that where the evidence shows an actual price increase from a consummated merger, it may not be necessary to define a relevant market since the purpose for doing so is to aid in determining whether a merger is anticompetitive.[14] In any event and most significantly, application of the

hypothetical monopolist methodology for defining relevant markets has vastly decreased their size—the most troublesome problem the agencies encountered with the courts in their earlier hospital-merger challenges.

The *Evanston Northwestern* decision has resulted in a sea change in the FTC's success in challenging provider mergers. Since 2007, it is undefeated: Two litigated hospital-merger victories—*FTC v. OSF Healthcare System*,[15] preliminarily enjoining the merger of two hospitals in Rockford, Illinois, and *ProMedica Health System, Inc. v. FTC*,[16] in which the Sixth Circuit upheld the FTC's decision that ProMedica's acquisition of St. Luke's Hospital in the Toledo area was unlawful; *Phoebe Putney*, an ongoing challenge to the merger of hospitals in Albany Georgia;[17] consent orders requiring hospital divestitures;[18] a victory in a litigated hospital-acquisition-of-physician-practice case—*St. Alphonsus Medical Center-Nampa v. St. Luke's Health System, Inc.*,[19] where the Ninth Circuit affirmed a district court decision holding that St. Luke's acquisition of a large physician group in Nampa, Idaho, which competed with physicians that St. Luke's already employed, was unlawful; several consent orders in other provider-merger enforcement actions;[20] and several merger abandonments by the parties in the face of an FTC investigation or complaint.[21]

As two commentators recently noted, "In the span of less than ten years, the FTC has gone from losing to winning every hospital merger challenge it brings."[22] Or, as Justice Potter Stewart explained during the heyday of merger enforcement in the 1960s, "The sole consistency that I can find is that in litigation under § 7, the Government always wins."[23] In simple terms, the FTC is on an unprecedented roll. As a result, antitrust advice regarding hospital mergers has become more conservative than it was ten years ago.

Interestingly, the agencies showed little interest in physician-practice mergers prior to the *Evanston Northwestern* decision, seeming to leave antitrust concern about those to state attorneys general, who had brought several cases,[24] and, in one case, to private parties.[25] That appeared to change in 2011 when the FTC threatened to challenge a hospital's plan to acquire two cardiology practices in Spokane, Washington.[26] Shortly thereafter, the Commission sued Renown Health, challenging its acquisition of two cardiology practices in Reno, Nevada, in a case settled by consent order.[27] As part of its more recent hospital-merger challenge in *OSF*, the Rockford case, the Commission also challenged the merger of their primary-care physician groups as part of the merger, but the court, enjoining the hospital merger, did not reach that issue.[28] And most recently, of course, the FTC won the *St. Alphonsus* case, now on appeal, in which the court ordered a hospital to divest an acquired primary-care physician practice. Prior to *Evanston Northwestern*, the Antitrust Division had addressed physician-practice mergers in several Business Review Letters, beginning in 1987.[29]

1This emphasis on FTC enforcement is not to overlook actions by the Antitrust Division. To a large extent, however, the Division and FTC have allocated the market in such a way that the FTC has primary responsibility for antitrust issues involving providers and the Division has responsibility for antitrust issues involving health
plans.

2 2007-2 Trade Cas. (CCH) ¶ 75,814 (FTC 2007) (*Evanston Northwestern*).

3 E.g., Carilion Clinic, Dkt. No. 9338 (FTC Nov. 25, 2009) (consent order) (imaging center and ambulatory surgery center).

4 E.g., H.I.G. Bayside Debt & LBO Fund II, L.P. (Surgery Center Holdings, Inc.), Dkt. No. C-4494 (FTC Dec. 22, 2014) (consent order).

5 E.g., FTC v. Lundbeck, Inc., 630 F.3d 1236 (8th Cir. 2011).

[6]*See* United States v. Hosp. Affiliates Int'l, 1980-81 Trade Cas. (CCH) ¶ 63,721 (E.D. La. 1980) (preliminary injunction blocking psychiatric hospital merger); Am. Med. Int'l, Inc., 104 F.T.C. 1 (1984).

[7]United States v. Carillion Health Sys., 707 F. Supp. 840 (W.D. Va.), *aff'd per curiam without published opinion*, 892 F.2d 1042 (4th Cir. 1989).

[8]E.g., FTC v. Univ. Health, Inc., 938 F.2d 1206 (11th Cir. 1991).

[9]E.g., United States v. Long Is. Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997).

[10]E.g., FTC v. Tenet Health Care Corp., 186 F.3d 1045 (8th Cir. 1999).

[11]*See* Timothy J. Muris, Chairman, FTC, "Everything Old is New Again: Health Care and Competition in the 21st Century," Prepared Remarks before the 7th Annual Competition in Health Care Forum (Nov. 7, 2002).

[12]Section 7A of the Clayton Act, 15 U.S.C. § 18a.

[13]*Evanston Northwestern*. Because the Commission felt that significant quality improvements from the merger would be lost in a divestiture, it ordered, instead, a conduct remedy requiring the acquiring and acquired hospitals to negotiate health plan contracts separately. *Evanston Northwestern*, 2007-2 Trade Cas. (CCH) at 108,602–03. The Commission emphasized, however, that "our rationale for not requiring divestiture in this case is likely to have little applicability to our consideration of the proper remedy in a future challenge to an unconsummated merger, including a hospital merger." In FTC v. OSF Healthcare System, 852 F. Supp. 2d 1069 (N.D. Ill. 2012) (*OSF*), the court specifically rejected the defendants' request that instead of preliminarily enjoining the merger, the court accept a stipulation preventing the merged firm from engaging in certain forms of potentially anticompetitive conduct. *OSF*, 852 F. Supp. 2d at 1085–86.

The federal agencies are unalterably opposed to conduct remedies except in extraordinary circumstances. State attorneys general appear much more willing to accept them, thus permitting the transaction to go forward but under agreed-to competitive constraints. *See*, e.g., Pa. v. Geisinger Health Sys. Found., No. 4:12-cv-01081-CCC (M.D. Pa. 2012) (consent decree); Wis. v. Kenosha Hosp. & Med. Ctr., 1997-1 Trade Cas. (CCH) ¶ 71,669 (E.D. Wis. 1997) (consent order). Thus, in the case of a merger that likely will be investigated, it may be helpful to work on a remedy with the state attorney general in an attempt to avoid a federal agency investigation and challenge. Recently, however, the Massachusetts Attorney General indicated that she objected to a proposed conduct consent degree with conduct remedies permitting Partners Healthcare System in Boston to acquire South Shore Hospital. Notice of Position of Attorney General Maura Healey Concerning the Pending Consent Judgment Between Partners and the Office of the Attorney General, Mass. v. Partners Healthcare System, Inc., No. 14-2033-BLS2 (Sup. Ct. Suffolk County, Jan. 26, 2015).

[14]Notwithstanding that, the FTC has indicated that it will continue to allege relevant markets in its merger cases because Section 7 of the Clayton Act, as well as the case law, seems to require it. Section 7 prohibits mergers whose "effect . . . may be substantially to lessen competition" in "any *line of commerce* . . . in any *section of the country*." 15 U.S.C. § 18 (emphasis added). *See* U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* § 4 (2010) (*Merger Guidelines*) ("In any merger enforcement action, the Agencies will normally identify one or more relevant markets in which the merge may substantially lessen competition"); *OSF*, 852 F. Supp. 2d at 1075 ("'It is essential . . . that the FTC identify a credible relevant market before a preliminary injunction may properly issue' because a merger's effect on competition cannot be properly evaluated without a well-defined market.").

[15]852 F. Supp. 2d 1069 (N.D.Ill. 2012)

[16]749 F.3d 559 (6th Cir. 2014) (*ProMedica*), *petition for cert. filed*, No. 14-762 (Dec. 22, 2014). Also worth reviewing are the district court decision extending a hold-separate agreement the parties had entered, FTC v. ProMedica Health Sys., 2011-1 Trade Cas. (CCH) ¶ 77,395 (N.D. Ohio 2011), and the FTC decision reviewed by the Sixth Circuit, ProMedica Health Sys., 2012-1 Trade Cas. (CCH) ¶ 77,840 (FTC 2012).

[17]FTC v. Phoebe Putney Health Sys., 133 S. Ct. 1003 (2013) (rejecting application of state-action exemption to hospital merger).

[18]E.g., Cmty. Health Sys., Dkt. No. C-4427 (FTC Apr. 11, 2014) (consent order).

[19]___ F.3d ___, 2015 WL 525540 (9th Cir. Feb. 10, 2015) (*St. Alphonsus*).

[20]E.g., H.I.G. Bayside Debt & LBO Fund II, L.P (Surgery Center Holdings, Inc.), Dkt. No. C-4494 (FTC Dec. 22, 2014) (consent order) (requiring divestiture of an ambulatory surgery center).

[21]E.g., Reading Health Sys., Dkt. No. 9353 (FTC Dec. 7, 2012) (order dismissing complaint); Inova Health Found., Dkt. No. 9326 (FTC June 17, 2008) (order dismissing complaint).

[22]Lisa J. Fales & Paul Feinstein, *How to Turn a Losing Streak into Wins: The FTC and Hospital Merger Enforcement*, ANTITRUST, Fall 2014 at 36.

[23]United States v. Von's Grocery Co., 384 U.S. 270, 301 (1966) (Stewart & Harlan, JJ., dissenting).

[24]E.g., Maine v. Cardiovascular & Thoracic Assocs., P.A., 1992-2 Trade Cas. (CCH) ¶ 69,985 (Me. Super. Ct. 1992).

[25]*See* HTI Health Servs. v. Quorum Health Group, Inc., 960 F. Supp. 1104 (S.D. Miss. 1997).

[26]*See* Statement of Bureau of Competition Director Richard Feinstein on Abandonment by Providence Health System & Services of its Plan to Acquire Spokane Cardiology and Heart Clinics Northwest (Apr. 8, 2011).

[27]Renown Health, Dkt. No. C-4366 (FTC Nov. 30, 2012) (consent order).

[28]OSF, 852 F. Supp.2d at 1076 (“Without expressing any opinion on the ultimate merits of this claim, the court observes that the FTC's likelihood of success on its claim involving the PCP market is distinctly lower than its claim involving the [inpatient general acute-care hospital services] market.”).

[29]E.g., Letter from Charles F. Rule, Assistant Attorney General, Antitrust Division, to William L. Trombetta (Aug. 28, 1987) (Business Review Letter to Danbury Surgical Associates); see also Letter from Joel I. Klein, Assistant Attorney General, Antitrust Division, to Donald H. Lipson (Jul. 7, 1997) (Business Review Letter to three gastroenterology practices in Allentown, Pennsylvania).