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Mergers and Joint Ventures: Antitrust Challenges for Hospitals and Physicians

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What's up?

- What are the latest merger and provider joint venture enforcement developments at the FTC?
- How does consumer and payor "willingness to pay" affect merger analysis?
- What's a "virtual" merger and what difference does it make?
- Joint ventures –
  - Pitfalls in provider collaborations
  - How should antitrust respond to health reform legislation's push for "Accountable Care Organizations"?

Hospital Merger Enforcement at the FTC

- FTC will continue to diligently investigate proposed transactions and challenge those mergers that are likely anticompetitive
- We also recognize that the vast majority of proposed hospital mergers will not result in competitive harm and may result in significant efficiencies (vast majority of hospital investigations are closed without filing complaint)
- Demonstrating that improvements in quality of care are a likely outcome of the merger will be given substantial weight

Hospital Merger Enforcement Background

- **Success in 1980s administrative litigation (Part III)**
  - *American Medical International* (1984)
  - *HCA* (1985) – affirmed by 7th Cir., cert. denied
- **Success in federal court (preliminary injunctions)**
  - *U.S. v. Rockford Memorial* (N.D. Ill. 1989), affirmed by 7th Cir., cert. denied
  - *FTC v. University Health* (11th Cir. 1991)
  - Non-profit hospitals subject to antitrust laws
- **String of losses from mid-1990s through 2001**
  - Mainly because of judicial acceptance of large geographic markets
  - Improvements of quality of care also played role

Hospital Merger Enforcement Background

- 2002: Chairman Muris – merger litigation task force and retrospective study of consummated mergers
  - *Evanston*: consummated merger, complaint filed in 2004
    - *Evidence of post-merger behavior available. Different than most prospective merger investigations (like Inova) which rely upon predictive model*

- 2004: DOJ/FTC Health Care Report
  - Analysis should not be affected by hospital's institutional status (non-profit vs. for-profit)
  - Merger Guidelines analysis (relevant markets, defenses)
  - Acknowledgement that hospital mergers raise unique issues
  - Types of evidence in all merger cases (e.g., strategic planning docs, customer [MCOs/employers] testimony) should be used by fact finder to help delineate relevant markets

FTC v. DOJ Review of Hospital Mergers

- Historically, both antitrust agencies have challenged hospital mergers
- Recently, the FTC rather than DOJ has reviewed virtually every proposed hospital merger
- Both agencies apply the Merger Guidelines and determine whether acquisition may violate Section 7 of Clayton Act
- Procedural difference: Preliminary Injunction/Administrative Trial v. Permanent Injunction

Definition of Relevant Product Market for Hospital Mergers

- General Acute Care Inpatient Hospital Services for Commercially Insured Patients
  - Cluster market
  - Widely recognized by courts
- Outpatient/tertiary??

Geographic Market

- **Defining the correct (or defensible) parameters of geographic market**
  - An historical area of weakness for the agencies
  - Testimony/documents from health plans, parties, other hospitals, and employers
  - Inflow/Outflow analysis (not Elzinga-Hogarty)
  - Econometric work??
- **Steering of patients (expand geographic market?)**
  - Will the presence of steering strengthen the competitive effects story by potentially disciplining "must-haves?"
- **Direct evidence of competitive effects to "back into" geographic market**

Theories of Competitive Harm

- **Traditional Unilateral Effects**
  - A-side and B-side close competitors in large surrounding area
  - Next best substitutes based on draw/patient data?
- **Merger will strengthen combined hospitals bargaining strength against health plans**
- **Can one hospital constrain a must-have?**
- **Disagreement Points**
- **Non-price Competition**

Story of Competitive Harm

- Why does competition matter?
- How does hospital competition impact health plan rates and consequently rates paid by employers, employees, and out-of-pocket expenses?
- Does a price increase by non-profit hospitals really matter?
  - "Populist" story to deal with sentiment in *Butterworth*

Other Challenging Issues

- State or local government
- Community reaction to the merger?
  - **Key to the Populist Message**
- Non-Profit issue (*Butterworth*)
  - Other non-profit hospitals
  - Lack of Board involvement in health plan contracts
  - Negative option: no documents “you got too much”
  - Financial incentives for contract negotiators
  - Behavior that demonstrates profit-maximizing

Quality of Care Claims

- Acquired hospital will obtain acquiring hospital's expertise
  - A-side is better than B-side
  - This is due to superior knowledge and/or practices
  - After the merger, this will rub off on A-side
- A-side would invest a bunch of money at B-side
  - The money would not be invested without the merger
  - The money will be spent on things that will improve quality (e.g., bed tower with private rooms, state-of-the-art cath labs)

Failing Firm Defense's Two Prongs

(1) Acquired firm was so depleted and the prospect of rehabilitation so remote that it faced the grave probability of a business failure;

(2) The acquiring firm was the only available purchaser.

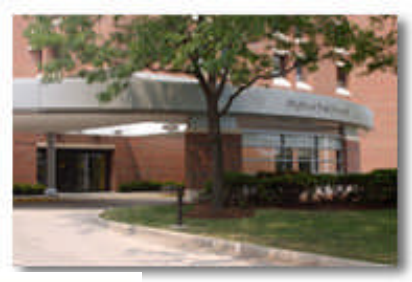
The merging parties carry burden of proof on both elements.

Flailing Firm/Weakened Competitor

- Hospital's financial weakness or declining position may reduce competitive concerns arising from a merger
- *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974): past or current strength as a competitor is not a good predictor of future competitive significance
- Beware of "**inverse** *General Dynamics*"

Recent Developments

- **Evanston/Highland Park** (2007)
  - Post-consummation challenge
  - Evidence of significant price increases
  - Efficiencies did not outweigh harm



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Recent Developments

- **Inova/Prince William** (2008)
  - Pre-consummation challenge
    - Federal court and administrative litigation
  - System purchase of independent hospital
  - Parties abandoned transaction
  - First successful challenge of a hospital merger in federal court in 15 years

Recent Developments

- **Carilion Clinic/Odyssey** (2009)
  - Post-consummation challenge
  - Dominant hospital system purchased strong independent outpatient centers
  - Evidence of price and quality competition
  - First litigation challenge to a merger between a hospital and outpatient provider
  - Unwind of transaction

Recent Developments

- **Scott & White acquisition of King's Daughters Hospital**
  - Not HSR-reportable
  - Failing firm was a critical issue
  - Was the search for an alternative purchaser sufficient?
  - Creative remedy: test whether the sole alternative purchaser was still interested

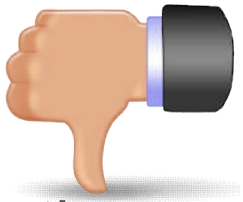
The New Horizontal Merger Guidelines

- Heavy influence from the *Commentary on the Horizontal Merger Guidelines* (2006)
- Captures accurately how the agencies actually evaluate mergers and the types of evidence that we most frequently rely on
- Provides a lot more "guidance" for competitive effects analysis, especially for differentiated products
- Significantly less reliance on an iterative approach to conducting the various steps in merger analysis (product market, geographic market)
- Provides more support – and notice – that the agencies may "back into" product market and geographic market

More Recent Developments

- Acquisitions involving physician practices or groups
- Analytical structure the same as used to review hospital mergers (product market; geographic market; etc.)
- Product market typically determined by type of practice (PCP; general surgery; cardiologist)
- Post-consummation, much more difficult to remedy since human capital the most important asset
- Significant spike in these types of investigations

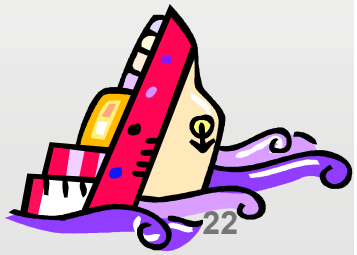
Observations on Inova Health System – Prince William Hospital



- Poor FTC track record on recent preliminary injunctions
- Defendants effectively converted cases to merits trials
- If PI motion failed, FTC had often then dropped merger challenge
- This time, FTC set out to change paradigm
  - FTC appoints Commissioner as Administrative Law Judge
  - FTC expedites administrative proceeding
  - FTC successfully opposes live witness evidentiary hearing
  - FTC has statements from market participants on likely impact
- Hospitals abandon transaction without waiting for judge to rule on PI

Observation on Scott & White investigation closing

- In post-acquisition investigation, FTC staff concerned that transaction did not satisfy "failing firm" defense since opportunity for alternative purchaser had been "cut short" by Scott & White takeover
- FTC and Scott & White agree in writing that new opportunity to buy on specific terms will be given to alternative purchaser
- Potential alternative buyer declines
- FTC issues statement announcing closing of investigation
- Rationale for use of interim letter procedure, rather than complaint, may be (1) no antitrust violation even if absence of alternative purchaser was not established yet at time deal closed or (2) no public interest in litigating technical compliance with failing company defense requirements if no competitive benefit from challenge



"Willingness to Pay" Evidence in Hospital Merger Enforcement

- FTC increasingly focusing on evidence of how much consumers are "willing to pay" to obtain services through a network with a particular hospital compared to a network without that hospital
- Pricing information and patient flow information can be used to estimate this "willingness to pay"
- This evidence can in turn be used to estimate the impact a merger will have on what a network-based health insurance plan would be willing to pay post-merger to access the hospitals in the merged enterprise compared to pre-merger pricing decisions
- If the two merging hospitals were close substitutes for a substantial portion of consumers, likelihood of perceived harm increases dramatically
- This analytical approach may even be used to estimate the cost impact of a merger where merger-specific direct pricing evidence is not available

How "Willingness to Pay" Fits in the Law

- The WTP approach seeks to provide a theoretical framework for longstanding concerns among payors that particular mergers will result in market power, even absent high share within what might previously have been defined as a larger geographic market based largely on patient flow data and willingness of some patients to switch to other hospitals.
- WTP analysis pushes assessment of merger legality toward decision on likely competitive effects without making a discrete first stop to decide geographic or even product market definition
  - Some may object that this analysis is inconsistent with traditional requirement that plaintiff define geographic and product market before assessing whether competitive harm in the market will occur
  - However, Clayton Act refers to substantial harm to competition "in any line of commerce in any section of the country." This suggests, perhaps, that harm need not be likely throughout the line of commerce in the section of the county affected, but merely "in" it.
  - Geographic market defined in *Evanston* is an early illustration, where market found is most explicable in light of effects evidence

Lessons for Parties Planning Affiliation

- Plan ahead
- Don't sink the deal with ill-advised statements
  - "Level the playing field," "leverage," "improve managed care contracts," "best of class rates"
- Articulate the pro-consumer and pro-competitive rationale
- Do the integration plan, don't just write the talking points for it
- Own the integration planning – don't let it be primarily the domain of consultants writing reports
- Address and engage stakeholders
  - Will they support merger past the topic sentence of an interview?

"Virtual" Merger Issues

- Health reform may drive increased consolidation by hospitals
- Not all alliances of affiliations are full-blown acquisitions or mergers
- Mergers subject to different antitrust standard than price fixing or agreements not to compete
  - Merger's legality depends on likely impact on competition. If merger is OK, parties, by definition, are permitted to fix prices.
  - In contrast, absent a merger, price fixing or other cartel behavior is either illegal or at least presumptively illegal
- Affiliations or alliances of non-profit hospitals may have cartel-like features or may be akin to merger
- Creation of holding company "above" two affiliating hospitals will not, by itself, warrant treatment as merger
- Similarly, clinical or other integration may be relevant to antitrust analysis, but may not be sufficient to make two firms into one if they retain separate economic identity in the marketplace
- Similar issues can arise with medical practice "groups without walls" – sharing a common tax ID is not an antitrust trump card

Virtual Merger Evaluation Criteria

- To be treated as a single entity, Supreme Court standard is whether affiliates will pursue the "common interests of the whole rather than [their own separate interests]". *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984)
  - Does parent have control over essential competitive and operational decisions of affiliates?
  - Are the participating hospitals' economic interests aligned?
    - Cf. *Health America Pennsylvania Inc. v. Susquehanna Health System*, 278 F. Supp. 2d 423 (M.D. Pa. 2003) (affiliation treated as merger)
    - *New York v. Saint Francis Hospital*, 94 F. Supp. 2d 399 (S.D.N.Y. 2000) (affiliation found violation of Sherman Act)

Joint Venture Pitfalls and Opportunities

- Joint ventures occupy space between mergers and solo operations
- Depending on facts, either merger or traditional agreement in restraint of trade types of analysis can apply, or in-between approaches
  - E.g., Supreme Court ruling in *American Needle v. NFL* (5/24/2010) confirms that teams may have legitimate basis for cooperating in certain business aspects, but they will not be viewed as a "single entity" for purposes of licensing products with team logos
- Is the crux of the joint venture anticompetitive or procompetitive?
- Do ancillary restraints pose antitrust problems?
- Is government regulatory scheme driving or encouraging competitor collaboration with antitrust risks?

Lesson from *U.S. v. Bluefield Regional Medical Center* (2005)

- State CON authority rejects Bluefield's proposal for new heart center:
  - "[The hospitals] failed to successfully negotiate . . . to reach a shared goal . . . to provide advanced cardiology services to the citizens of southern West Virginia and southwestern Virginia. . . . [We] would have preferred that the parties work together to present a project that could have been approved under the existing law. Instead, the parties fought among themselves [and] failed to resolve their differences"
- Two hospitals, following consultation with state, agree on plans for joint submissions of CON proposals for new heart and cancer care centers
- State grants CON for new heart center
- Hospitals' agreements contain market allocation/non-compete provisions that DOJ claimed were not necessary for any joint venture
- DOJ also claimed that while parties were collaborating to seek state approval, the new programs would not, in fact, be joint ventures
- DOJ challenged ancillary restrictions as unreasonable restraints of trade
- Consent judgment finalized in 2005 over objections of West Virginia Health Care Authority which raised "state action" argument based on state involvement, CON process and state regulation of hospital rates

Joint Venture Antitrust in a Reformed Health Care World

- Health reform legislation promotes "Accountable Care Organizations" ("ACOs") and "Medical Home" initiatives
  - For example, by January 2012, HHS is to establish a shared savings program under which providers can work together through an ACO to manage and coordinate care for Medicare beneficiaries
  - ACOs will be assessed based on factors such as clinical processes and outcomes, patient and caregiver experiences, use of electronic health record technologies, e-prescribing and utilization rates.
  - Providers will be paid based on the Medicare fee schedule, but ACOs that meet performance standards will be eligible to receive additional payments. Some ACOs may be paid on a partial capitation model.
- Policymakers will be striving to reconcile antitrust concerns about competitor collaborations with the public policy objective to foster innovation, cost control and quality improvement

Enforcement Perspective on "New" Types of Provider Joint Ventures

- Bona fide ACO should have solid antitrust footing based on FTC and DOJ guidance on clinically and/or financially integrated provider networks
- Decision of HHS to contract with an ACO would be strong indicator of integration and of customer/purchaser recognition of value of integration
- Past FTC enforcement has typically involved provider collaboration in managed care contracting and pricing, without integration
- Area of possible interest could be broad-based ACOs representing bulk of community providers if they purport to require provider exclusivity, so as to foreclose alternative competing programs.
  - This may not be a significant concern for Medicare alone if HHS may not be entertaining multiple ACOs in the same local market area initially anyway.
  - However, this concern could arise if ACO contracting practices spill into commercial plan products and pricing negotiations.
- Ultimately, should not be tension between antitrust and health reform, since both seek to foster innovation and choice

Old Wine in New Bottles

- Some providers may seek to employ new health reform lingo to try out familiar "united front" managed care contracting strategies, with lip service to integration
- Enforcement agencies will likely pierce the rhetoric, where integration claims are empty, to challenge price fixing activities. Cf. *North Texas Speciality Physicians v. FTC*, No. 06-60023 (5th Cir. 2008)
- FTC and DOJ may not, though, press to the limit where there is a legitimate quality improvement and clinical integration argument