THE CONTINUING SAGA OF HOSPITAL MERGER ENFORCEMENT

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The Federal Trade Commission prevailed in four recent, fully litigated health care provider merger cases, though it had to visit courts of appeals in the Sixth, Third, and Seventh Circuits along the way. The Sixth Circuit upheld the FTC's win in *ProMedica*, while the Third and Seventh Circuits reversed district court losses for the FTC in *Hershey* and *Advocate*.[1] The FTC also prevailed in a primary care physician merger case, *St. Luke's-Saltzer*, which involved similar economic and legal issues. That case also reached the appellate stage, with the Ninth Circuit upholding the district court's ruling in favor of the FTC.[2] Over the same period, several other hospitals abandoned proposed mergers in the face of FTC opposition.

Four merger rulings in a single industry by appellate courts in as many years is remarkable. Collectively, these rulings speak directly to the economic and legal issues that lie at the heart of merger cases: market definition, competitive effects, conduct remedies, quality and cost efficiencies, and innova-

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[1] ProMedica Health Sys., Inc., FTC Docket No. 9346, 2012 WL 2450574 (June 25, 2012), *aff'd*, ProMedica Health Sys., Inc., v. FTC, 749 F.3d 559 (6th Cir. 2014); FTC v. Penn State Hershey Med. Ctr., 185 F. Supp. 3d 552 (M.D. Pa. 2016), *rev'd*, 838 F.3d 327, 343 (3d Cir. 2016); FTC v. Advocate Health Care, No. 15 C 11473, 2016 WL 3387163 (N.D. Ill. June 20, 2016), *rev'd*, 841 F.3d 460 (7th Cir. 2016), *on remand* 2017 WL 1022015 (N.D. Ill. Mar. 16, 2017). The parties did not appeal in *FTC v. OSF Healthcare System*, 852 F. Supp. 2d 1069 (N.D. Ill. 2012).

[2] Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., No. 1:12-cv-00560, 2014 WL 407446 (D. Idaho Jan. 24, 2014), *aff'd*, 778 F.3d 775 (9th Cir. 2015).

tion. We discuss these four cases, with an emphasis on economic and antitrust questions that now appear resolved, as well as those that remain open.

I. THREE DECADES OF HOSPITAL MERGER ENFORCEMENT

Loosely speaking, each of the last three decades marked a distinct era of hospital merger enforcement and litigation outcomes. In the 1990s, the FTC and Department of Justice (DOJ) lost six successive hospital merger cases. In the 2000s, the agencies largely halted prospective hospital merger enforcement—neither agency would challenge a prospective hospital merger until 2008, when the FTC challenged one in Northern Virginia. The parties abandoned that deal shortly after the FTC sued, marking the first agency win in over a decade.[3] The FTC's successful challenge in that case set the stage for the 2010s, when the FTC launched a series of prospective hospital merger challenges, as well as three primary care physician merger challenges, and ultimately prevailed in each fully litigated case.

A. THE 1990S—SEVEN STRAIGHT GOVERNMENT LOSSES

In the late 1980s and early 1990s, the DOJ and FTC won several hospital merger challenges, including *United States v. Rockford Memorial Corp*. In so doing, the agencies set a precedent for using the Elzinga-Hogarty (E-H) methodology to define relevant geographic markets in hospital cases.[4] The E-H methodology, originally developed for commodity markets, relies on the flows of sales into and out of a region to determine the relevant geographic market.[5] Applied to hospital mergers, this methodology indicated that relevant geographic markets should be defined as areas from which few patients leave and into which few patients enter.[6] Notably, the DOJ and FTC, and not just

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[3] Order Dismissing Complaint, Inova Health Sys. Found., FTC Docket No. 9326 (June 17, 2008), www.ftc.gov/sites/default/files/documents/cases/2008/06/080617orderdismisscmpt.pdf; Joint Stipulated Motion for Order Dismissing Complaint, FTC v. Inova Health Sys. Found., No. 1:08-cv-460 (E.D. Va. June 11, 2008), www.ftc.gov/sites/default/files/documents/cases/2008/06/080611commonwealthstip.pdf.

[4] *See, e.g.*, United States v. Rockford Mem'l Corp., 717 F. Supp. 1251, 1271 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990); FTC v. Univ. Health, 938 F.2d 1206 (11th Cir. 1991).

[5] Kenneth Elzinga & Thomas Hogarty, *The Problem of Geographic Market Definition: The Case of Coal*, 23 ANTITRUST BULL. 1, 2 (1978); Kenneth Elzinga & Thomas Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 ANTITRUST BULL. 45, 45 (1973). See detailed discussion in Cory S. Capps, *From Rockford to Joplin and Back Again: The Impact of Economics on Hospital Merger Enforcement*, 59 ANTITRUST BULL. 443, § II (2014).

[6] Memorandum Opinion & Order at 9, FTC v. Penn State Hershey Med. Ctr., No. 1:15-cv-2363 (M.D. Pa. May 9, 2016).

Relatedly, both the agencies and defendants also sometimes used, at least superficially, critical loss analysis (CLA) to define geographic markets. Barry C. Harris & Joseph J. Simons, *Focusing Market Definition: How Much Substitution Is Necessary?* 12 RESEARCH L. & ECON. 151, 157 (1989). CLA entails two steps. First, compute the *critical loss*, defined as the percentage of customers that would have to leave a market for a specified price increase to be unprofitable.

defendant hospitals, used E-H to define markets.[7] In this respect, the agencies' initial successes sowed the seeds of their future losses.

Indeed, between 1994 and 1999, the federal agencies lost six successive hospital merger cases.[8] In addition, in 1999, California sued to enjoin a merger of two hospitals in San Francisco's East Bay and lost, and the Ninth Circuit upheld that outcome.[9] The predominant reason for all of these losses was that courts rejected the relatively compact geographic markets—and thus the high shares—alleged by the government.[10] For instance, in *Freeman*, the

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Second, estimate the *actual loss* that would occur in response to the specified price increase. If the actual loss exceeds the critical loss, then the hypothesized price increase would not be profitable and the putative market must be expanded. However, in hospital cases, high patient flows formed the main basis for arguments that the actual loss was likely to exceed the critical loss. Thus, CLA tended to produce geographic markets similar to those identified by E-H because both rely on patient flows to accept or reject a proposed geographic market.

There are important theoretical limitations to critical loss analysis. *See, e.g.*, Kenneth L. Danger & Harry E. Frech, *Critical Thinking About "Critical Loss" in Antitrust*, 46 ANTITRUST BULL. 339 (2001); Michael L. Katz & Carl Shapiro, *Critical Loss: Let's Tell the Whole Story*, ANTITRUST, Spring 2003, at 49; James Langenfeld & Wenqing Li, *Critical Loss Analysis in Evaluating Mergers*, 46 ANTITRUST BULL. 299 (2001); Daniel P. O'Brien & Abraham L. Wickelgren, *A Critical Analysis of Critical Loss Analysis*, 71 ANTITRUST L.J. 161 (2004). For a response to some of these critiques, see David T. Scheffman & Joseph J. Simons, *The State of Critical Loss Analysis: Let's Make Sure We Understand the Whole Story*, ANTITRUST SOURCE (Nov. 2003), www.americanbar.org/content/dam/aba/publishing/antitrust_source/03/11/scheffman.authcheckdam.pdf.

[7] Cory S. Capps et al., *Antitrust Policy and Hospital Mergers: Recommendations for a New Approach*, 47 ANTITRUST BULL. 677, 678–80, (2002). *See also, e.g.*, United States v. Rockford Mem'l Corp., 717 F. Supp. 1251, 1267 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990)); FTC v. Freeman Hosp., 911 F. Supp. 1213 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995); FTC v. Butterworth Health, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd mem.*, 121 F.3d 708 (6th Cir. 1997); United States v. Mercy Health Servs., 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997).

[8] Adventist Health Sys.-West, No. 9234, 117 F.T.C. 224 (1994); FTC v. Freeman Hosp., 911 F. Supp. 1213 (W.D. Mo. 1995), *aff'd* 69 F.3d 260 (8th Cir. 1995*);* FTC v. Butterworth Health, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd mem.*, 121 F.3d 708 (6th Cir. 1997); United States v. Mercy Health Servs., 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997); FTC v. Tenet Healthcare, 186 F.3d 1045 (8th Cir. 1999). In another loss, though on different grounds, the Eleventh Circuit in 1994 upheld a Florida district court ruling that the acquisition of Cape Coral Medical Center by Lee Memorial Hospital was immune under the state action doctrine from FTC scrutiny. FTC v. Hosp. Bd. of Dirs. of Lee Cty., 38 F.3d 1184 (11th Cir. 1994).

[9] California v. Sutter Health Sys., 84 F. Supp. 2d 1057 (N.D. Cal.), *aff'd mem.*, 2000-1 Trade Cas. (CCH) ¶ 87,665 (9th Cir. 2000), *revised*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001).

[10] Although both the government and the parties used E-H, the courts favored the so-called strong market version of the E-H test, in which both the inflow and outflow percentages must be less than 10%. The smaller markets proposed by the government, with inflow and outflow statistics up to 25%, are the so-called weak market version of the E-H test. *See* David Dranove & Andrew Sfekas, *The Revolution in Health Care Antitrust: New Methods and Provocative Implications*, 87 MILBANK Q. 607, 611 (2009); *see also* H.E. Frech, James Langenfeld & R. Forrest McCleur, *Elzinga-Hogarty Tests and Alternative Approaches for Market Share Calculations in Hospital Markets*, 71 ANTITRUST L.J. 921 (2004); Martin Gaynor et al., *A Structural Approach to Market Definition with an Application to the Hospital Industry*, 61 J. INDUS. ECON. 243 (2013).

FTC proposed a 27-mile radius around Joplin, Missouri, but the court adopted the 50-mile radius area the merging hospitals advanced.[11] Likewise, in *Mercy*, the DOJ proposed a 15-mile radius around Dubuque, Iowa, but the court likewise rejected that as too narrow.[12] E-H tends to identify broad geographic markets because it is common for a fraction of patients to travel for hospital care. Consequently, accepting the E-H methodology led courts to adopt broad geographic markets and, ultimately, to rule against the government.[13]

B. THE 2000s—THE INFLUENCE OF ECONOMIC RESEARCH

After the string of losses in the 1990s, the federal agencies did not challenge a hospital merger for nearly a decade. Meanwhile, economic research on hospital competition continued. An influential 1993 paper by David Dranove, Mark Shanley, and William White observed that, with the spread of managed care and selective contracting, hospital competition had shifted from being patient-driven to payer-driven.[14] Prior to selective contracting, patients had largely unfettered choice of provider and were insulated from hospital prices by insurance. Hospital reimbursement was based on cost. This gave hospitals little incentive to set low prices. However, as the industry transitioned to payer-driven competition, selective contracting created a real incentive for hospitals to lower their prices: managed care organizations stood to benefit from lower hospital prices and could use network exclusion to direct patients away from high-priced hospitals and cause them to lose patients.

Gregory Vistnes extended the work of Dranove et al. by introducing the theory of two-stage competition, wherein hospitals first compete on price for inclusion in payers' networks and then compete with other in-network hospitals on non-price factors to entice patients.[15] Vistnes' framework provided insight into why patient flows were not a reliable basis for defining geographic markets and drawing competitive inferences:

> [The] two-stage model also helps explain several otherwise puzzling fact patterns associated with anticompetitive hospital mergers. . . . [A] merger can significantly reduce first-stage price competition even when patient flow data show that multiple hospitals draw patients from the same region . . . .

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[11] *Freeman Hospital*, 911 F. Supp. at 1218–19, 1222.

[12] *Mercy Health Services*, 902 F. Supp. at 976.

[13] Geographic market definition loomed large in five of the six loses. In the sixth, the district court agreed that the merger would likely enhance market power but concluded that, because the merging hospitals were nonprofit organizations, they would not exercise market power. *Butterworth*, 946 F. Supp. at 1296–97.

[14] David Dranove et al., *Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition*, 36 J.L. & ECON. 179, 182 (1993).

[15] Gregory Vistnes, *Hospitals, Mergers, and Two-State Competition*, 67 ANTITRUST L.J. 671, 672 (2000).

> [W]hile those fact patterns may suggest significant second-stage competition, they shed little light on the magnitude of first stage competition.[16]

The problem with using patient flows to judge pricing power—whether in the context of merging parties or a hypothetical monopolist test—is that patient flows reflect the wrong stage of competition. The analysis of pricing and market power should focus on the stage in which price outcomes are actually determined: stage-one negotiations between payers and hospitals.

Two papers published in the early 2000s—one by Robert Town and Gregory Vistnes and the other by Cory Capps, David Dranove, and Mark Satterthwaite—introduced empirical techniques to quantify the bargaining leverage of a hospital or system in stage-one negotiations with payers.[17] Both papers analyzed the difference in the value of health plans' networks with and without a particular hospital (or system), which Capps et al. labeled "willingness-to-pay" (WTP).[18] The two papers showed that hospitals and systems with greater bargaining leverage (i.e., higher WTP) had higher prices.[19]

In addition to theoretical and methodological progress, a body of empirical research into the effects of hospital consolidation and case studies of specific hospital mergers was developing. A survey published by the Robert Wood Johnson Foundation (RWJF) in 2006 summarized the general conclusion from several dozen papers published mostly between 1995 and 2003: "The average metropolitan resident saw a reduction in hospital competition, effectively, from six to four local competitors. . . . The balance of the evidence indicates that the 1990–2003 consolidation in metropolitan areas raised hospital prices by at least five percent and likely by significantly more."[20] The study also reported that research findings on quality changes and cost savings were mixed and limited, with the bulk of the available evidence indicating that (1)

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[16] *Id.* at 673.

[17] Robert J. Town & Gregory Vistnes, *Hospital Competition in HMO Networks*, 20 J. HEALTH ECON. 733, 734 (2001); Cory Capps et al., *Competition and Market Power in Option Demand Markets*, 34 RAND J. ECON. 737, 737 (2003). The logic of these models and their influence is discussed at greater length in Part IV of Capps, *supra* note 5.

[18] Suppose a health plan's network is worth $10 million to consumers with Hospital X included and worth $8 million with Hospital X excluded. In this case, adding Hospital X increases the value of the network by $2 million and so the health plan would be willing to pay up to $2 million to include Hospital X in its network. This explains the basic formula for the WTP for a given hospital, which generalizes to sets of hospitals (i.e., systems):

WTP for Hospital X = Value of Network with X – Value of Network without X.

[19] Related research by Katherine Ho has established that having a network of hospitals with higher WTP increases the demand for a health plan. *See* Katherine Ho, *The Welfare Effects of Restricted Hospital Choice in the US Medical Care Market*, 21 J. APPLIED ECONOMETRICS 1039 (2006).

[20] William Vogt & Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* 11 (Robert Wood Johnson Found. Synthesis Project, Research Report No. 9, 2006).

consolidation is more likely to lower quality than raise it and (2) combining hospitals under a single license likely produces cost savings.[21]

The DOJ and FTC also held extensive hearings on all aspects of hospital competition and, in 2004, released a comprehensive survey of what they learned. Regarding pricing, the agencies reported results consistent with the RWJF survey: "Most studies of the relationship between competition and hospital prices have found that high hospital concentration is associated with increased prices, regardless of whether the hospitals are for-profit or nonprofit."[22]

In 2002, the FTC also launched a retrospective hospital merger study, issuing subpoenas for documents and pricing data to recently formed hospital systems.[23] For some mergers, the FTC concluded that prices had not increased or had increased only for some payers. However, in its review of the acquisition of Highland Park Hospital by Evanston Northwestern Healthcare (both located in the northern suburbs of Chicago), the FTC found evidence of substantial price increases and, in 2004, it sued to unwind that merger.[24]

The *Evanston* trial focused heavily on the effect of the merger on stage-one bargaining between the merged hospitals and area payers.[25] The FTC's case was likely aided by the fact that experts from both sides largely agreed that

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[21] *Id*. at 10. A follow-on survey of subsequent research generally confirmed the earlier findings. Martin Gaynor & Robert J. Town, *The Impact of Hospital Consolidation—Update* 6 (Robert Wood Johnson Found. Synthesis Project, Issue Brief No. 9, June 2012).

[22] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, A REPORT BY THE FEDERAL TRADE COMMISSION AND THE DEPARTMENT OF JUSTICE—IMPROVING HEALTH CARE: A DOSE OF COMPETITION 15 (2004) (Exec. Summary).

[23] Press Release, Fed. Trade Comm'n, Federal Trade Commission Announces Formation of Merger Litigation Task Force (Aug. 28, 2002), www.ftc.gov/opa/2002/08/mergerlitigation.htm.

A recently published collection of articles by FTC staff economists and experts in various hospital litigation matters describes the circumstances in which the FTC has found, and not found, evidence of hospital market power. *See generally Special Issue: Hospital Mergers and Antitrust Policy*, 18 INT'L J. ECON. BUS. 1 (2011). The paper in that issue by Steven Tenn presents evidence of significant post-merger price increases in the case that the State of California litigated and lost in 2001. Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, 18 INT'L J. ECON. BUS. 65 (2011).

[24] Initial Decision, Evanston Nw. Healthcare Corp., FTC Docket No. 9315 (Oct. 20, 2005) [hereinafter *Evanston* Initial Decision], www.ftc.gov/sites/default/files/documents/cases/2005/10/051020initialdecision.pdf; Complaint, Evanston Nw. Healthcare, FTC Docket No. 9315 (Feb. 10, 2004), www.ftc.gov/sites/default/files/documents/cases/2004/02/040210emhcomplaint.pdf.

[25] *See generally* Final Order, Evanston Nw. Healthcare Corp., FTC Docket No. 9315 (Apr. 24, 2008) [hereinafter *Evanston* Final Order], www.ftc.gov/sites/default/files/documents/cases/2008/04/080424finalorder.pdf; *see, e.g.*, *Evanston* Initial Decision at 16–19, FTC Docket No. 9315; Opinion of the Comm'n by Chairman Deborah Platt Majoras at 10, 62–63, Evanston Nw. Healthcare Corp., FTC Docket No. 9315 (Aug. 6, 2007) [hereinafter *Evanston* Commission Opinion], www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf; Concurring Opinion of Comm'r J. Thomas Rosch at 1–2, Evanston Nw. Healthcare Corp., FTC Docket No. 9315 (Aug. 6, 2007).

prices had increased after the acquisition—though they disagreed strongly over whether the cause was increased market power or other factors. Testimony at the administrative trial by Kenneth Elzinga, co-creator of the E-H test, that it was inappropriate to use the E-H test to define a relevant geographic market in hospital merger cases surely bolstered the FTC's case.[26]

The FTC successfully argued to the administrative law judge that the merger had substantially lessened competition. The full Commission upheld that win.[27] Perhaps the most lasting effect of the Commission's opinion is that it placed the analytic focus squarely on the effect of the merger on the leverage of the merging hospitals in negotiations with payers:

> In bargaining markets, prices and other conditions of sale are set through individual negotiations between a buyer and seller. . . . Contrary to [Evanston Northwestern's] position, bargaining markets are quite common and fully consistent with unilateral effects theory. And *most economists who have recently studied the issue have concluded that bargaining models are appropriate for hospital markets because bilateral negotiations between MCOs and hospitals determine prices that often are unique to the particular negotiation*.[28]

Ever since the Commission's opinion in *Evanston* placed the focus in hospital merger cases on bargaining, it has largely remained there.

C. THE 2010S—ENFORCEMENT REVIVAL

In the wake of *Evanston*, the FTC resumed challenging hospital mergers. In 2008, the FTC challenged Inova Health System's proposed acquisition of Prince William Hospital, which Inova abandoned after the FTC sued to enjoin the transaction.[29] Other FTC wins followed:

- In 2011, the FTC sued to undo ProMedica Health System's acquisition of St. Luke's Hospital in Toledo, Ohio. The transaction was not reportable under the Hart-Scott-Rodino (HSR) Act so the acquisition closed, but the FTC and the parties entered a hold-separate agreement intended

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[26] *Evanston* Initial Decision, *supra* note 24, at 30–31.

[27] The case finally concluded in April 2008 when the Commission, given that the merger was over seven years old when the merits ruling was issued, imposed a conduct remedy rather than divestiture. *Evanston* Final Order, *supra* note 25.

[28] *Evanston* Commission Opinion, *supra* note 25, at 62 (citations omitted, emphasis added) (citing Capps et al., *supra* note 17; Town & Vistnes, *supra* note 17).

[29] Press Release, Fed. Trade Comm'n, FTC Approves Order Dismissing Administrative Complaint Against Inova Health System Foundation and Prince William Health System, Inc. (June 17, 2008), www.ftc.gov/news-events/press-releases/2008/06/ftc-approves-order-dismissing-administrative-complaint-against.

to preserve the option to divest St. Luke's.[30] Ultimately, as we discuss below, the FTC prevailed on the merits and secured a divestiture.

- In 2011, the FTC sued to block OSF Healthcare's proposed acquisition of Rockford Health System in Rockford, Illinois. The FTC prevailed in 2012 when the parties abandoned the transaction shortly after the district court issued a preliminary injunction.[31]
- In 2012, Reading Health System in Reading, Pennsylvania called off its planned purchase of the Surgical Institute of Reading after the FTC issued an administrative complaint.[32] The FTC alleged that the merger would reduce competition in several surgical service lines and increase Reading's "already immense bargaining leverage," leading to higher prices for consumers.[33]
- In 2013, National Park Medical Center and Mercy Hot Springs, two hospitals in Hot Springs, Arkansas, abandoned their proposed merger after the FTC indicated that it would sue.[34]
- In 2013, in a physician merger case, the FTC sued to unwind St. Luke's Hospital's acquisition of Saltzer Medical Group in Nampa, Idaho.[35] As we discuss below, in January 2014, the FTC prevailed at the district court level and, in February 2015, the Ninth Circuit upheld that win.

During this time, the FTC did have one loss—Phoebe Putney's proposed acquisition of Palmyra Park Hospital in Albany, Georgia—but not on the basis of competitive effects.[36] There, the district and circuit courts held that, because Phoebe Putney was owned by the Hospital Authority of Dougherty

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[30] Fed. Trade Comm'n, *What Is the Premerger Notification Program?* 1 (Mar. 2009), www.ftc.gov/sites/default/files/attachments/premerger-introductory-guides/guide1.pdf.

[31] Press Release, Fed. Trade Comm'n, OSF Healthcare System Abandons Plan to Buy Rockford in Light of FTC Lawsuit; FTC Dismisses Its Complaint Seeking to Block the Transaction (Apr. 13, 2012), www.ftc.gov/news-events/press-releases/2012/04/osf-healthcare-system-abandons-plan-buy-rockford-light-ftc.

[32] Mike Urban, *Merger Plan Terminated 'With Regret': Reading Health System Ends Bid in Wake of State, Federal Pressure*, READING EAGLE, Nov. 20, 2012, www2.readingeagle.com/article.aspx?id=429181.

[33] Complaint ¶¶ 4, 7, Reading Health Sys. Corp., FTC Docket No. 9353 (Nov. 16, 2012), www.ftc.gov/sites/default/files/documents/cases/2012/11/121116readingsurgicalcmpt.pdf.

[34] Press Release, Fed. Trade Comm'n, Statement of FTC Competition Director Richard Feinstein on Today's Announcement by Capella Healthcare That It Will Abandon Its Plan to Acquire Mercy Hot Springs (June 27, 2013), www.ftc.gov/news-events/press-releases/2013/06/statement-ftc-competition-director-richard-feinstein-todays.

[35] Press Release, Fed. Trade Comm'n, FTC and Idaho Attorney General Challenge St. Luke's Health System's Acquisition of Saltzer Medical Group as Anticompetitive (Mar. 12, 2013), www.ftc.gov/news-events/press-releases/2013/03/ftc-idaho-attorney-general-challenge-st-lukes-health-systems.

[36] Complaint, FTC v. Phoebe Putney Health Sys., No. 11-cv-58-WLS (M.D. Ga. Apr. 26, 2011) [hereinafter *Phoebe Putney* Complaint], www.ftc.gov/sites/default/files/documents/cases/2011/04/110426phoebeputneycmpt.pdf.

County, the acquisition was immune under the state action doctrine.[37] The FTC appealed to the Supreme Court, which reversed the lower courts because the State of Georgia had not met the standards necessary for state action immunity to apply.[38] Nonetheless, in early 2015, the FTC concluded that divestiture was not feasible and entered into a settlement with Phoebe Putney that included a behavioral remedy.[39]

Apart from the state action case, by 2013 the FTC had compiled an impressive series of litigation wins. After a pause, in late 2015 the FTC challenged three more hospital mergers: (1) Cabell Huntington Hospital and St. Mary's Medical Center in Huntington, West Virginia; (2) Penn State Hershey Medical Center and PinnacleHealth System in Harrisburg, Pennsylvania; and (3) Advocate Health Care and NorthShore University HealthSystem in the northern Chicago suburbs. The government's winning streak abruptly ended when district courts in Illinois and Pennsylvania denied the FTC's requests for preliminary injunctions in the *Advocate* and *Hershey* cases. Harkening back to the cases of the 1990s, both district courts rejected the FTC's alleged relevant geographic markets.[40] The FTC also failed in its challenge to the West Virginia merger, having abandoned the case after the state approved a "cooperative agreement" between Cabell and St. Mary's.[41]

The FTC promptly appealed both litigation losses, bringing the FTC to a total of five hospital merger-related trips through the appeals process in three years. As noted, the *Phoebe Putney* appeal focused on state action immunity. The other four, however, focused on core issues of merger analysis, including market definition, efficiencies, and structural presumptions. Four appellate decisions in such a short span, and in a single industry no less, is remarkable. And the FTC ultimately prevailed in each case. We will examine those cases in more detail and attempt to derive lessons and identify open questions.

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[37] Order at 8, 17, FTC v. Phoebe Putney Health Sys., 663 F.3d 1369 (11th Cir. 2011), www.ftc.gov/sites/default/files/documents/cases/2011/12/111214phoebeputneyorder.pdf. The Hospital Authority of Dougherty County leased the hospital to Phoebe Putney Health System for $1 per year. *Phoebe Putney Complaint* ¶ 27, No. 11-cv-58-WLS.

[38] FTC v. Phoebe Putney Health Sys., Inc., 568 U.S. 216 (2013).

[39] No court heard the merits of the case. Fed. Trade Comm'n, Statement of the Federal Trade Commission In the Matter of Phoebe Putney Health System, Inc. et al. (Mar. 31, 2015), www.ftc.gov/system/files/documents/public_statements/634181/150331phoebeputneycommstmt.pdf. *See also* Christopher Garmon & Laura Kmitch, Health Care Competition or Regulation: The Unusual Case of Albany, Georgia, (2017) (unpublished manuscript), papers.ssrn.com/sol3/papers.cfm?abstract_id=3048839.

[40] *See* Cory Capps et al., *The Long, Slow Decline of Elzinga-Hogarty and What Comes After*, ANTITRUST CHRON., Summer 2017.

[41] The West Virginia legislature passed a law that granted antitrust immunity to certain cooperative agreements, and the West Virginia Health Care Authority approved the cooperative agreement between Cabell and St. Mary's in March 2016. West Virginia Health Care Authority, Cooperative Agreement Decision, *In Re:* Cabell Huntington Hospital, Inc., No. 16-2/3-001 (June 22, 2016), www.hca.wv.gov/About/Documents/Decision.pdf.

Before turning to those cases, we offer some context on the extent to which enforcement by the FTC and other agencies precludes provider consolidations. As we make clear in this article, the agencies have challenged—and, of late, blocked—multiple health care provider mergers. Even so, the FTC's health care merger enforcement actions represent only a small percentage of a large number of transactions. Based on a report by the American Hospital Association, in each year from 2010 to 2015, between 72 and 107 hospital mergers and acquisitions were announced.[42] Challenging on average one to two hospital mergers per year implies that over 97 percent of mergers went unchallenged.

A challenge rate of 2 to 3 percent in the hospital sector is roughly in line with the overall rate of merger challenges. Between October 1, 2015, and September 30, 2016, about 1800 mergers and acquisitions covering a vast array of industries were reportable under the HSR Act. The DOJ and FTC brought a total of 47 merger enforcement actions over that period, a challenge rate of about 2.6 percent.[43]

One distinction of health care provider mergers is that fewer challenges are resolved through consent orders. For example, the FTC accepted consent orders in 73 percent of its overall enforcement challenges during fiscal year 2016.[44] Divestiture remedies in hospital merger cases are comparatively rare. In large part, this is because individual hospitals cannot practically be subdivided in order to allay competitive concerns. When two systems with multiple hospital locations merge, divestiture is viable and has been used.[45] But those situations account for a minority of the FTC's challenges.

II. FOUR APPELLATE OPINIONS IN FOUR YEARS

A. ProMedica-St. Luke's

In September 2010, ProMedica Health System, a three-hospital system in Toledo, acquired nearby St. Luke's Hospital, an independent community hos-

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[42] Am. Hospital Ass'n, Trendwatch Chartbook 2016, at 27, chart 2.9, www.aha.org/research/reports/tw/chartbook/2016/2016chartbook.pdf. This is based on announced mergers. HSR filings and merger investigations are non-public, so there is no definitive way to calculate the exact number of hospital mergers that go unchallenged. Fed. Trade Comm'n, *supra* note 30, at 8. Parties may request the termination of the HSR waiting period before the statutory time period (usually 30 days) has expired; HSR Early Termination Notices are public.

[43] Fed. Trade Comm'n & U.S. Dep't of Justice, Hart-Scott Rodino Annual Report, Fiscal Year 2016, at 2 (2016), www.ftc.gov/system/files/documents/reports/federal-trade-commission-bureau-competition-department-justice-antitrust-division-hart-scott-rodino/p110014_fy_2016_hsr_report_final_october_2017.pdf.

[44] *Id.*

[45] *CHS Completes HMA Acquisition*, Becker's Hospital Rev. (Jan. 27, 2014), www.beckershospitalreview.com/hospital-transactions-and-valuation/chs-completes-hma-acquisition.html.

pital. Although the acquisition fell below the HSR filing threshold, the FTC opened an investigation. The FTC and the parties also negotiated a Hold Separate Agreement in order to preserve the stand-alone viability of St. Luke's in the event that the FTC challenged the merger and prevailed.[46] Under the agreement, ProMedica could not fire St. Luke's staff, close or consolidate service lines, or terminate payer contracts.[47]

In January 2011, the FTC and the State of Ohio sued in district court for a temporary restraining order and preliminary injunction to prevent ProMedica from integrating St. Luke's in a way that would make divestiture challenging or impossible.[48] The FTC also filed a Part III administrative complaint that would allow it to seek divestiture.[49] The district court judge ruled that the Hold Separate Agreement should remain in place until the resolution of the FTC's administrative proceedings, including any appeals, in order to "preserve the possibility of meaningful permanent relief and to prevent interim harm."[50] The administrative trial began in May 2011.

In a rare event in the history of hospital merger cases, both sides agreed on the appropriate relevant geographic market: Lucas County, Ohio.[51] In addition to the parties' hospitals, Mercy Health Partners operated three hospitals in Lucas County, and the University of Toledo Medical Center (UTMC) had

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[46] Findings of Fact & Conclusions of Law ¶¶ 36–40, FTC v. ProMedica Health Sys., Inc., No. 3:11-cv-47, 2011 WL1219281 (N.D. Ohio Mar. 29, 2011) [hereinafter *ProMedica* Findings of Fact], www.ftc.gov/sites/default/files/documents/cases/2011/03/110329promedicafindings.pdf.

[47] *Id.* ¶ 38.

[48] Complaint for Temporary Restraining Order & Preliminary Injunction, FTC v. ProMedica Health Sys., Inc., No. 3:11-cv-47 (N.D. Ohio Jan. 7, 2011), www.ftc.gov/sites/default/files/documents/cases/2011/01/110107promedicacmpt.pdf.

As described above, in *Evanston*, the FTC won its retrospective challenge on the merits. However, although the Administrative Law Judge ordered the parties to divest Highland Park, the Commission on appeal ruled that a conduct remedy, rather than a divestiture, was appropriate due to the length of time that had passed and "greater risk of unforeseen costs and failure." The Commission expressed concern that some investments in Highland Park in the years since the merger would be undermined by a divestiture, putting quality of care at risk. The Commission's conduct remedy required Highland Park to negotiate payer contracts separately from Evanston Northwestern. The Commission stated that the remedy was "not ideal" and that "[d]ivestiture is the preferred remedy . . . where it is relatively clear that the unwinding of a hospital merger would be unlikely to involve substantial costs." *See Evanston* Opinion of the Commission, *supra* note 25, at 4, 89–91.

[49] Complaint, ProMedica Health Sys., Inc., FTC Docket No. 9346 (Jan. 6, 2011) [hereinafter *ProMedica* Complaint], www.ftc.gov/sites/default/files/documents/cases/2011/01/110106promedicacmpt.pdf.

[50] *ProMedica* Findings of Fact, *supra* note 46, § IV Conclusion).

[51] Initial Decision ¶¶ 321–322, ProMedica Health Sys., Inc., FTC Docket No. 9346 (Dec. 12, 2011) [hereinafter *ProMedica* Initial Decision], www.ftc.gov/sites/default/files/documents/cases/2012/01/120105promedicadecision.pdf.

one. UTMC did not offer obstetric (OB) services, and only two of the three Mercy hospitals did.[52]

In a departure from most of its hospital merger complaints, the FTC alleged two inpatient relevant product markets. The first is standard in modern FTC hospital merger complaints: general acute care (GAC) inpatient hospital services sold to commercial insurers.[53] This cluster market included the full range of primary and secondary GAC services, which both St. Luke's and ProMedica offered, but excluded high-acuity tertiary services that ProMedica offered but, with few exceptions, St. Luke's did not.[54] In the GAC relevant product market, the merger reduced the number of competitors from four to three.

The FTC's second product market consisted of just inpatient OB services sold to commercial health insurers.[55] The FTC argued that "it is appropriate to define a narrower relevant service where it more fully accounts for unique competitive conditions. Here, these unique competitive conditions include that there are fewer hospitals offering inpatient obstetrical services in Lucas County . . . ."[56] In this relevant product market, the merger reduced the number of competitors from three to two (since UTMC did not offer OB services).

The merging hospitals disagreed with the FTC's approach to product market definition. They argued that there was no legal precedent for carving out OB services from the cluster of inpatient GAC services and that the product market should include all primary, secondary, and tertiary services because payers negotiate contracts for those services as a single package.[57] (Although payers and providers also typically negotiate both inpatient and outpatient pricing at the same time and in the same contracts, the hospitals and the FTC agreed that outpatient services should not be included in the product market.)

Despite this disagreement, both parties presented evidence that the merger resulted in concentration sufficiently high to be presumed (rebuttably) likely to enhance market power.[58] The FTC's economic expert, Dr. Robert Town, reported combined market shares of 58.3 percent (based on bed days) for inpatient services and 80.5 percent for OB services, with changes in HHIs above

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[52] *Id.* ¶¶ 82, 94, 99 &110.

[53] *ProMedica* Complaint, *supra* note 49, ¶¶ 12–13.

[54] *ProMedica* Initial Decision, *supra* note 51, ¶¶ 56, 74.

[55] *ProMedica* Complaint, *supra* note 49, ¶¶ 14–15.

[56] *Id.* ¶ 15.

[57] Respondents' Post-Trial Brief at 45–46, ProMedica Health Sys., Inc., FTC Docket No. 9346 (Sept. 15, 2011) [hereinafter *ProMedica* Respondents' Post-Trial Brief], www.ftc.gov/sites/default/files/documents/cases/2011/09/110915respposttrialbrief.pdf.

[58] U.S. Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines § 5.3 (2010) [hereinafter Merger Guidelines].

1000 points for each alleged market. The merging parties' economic expert, Margaret Guerin-Calvert, calculated that ProMedica's post-acquisition market share would be 53 to 58 percent and agreed that, under the Merger Guidelines, the acquisition "would be presumed to result in increased market power."[59]

To support his claim that the HHI presumptions were valid, Dr. Town presented analysis showing that market shares were correlated with prices.[60] Dr. Town also presented results from a WTP merger simulation model, predicting that rates throughout the ProMedica system would increase by 16.2 percent—10.8 percent at the ProMedica hospitals and 38.4 to 56.2 percent at St. Luke's.[61] Using the same patient-level demand model that underlies the WTP model, Dr. Town also estimated diversion ratios and testified that ProMedica was St. Luke's closest competitor.[62] Consistent with the diversions, CEOs of both hospitals testified that St. Luke's viewed ProMedica as its closest competitor prior to the acquisition.[63]

The FTC also presented testimony from payers that they would not be able to successfully market a network in Lucas County without the combined system, especially because of St. Luke's location in an easily accessible and growing area in southwestern Lucas County.[64] Payers testified that having a geographically broad network made their plans more marketable and that a network excluding all ProMedica hospitals and St. Luke's would be undesirable.

The FTC also alleged that the acquisition would lead to lower quality of care by eliminating non-price competition and a high-quality hospital choice for patients.[65] Furthermore, since St. Luke's regularly out-performed ProMedica's hospitals on quality metrics, the FTC argued that the acquisition was not likely to improve quality.[66]

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[59] *ProMedica* Initial Decision, *supra* note 51, at 150 (citing to Findings ¶¶ 357–360, 368–369).

[60] *Id.* at 168 (citing to Findings ¶ 610).

[61] *Id.* at 170 (citing to Findings ¶ 625). Guerin-Calvert argued for certain adjustments to Town's WTP analysis, but she still predicted a 7.3% price increase. *Id.* at 170–71 (citing to Findings ¶ 626).

[62] *Id.* ¶ 457. The diversion ratio from Hospital A and to Hospital B is generally calculated as the percentage of Hospital A's patients who, were Hospital A not available, would switch to Hospital B. Stated differently, the diversion ratio measures the percentage of Hospital A's patients for whom Hospital B is the next best substitute.

[63] *Id.* ¶ 440.

[64] *Id.* ¶¶ 566–568; Complaint Counsel Post-Trial Brief at 41–42, ProMedica Health Sys., Inc., FTC Docket No. 9346 (Sept. 20, 2011) [hereinafter *ProMedica* Complaint Counsel Post-Trial Brief], www.ftc.gov/sites/default/files/documents/cases/2011/09/110920ccposttrialbrief.pdf.

[65] *ProMedica* Complaint, *supra* note 49, ¶ 33. St. Luke's was widely regarded as low cost and high quality. *ProMedica* Initial Decision, *supra* note 51, ¶¶ 758–759.

[66] *ProMedica* Complaint Counsel Post-Trial Brief, *supra* note 64, at 61–63.

In response, ProMedica argued that excess bed capacity in the Toledo area would force hospitals to compete aggressively for patients and that Mercy Health, a rival, had plans to reposition its offerings, which, taken together, would constrain the combined system's ability to increase prices.[67] ProMedica contended that physicians, employers, and payers could engage in steering to direct patients by providing incentives to use lower-priced competitors instead of ProMedica.[68] The parties further argued that St. Luke's financial condition made it a weakened and less relevant competitor.[69] Finally, the parties argued that, even if the court found that the merger was likely to substantially lessen competition, ProMedica should be allowed to adopt the same conduct remedy that the FTC Commissioners imposed in the *Evanston* case; that remedy would replace divestiture with the requirement that the merged system separately negotiate St. Luke's contracts and ProMedica's contracts.[70]

Nearly a year after the complaints were filed, the Administrative Law Judge held that the acquisition was anticompetitive and ordered ProMedica to divest St. Luke's.[71] The court defined a single relevant product market that included the primary, secondary, and tertiary general acute care inpatient services—including OB—on the grounds that they were collectively demanded by payers and were contracted together.[72] In effect, it rejected both of the FTC's alleged relevant product markets (rejecting the omission of tertiary services from the FTC's general acute care services product market and rejecting the inpatient OB product market entirely). Nonetheless, the court concluded that the FTC had proven the main relevant product market alleged in its complaint, "GAC inpatient hospital services sold to commercial health plans."[73]

Although neither the FTC nor the parties offered market share or HHI calculations for this specific relevant product market,[74] the court concluded that payers were "unequivocal in testifying that ProMedica will be able to increase

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[67] *ProMedica* Respondents' Post-Trial Brief, *supra* note 57, at 59–61.

[68] *Id.* at 56–59.

[69] *Id.* at 90–91.

[70] *ProMedica* Respondents' Post-Trial Brief, *supra* note 57, at 81.

> If the ALJ finds that the joinder violated Clayton Act Section 7 . . . the ALJ should require ProMedica to create a second team dedicated to negotiating and administering managed care contracts exclusively for St. Luke's . . . This remedy, which is virtually identical to the remedy the FTC imposed in *Evanston Northwestern Healthcare* would both eliminate the potential for ProMedica to exercise any additional bargaining leverage the joinder might confer and alleviate any risk that St. Luke's will not survive as an independent community hospital.

Id. *But see* discussion *supra* note 48.

[71] *ProMedica* Initial Decision, *supra* note 51.

[72] *Id.* at 140–45.

[73] *Id.* at 146.

[74] *Id.* at 150.

rates due to its newly enhanced bargaining leverage."[75] Citing high concentration, the court held that "the Joinder is presumptively illegal."[76]

The court declined to rule on whether the merger would lessen quality, noting that "it is not necessary to also prove that the Joinder will likely harm the quality of hospital care."[77] It did, however, reject the various quality and other efficiency defenses raised by ProMedica, generally stating that there was not sufficient evidence that the claimed efficiencies would offset the reduction in competition.[78] Regarding the proper treatment of efficiencies from capital cost avoidance—an issue that would resurface in future hospital merger cases, especially *Hershey*[79]—the court held that "In general, capital cost avoidance claims are not cognizable efficiencies . . . . To the extent that avoided capital investments would have benefitted the community, capital avoidance with respect to those investments are not efficiencies, but rather constitute anticompetitive harm resulting from the Joinder."[80]

Finally, the judge rejected ProMedica's claim that the structural remedy of creating separate, firewalled negotiating would address the risk of harm to competition. Although the Commission had imposed that remedy in the *Evanston* case, that was in the context of a consummated merger that was not subject to a Hold Separate order and that, by the time litigation was winding down, was seven years old.[81] In contrast, the judge held that divesting St. Luke's would not entail substantial costs and that, therefore, the "usual remedy of divestiture should be ordered in this case."[82]

ProMedica appealed the ruling to the full Commission. The Commission upheld the Administrative Law Judge's determination that the acquisition was anticompetitive, as well as the divestiture order.[83] However, the Commission redefined the relevant product markets, adopting the markets that the FTC

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[75] *Id.* at 171.

[76] *Id.* at 214.

[77] *Id.* at 176.

[78] *Id.* at 196–203.

[79] FTC v. Penn State Hershey Med. Ctr., 185 F. Supp. 3d 552 (M.D. Pa. 2016), *rev'd*, 838 F.3d 327, 343 (3d Cir. 2016).

[80] *ProMedica* Initial Decision, *supra* note 51, at 202–03. At the same time, the judge also held that "avoiding undertaking the major expense of building a new facility or bed tower is a cognizable efficiency" *Id.* at 202. Other examples of potential efficiencies from capital cost avoidance include reducing costs related to medical equipment or electronic health care records and shifting service across the merging hospitals' campuses rather than improving one or the other. (These were not at issue in *ProMedica*.)

[81] *Id.* at 207–09.

[82] *Id.* at 209.

[83] Opinion of the Comm'n by Comm'r Brill at 59, ProMedica Health Sys., Inc., FTC Docket No. 9346 (Mar. 28, 2012) [hereinafter *ProMedica* Brill Opinion], www.ftc.gov/sites/default/files/documents/cases/2012/03/120328promedicabrillopinion.pdf.

staff had argued at trial.[84] Although it noted that the issue would not affect the outcome in the case at hand, the Commission stated that appropriate product market definition would be important for "analytical precision and guidance for future cases."[85]

Specifically, the Commission excluded tertiary services from the product market because one of the merging parties, St. Luke's, did not offer those services: "Absent an overlap or potential overlap involving a given service line, there is no substantial lessening of competition, and, thus, no need to include the service in the relevant product market."[86] The Commission also held that because market conditions—especially the number of competitors—differed, and because a separate market for OB services passes the hypothetical monopolist test as set forth in the Merger Guidelines, inpatient OB services should be analyzed as a separate relevant product market.[87] The Commission otherwise generally agreed with the Administrative Law Judge.[88]

The merging parties appealed to the Sixth Circuit, focusing on three central arguments. First, the FTC had not met its burden to define an appropriate relevant product market. Second, it was inappropriate for the Commission to rely on concentration statistics and structural presumptions in what was, as both sides agreed, a unilateral effects case involving sellers of differentiated products. Third, St. Luke's was a weakened competitor.[89]

The Sixth Circuit sided with the FTC on all counts. The product market discussion largely recapped and adopted the logic of the Commission's opinion.[90] The circuit court's analyses of the utility of structural presumptions in a

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[84] *Id.* at 22–26. At trial, the FTC argued that tertiary services not offered by St. Luke's should be excluded. However, the complaint argued only for the exclusion of "more sophisticated and specialized tertiary and quaternary services, such as major surgeries and organ transplants." *ProMedica* Complaint, *supra* note 49, ¶ 13.

[85] *ProMedica* Brill Opinion, *supra* note 83, at 16.

[86] *Id.* at 23 (internal citations omitted).

[87] *Id.* at 22–26. The Commission's product market definition appears to differ from the market alleged in the FTC staff's original complaint. The Commission's approach subdivides GAC services offered by both parties into (1) GAC inpatient services other than OB and tertiary services and (2) OB inpatient services. *Id.* at 22, 24. ("We conclude that that tertiary services are not part of the GAC inpatient hospital services market in this case . . . . [W]e conclude that inpatient OB services are not in the GAC inpatient hospital services cluster market but rather constitute a separate relevant product market"). In contrast, the complaint alleges "general acute-care inpatient hospital services" other than "more sophisticated and specialized tertiary and quaternary services" but *inclusive* of OB inpatient services and, separately, inpatient OB services. *ProMedica* Complaint, *supra* note 49, ¶¶ 12–15.

[88] *ProMedica* Brill Opinion, *supra* note 83, at 2.

[89] ProMedica Health Sys. v. FTC, 749 F.3d 559, 572 (6th Cir. 2014).

[90] *Id.* at 568. ("The relevant markets, for purposes of analyzing the merger's competitive effects, are what the Commission says they are: (1) a cluster market of primary (but not OB) and secondary inpatient services (hereafter, the "GAC market"), and (2) a separate market for OB services.").

merger of differentiated sellers and of the weakened competitor argument were more involved and are more likely to affect future merger cases.

ProMedica's argument against the FTC's reliance on the HHI-based structural presumption was rooted in the Merger Guidelines, which explain that in differentiated products industries "[s]ubstantial 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 firm as their next-best choice."[91]

Accordingly, as summarized by the Sixth Circuit, "[W]hat the Commission should have focused on, ProMedica says, is the extent to which consumers regard ProMedica as their next-best choice after St. Luke's, or vice-versa. And ProMedica therefore argues that the Commission was wrong to presume the merger illegal based upon HHI data alone."[92]

In fact, the HHI is closely related to the Cournot model of competition, a model that applies to sellers of relatively homogeneous goods. Under Cournot competition, a higher HHI and a larger increase in the HHI generally do imply a greater likelihood of harm.[93] But the HHI is not as directly related to pricing or the risk of harm in industries with differentiated sellers, such as hospitals. Instead, the closeness of competition between the merging parties—that is, whether a significant body of customers views one firm as the next-best substitute for the other—is more probative.[94] Moreover, because the HHI is a single number that applies equally to all firms in a market, it generally does not inform the degree of substitution (i.e., closeness of competition) between any two firms within a market.[95] Recognizing this distinction, and that all

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[91] Merger Guidelines, *supra* note 58, § 6.1. The Merger Guidelines also state, "The extent of direct competition between the products sold by the merging parties is central to the evaluation of unilateral effects."

[92] *ProMedica*, 749 F.3d at 569.

[93] *See generally* Louis Kaplow & Carl Shapiro, *Antitrust*, *in* 2 HANDBOOK OF LAW AND ECONOMICS, 1072 (A. Mitchell Polinsky & Steven Shavell eds., 2007). As they explain, under Cournot competition, a higher HHI is associated with a higher price-cost margin. *See also* Gregory Werden & Luke Froeb, *Choosing Among Tools for Assessing Unilateral Merger Effects* (Vanderbilt Law & Econ. Research Paper No. 11-19, 2011), www.masonlec.org/site/files/2011/04/MergerTools.pdf. They show that under Cournot competition, the marginal cost reduction necessary to prevent a price increase is larger as the increase in the HHI from a merger is greater. For a full analysis of the effects of mergers in Cournot industries, see Joseph Farrell & Carl Shapiro, *Horizontal Mergers: An Equilibrium Analysis*, 80 AM. ECON. REV. 107 (1990).

[94] Kaplow & Shapiro, *supra* note 93, § 4.1. Werden & Froeb, *supra* note 93, at 17. *See also* Carl Shapiro, *Mergers with Differentiated Products*, ANTITRUST, Spring 1996, at 23.

[95] In a market with four firms with equal shares of 25 percent each, the HHI will be 2500 and the HHI increase from any merger in this market will be the same, 1250 (based on the $2S_1S_2$ formula). Neither measure indicates the closeness of competition between any two of these firms. To illustrate, suppose the differentiation is geographic, with the four firms located along a road. Each will have at least one closest competitor (a neighboring firm) and at least one more distant

sides agreed that unilateral effects analysis provided the appropriate lens through which to analyze the merger, the Sixth Circuit observed that ProMedica's argument "is one to be taken seriously."[96]

The court, nonetheless, rejected ProMedica's argument. It noted that the FTC had presented additional evidence in support of the conclusion that the merger would lessen competition. First, the FTC had shown a strong correlation between market shares and prices, which the court took as evidence that an increase in share would likely increase prices.[97] Second, the court reviewed, and deemed credible, evidence that the merger would increase ProMedica's bargaining leverage in negotiations with insurers.[98] Accordingly, it concluded that "the Commission had every reason to conclude that, as ProMedica's dominance in the relevant markets increases, so does the need for MCOs to include ProMedica in their networks—and thus so too does ProMedica's leverage in demanding higher rates."[99]

Overall, the Sixth Circuit appears to have accepted the premise that HHIs and structural presumptions, standing alone, are insufficient to meet the FTC's burden in a unilateral effects case. But the opinion indicates that the FTC can meet its burden by combining HHI evidence and structural presumptions with sufficient additional evidence showing closeness of competition between the merging parties.[100] The court also gave significant weight to the magnitude by which the post-merger HHI exceeded the Merger Guidelines threshold.[101] Based on its reference to HHI being "multiples of the numbers necessary for the presumption of illegality," the opinion suggests a sliding scale approach such that sufficiently high post-merger concentration may lessen the burden

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competitor (a non-neighboring firm). Yet, the HHI and change in HHI are the same for all possible mergers and, thus, cannot distinguish a merger of close competitors from a merger of distant competitors.

[96] *ProMedica*, 749 F.3d at 569.

[97] *Id.* at 569–70. Although the Sixth Circuit did not review it in detail, the FTC presented additional evidence—documents, testimony, and expert analysis including diversion ratios and merger simulation—of close competition between ProMedica and St. Luke's. *See ProMedica* Brill Opinion, *supra* note 83, at 42; Brief for the Respondent in Opposition at 24–27, ProMedica Health Sys. v. FTC, No. 14-762 (U.S. Apr. 2015), www.ftc.gov/system/files/documents/cases/150401promedicabriefopp.pdf, *cert. denied*, 135 S. Ct. 2049 (2015).

[98] *ProMedica*, 749 F.3d at 569–70. For a discussion of the importance of evaluating hospital mergers through the lens of bargaining, which is how prices are actually determined in the industry, see Capps, *supra* note 5.

[99] *ProMedica*, 749 F.3d at 570.

[100] *Id.* at 572; *see also* id. at 571 ("That the Commission did not merely rest upon the presumption, but instead discussed a wide range of evidence that buttresses it, makes ProMedica's task more difficult still.").

[101] *Id.* at 568. In the GAC product market, the merger increased the HHI by 1078 to reach 4391; for inpatient OB services, the HHI increased by 1323 to reach 6584. *Id.* at 568.

on the FTC to provide additional evidence of close competition (and vice-versa).[102]

The third major basis of ProMedica's appeal was its argument that, due to its poor financial condition, St. Luke's, though not actually failing, "was not a meaningful competitive constraint on ProMedica."[103] The Sixth Circuit used a colorful metaphor to describe the high bar it applied to this defense: "[T]his argument is the Hail-Mary pass of presumptively doomed mergers—in this case thrown from ProMedica's own end zone."[104] More formally, the court explained that this argument would require compelling evidence that the weakened firm's current market shares overstate its likely future competitive significance to a degree sufficient to undermine the structural presumption. It determined that the record showed otherwise.[105]

The Sixth Circuit concluded that the Commission's decision was "comprehensive, carefully reasoned, and supported by substantial evidence in the record," and denied ProMedica's request to overturn the Commission's decision.[106] ProMedica appealed, but the Supreme Court denied certiorari, and ProMedica began the process of divesting St. Luke's.[107] In June 2016, more than five years after filing suit to unwind the merger, the FTC approved a divestiture plan under which St. Luke's would resume operations as an independent hospital.[108] One year later, St. Luke's CEO stated, "[W]e're stronger than we've been in a long time."[109] He further explained that the hospital broke even in 2016, realized a small loss in 2017 due to one-time expenses, such as converting to electronic health records, and expected to realize a profit in 2018.[110] Since the divestiture, St. Luke's has expanded its operating facilities and cardiovascular offerings and launched a family medicine residency program.[111]

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[102] *Id.* at 569.

[103] *Id.* at 572.

[104] *Id.*

[105] *Id.*

[106] *Id.* at 573.

[107] The Commission's order became final when the Supreme Court denied certiorari on May 4, 2015. Application for Proposed Divestiture of St. Luke's Hospital at 1–2, ProMedica Health Sys., Inc., FTC Docket No. 9346 (Apr. 25, 2016), www.ftc.gov/system/files/documents/cases/160503promedicaapplication.pdf.

[108] Press Release, Fed. Trade Comm'n, FTC Approves ProMedica Health System's Divestiture of Former Rival St. Luke's Hospital (June 24, 2016), www.ftc.gov/news-events/press-releases/2016/06/ftc-approves-promedica-health-systems-divestiture-former-rival-st.

[109] Lauren Lindstrom, *St. Luke's Hospital Touts Gains a Year after Breakup with ProMedica System*, TOLEDO BLADE (July 22, 2017), www.toledoblade.com/Medical/2017/07/22/St-Luke-s-Hospital-touts-gains-a-year-after-breakup-with-ProMedica-system.html.

[110] *Id.*

[111] Madison Humphrey, *St. Luke's Hospital Cuts Ribbon on Hybrid Operating Room and Electrophysiology Lab*, TOLEDO BLADE (Dec. 2, 2018), www.13abc.com/content/news/St-Lukes-

B. ST. LUKE'S-SALTZER

In December 2012, St. Luke's Health System, a large multihospital system in Idaho, acquired Saltzer Medical Group and entered a five-year contract with Saltzer's physician staff. Saltzer, the "largest, independent, multispecialty physician group" in the state, was based in Nampa, Idaho (about 30 minutes west of Boise) and employed 41 physicians.[112] Prior to the acquisition, St. Luke's already operated a variety of facilities, including seven inpatient hospitals and dozens of physician clinics from central Idaho to eastern Oregon. St. Luke's employed or contracted with 500 physicians.[113]

St. Luke's and Saltzer's closest competitors in the Nampa area, St. Alphonsus and Treasure Valley Hospital, sued for a preliminary injunction to halt the transaction.[114] The private complaint alleged that the transaction would result in harm to competition (and to the competitors, St. Alphonsus and Treasure Valley Hospital) through both horizontal and vertical effects. The central alleged horizontal mechanism of harm was a reduction in competition in the "primary care physician services market in Nampa" and the central alleged vertical mechanism was that the acquisition would "result in the foreclosure of a critical source of patients (and admissions)—the Saltzer physicians."[115] In other words, the vertical allegation was that, post-acquisition, Saltzer physicians would shift referrals from the two plaintiff hospitals to St. Luke's hospitals and "very likely increase St. Luke's dominance in the general acute-care services and outpatient surgery services markets."[116]

The court denied a preliminary injunction, largely because it accepted St. Luke's argument that it would not be difficult to divest Saltzer after a trial on the merits, should the court so order.[117] Several months later, in March 2013,

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Hospital-cuts-ribbon-on-Hybrid-Operating-Room-and-Electrophysiology-Lab-501749471.html; Jon Chavez, *St. Luke's Family Medicine Facility Nears Completion*, TOLEDO BLADE (Mar. 7, 2018), www.toledoblade.com/Medical/2018/03/07/St-Luke-s-family-medicine-facility-nears-completion.html.

[112] Findings of Fact & Conclusions of Law at Findings ¶¶ 20, 18, Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., No. 1:12-cv-00560-BLW, 2014 WL 407446 (D. Idaho Jan. 24, 2014) [hereinafter *St. Luke's* Findings of Fact], www.ftc.gov/system/files/documents/cases/140124stlukesfindings.pdf.

[113] *Id.* at Findings ¶¶ 10–12.

[114] Complaint for Preliminary and Permanent Injunction and Damages, Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.,12-cv-560-BLW (D. Idaho filed Nov. 12, 2012), dlbjbjzgnk95t.cloudfront.net/0393000/393749/stlukes.pdf.

[115] *Id.* ¶¶ 127, 92–95.

[116] *Id.* ¶ 95.

[117] Memorandum Decision and Order, Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 12-cv-560-BLW, 2012 U.S. Dist. LEXIS 181363 (D. Idaho Dec. 20, 2012), www.gpo.gov/fdsys/pkg/USCOURTS-idd-1_12-cv-00560/pdf/USCOURTS-idd-1_12-cv-00560-0.pdf. District Judge Winmill wrote: "Given that trial can be held by July 29, 2013, the gradual integration and the built-in unwinding process mean that the Court will have no difficulty in ordering an immediate and complete divestiture if that is the result compelled at trial." *Id.* at *10.

the FTC and the State of Idaho sued to block the acquisition.[118] Their complaint alleged that the acquisition combined the two largest providers of adult primary care services in Nampa and that the combined system would have increased bargaining leverage over payers, resulting in increased prices.[119] It did not include an analog of the vertical allegation in the private complaint. The court consolidated the private and government cases and scheduled trial for September.[120]

The government and the parties agreed that "Adult Primary Care Services sold to commercially insured patients" (adult PCP services) was an appropriate relevant product market.[121] However, the parties disagreed sharply over the appropriate relevant geographic market. The government's proposed relevant geographic market was the Nampa area, which it defined as "five zip codes that encompass the towns of Nampa and Caldwell, Idaho."[122] Pre-acquisition, St. Luke's had 8 adult PCPs practicing in Nampa, Saltzer had 16 (along with 8 pediatricians), and St. Alphonsus had 9.[123] Within the government's alleged geographic market, the acquisition resulted in a combined market share of 78 percent, with an HHI increase of over 1600 to 6219.[124]

See also Plaintiffs' Joint Pre-Trial Memorandum at 34, Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 12-cv-560-BLW (D. Idaho filed Sept. 10, 2013) [hereinafter *St. Luke's* Plaintiffs' Pre-Trial Memorandum] ("During the preliminary injunction hearing, St. Luke's represented to this Court that it could easily unwind the Acquisition (*i.e.*, order divestiture) if the Court found after the merits trial that the Acquisition violated Section 7.").

[118] Complaint, FTC v. St. Luke's Health Sys., Ltd., 13-cv-116-BLW (D. Idaho filed Mar. 12, 2013) [hereinafter *St. Luke's* FTC Complaint], www.ftc.gov/sites/default/files/documents/cases/2013/03/130312stlukescmpt.pdf.

[119] *Id.* ¶¶ 1–3, 33. Adult primary care physicians were defined as doctors with specialties in internal medicine, family practice, or general practice. The FTC excluded obstetricians and gynecologists from their proposed market because "[t]hose services generally complement, rather than substitute for, general PCP services." *Id.* ¶¶ 24–25.

[120] The government's suit was consolidated with the suit brought by St. Alphonsus and Treasure Valley Hospital. Order of Consolidation, Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 12-cv-560-BLW (D. Idaho Mar. 19, 2013), www.ftc.gov/sites/default/files/documents/cases/2013/03/130319stlukeorder.pdf.

[121] *St. Luke's* Findings of Fact, *supra* note 112, at Finding ¶ 48, *St. Luke's*, 2014 WL 407446 ("[T]here is no dispute that the relevant product market is Adult Primary Care Services."). The government also alleged that "Defendants also do not dispute that general pediatric physician services sold to commercially insured patients . . . is a second relevant service market." *St. Luke's* Plaintiffs' Pre-Trial Memorandum, *supra* note 117, at 5–6, *St. Luke's*, 12-cv-560-BLW. Pediatric services did not play a major role in the trial or outcome.

[122] *St. Luke's* FTC Complaint, *supra* note 118, ¶ 27, *St. Luke's*, 13-cv-116-BLW.

[123] *St. Luke's* Findings of Fact, *supra* note 112, at Findings ¶¶ 6, 17, 19, *St. Luke's*, 2014 WL 407446.

[124] Market share was based on visits. Plaintiffs' Demonstratives for the Testimony of Dr. Dranove at 36, *St. Luke's*, 12-cv-560-BLW (D. Idaho filed Oct. 2, 2013) [hereinafter Dranove Testimony Demonstratives]. Dranove testified that 68% of Nampa residents select a PCP within a Nampa zip code and less than 16% of Nampa residents travel elsewhere (e.g., to Boise) for primary care services. His diversion analysis showed that St. Luke's and Saltzer are each other's closest substitutes for patients residing in Nampa. *Id.* at 26, 33.

St. Luke's criticized the government's geographic market as overly narrow and argued that PCPs in Nampa are constrained by physicians located outside the alleged Nampa area market, but did not formally advance an alternative.[125] They stated that within the 90 percent service area for Nampa physicians (i.e., the set of zip codes that account for 90 percent of Nampa physicians' visits), "Nampa physicians account for only one-third of the PCP services provided to the patients."[126] Like the defendants in *ProMedica*, St. Luke's also criticized the government's reliance on HHIs as a valid indicator of the risk of competitive harm.[127]

The remainder of St. Luke's defense centered on efficiency claims that the combined system would lower health care costs and incentivize innovation by moving toward risk-based and value-based contracting and away from fee-for-service contracting.[128] St. Luke's also touted benefits from physician integration, including better care management, increased preventive care, and improved cost management, helped by its electronic medical record system.[129] The government countered that some of the efficiencies could be achieved without the merger while other benefits would take years to achieve.[130]

This case presented a rare opportunity to test the parties' efficiency claims because, in the years leading up to the Saltzer acquisitions, St. Luke's had acquired more than 70 physician groups, including several dozen PCP practices.[131] Despite that, St. Luke's offered no systematic, quantitative evidence that its past PCP acquisitions had resulted in the types of efficiencies that it argued would flow from the Saltzer acquisition.[132] On the other hand, the FTC's expert did analyze whether overall medical expenditures for patients under the care of PCP groups acquired by St. Luke's had increased or decreased post-acquisition, a test of the parties' claim that the acquisition would reduce costs.[133] He found no evidence of medical cost savings from St. Luke's

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[125] Defendants' Pre-Trial Memorandum at 22, *St. Luke's*, 12-cv-560-BLW (D. Idaho filed Sept. 10, 2013).

[126] *Id.*

[127] *Id.* at 21.

[128] *St. Luke's* Findings of Fact, *supra* note 112, at Findings ¶¶ 172–177.

[129] *Id.* at Findings ¶¶ 186–190.

[130] *St. Luke's* Plaintiffs' Pre-Trial Memorandum, *supra* note 117, at 20–22.

[131] *St. Luke's* FTC Complaint, *supra* note 118, ¶ 39.

[132] For example, St. Luke's noted that it had "acquired or affiliated with several previously independent physician practices—including a number of PCPs, who play a particularly important role in providing high-value integrated care." Defendants' Pre-Trial Memorandum at 13, *supra* note 125. But neither St. Luke's nor its experts presented empirical analysis to show cost savings or other improvements from those transactions. *See, e.g.*, *St. Luke's* Findings of Fact, *supra* note 112, at Finding ¶ 181.

[133] Aspects of St. Luke's integrated delivery model that it asserted would reduce costs included "a physician culture of teamwork and focus on value for patients including value that is derived through appropriate utilization of evidence-based care . . . to improve care and lower cost"; "all

past acquisitions and some evidence that the acquisitions had increased medical expenditures.[134]

The FTC's clinical quality expert testified that the transaction was "not necessary for Saltzer or St. Luke's to provide integrated care" and that it was "neither necessary nor sufficient for transitioning away from fee-for-service—i.e., aligning provider incentives."[135] The court agreed that the fee-for-service model under which providers earn more by rendering more services was a central driver of high and growing health care costs in the United States.[136] Yet the court ultimately concluded that the benefits of moving away from the fee-for-service model were not merger-specific:

> There is no empirical evidence to support the theory that St. Luke's needs a core group of employed primary care physicians beyond the number it had before the Acquisition to successfully make the transition to integrated care.
>
> . . . .
>
> . . . Because a committed team can be assembled without employing physicians, a committed team is not a merger-specific efficiency of the Acquisition.[137]

In addition, the court observed that the professional services agreement (PSA) that would govern the post-acquisition relationship between St. Luke's and the Saltzer physicians featured fee-for-service incentives, but, as originally crafted, included no specific quality or other value-based incentives.[138] In other words, even as the parties argued that the acquisition would advance more efficient, integrated care, the actual structure of the deal embedded tradi-

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or most revenue to providers from one common source, so that all components of the system have an interest in helping to lower the costs of the other components"; and "a population health focus that includes timely identification of patients whose conditions make them particularly at risk for need of costly care." Defendants' Pre-Trial Memorandum, *supra* note 125, at 12.

[134] Dranove Testimony Demonstratives, *supra* note 124, at 50–51.

[135] Plaintiffs' Demonstratives for the Testimony of Dr. Kizer at 7, *St. Luke's*, 12-cv-560-BLW (D. Idaho Oct. 21, 2013), www.ftc.gov/system/files/documents/cases/131021stlukedemokizer.pdf.

[136] *St. Luke's* Findings of Fact, *supra* note 112, at Findings ¶¶ 150–154.

[137] *Id.* at Findings ¶¶ 181, 185 (internal citations omitted).

[138] "The PSA guarantees Saltzer physicians' annual compensation for the first two years after the agreement will be no less than the average for three years ending September 30, 2011. The PSA also specifies that Saltzer physicians will be compensated on the basis of work Relative Value Units ("wRVUs") for the procedures and services performed by the physicians." *Id.* at Findings ¶ 33. Payment on the basis of wRVUs is fee-for-service payment. "A plan to implement quality-based incentives was referenced in the PSA, but specific quality incentives were not built into the contract at the outset because, according to [Saltzer's] Dr. Patterson, 'it takes time to develop what the outcome measures would be, and so it wasn't something that could be established at the time.'" *Id.* at Finding ¶ 37. Nonetheless, the court also held that "One of the driving forces behind the Acquisition is St. Luke's desire to improve quality and reduce costs by moving toward value-based or risk-based care and away from fee-for-service ("FFS") care." *Id.* at Finding ¶ 150.

tional, fee-for-service incentives.[139] This shortcoming, along with the lack of evidence from St. Luke's of benefits from its past PCP acquisitions, left the district court without merger-specific, verified efficiencies to credit.

Had St. Luke's been able to show either that its past PCP acquisitions had resulted in cost-savings or that the acquisition agreement significantly shifted the Saltzer physicians' incentives away from producing volume and towards producing value—or both—the outcome at trial might have been different. Indeed, the FTC might have made a different enforcement decision.

Another novel aspect was the relatively small number of PCPs at issue: in the FTC's relevant market, St. Luke's had 8 and Saltzer had 16.[140] Not surprisingly, St. Luke's argued that entry of PCPs, particularly in the form of expansion by St. Luke's rival St. Alphonsus, would defeat any attempt to exercise market power.[141] The government responded by arguing that record evidence showed that recruiting PCPs into the area was difficult.[142] The court largely agreed and concluded that the history of entry into the area showed that it is difficult for existing organizations to recruit PCPs and difficult for new PCPs to enter on their own.[143]

The FTC and the parties also disagreed over the appropriate remedy should the court deem the merger anticompetitive. The FTC sought full divestiture. Echoing the *Evanston* remedy, St. Luke's proposed a conduct remedy with (1) separate negotiation of fee-for-service contracts but (2) an exemption for risk-based contracting because those require the "full panel of physicians."[144] St. Luke's argued that a divestiture was not appropriate because it would "likely lead to dissolution" of Saltzer and that spinning off Saltzer would leave the physician group in financial hardship.[145]

After a trial in October 2013, the district court ruled in favor of the government, permanently enjoining the acquisition and ordering St. Luke's to divest Saltzer.[146] The Court determined that the Nampa area was the correct relevant

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[139] Leading into the trial, the parties presented a new PSA that would base up to 20% of the Saltzer physicians' compensation on quality. *Id.* at Findings ¶¶ 37, 39. ("A plan to implement quality-based incentives was referenced in the PSA, but specific quality incentives were not built into the contract at the outset . . . . Saltzer and St. Luke's have amended their initial PSA to include an addendum that provides for up to 20 percent of Saltzer's compensation being put at risk or otherwise tied to quality-based incentives.").

[140] *Id.* at Findings ¶¶ 17, 19. The alleged market share based on the number of PCPs was almost 60%. *St. Luke's* FTC Complaint, *supra* note 118, ¶ 3. The alleged market share based on physician visits was 78%. Dranove Testimony Demonstratives, *supra* note 124, at 36.

[141] Defendants' Pre-Trial Memorandum, *supra* note 125, at 25.

[142] *Id.* at 24–25; *St. Luke's* Findings of Fact, *supra* note 112, at Findings ¶¶ 209–214.

[143] *St. Luke's* Findings of Fact, *supra* note 112, at Conclusions ¶¶ 29–334.

[144] Defendants' Pre-Trial Memorandum, *supra* note 125, at 32–33.

[145] *Id.* at 31–32.

[146] *St. Luke's* Findings of Fact, *supra* note 112, at Conclusions ¶¶ 79–80.

geographic market and that the acquisition would allow St. Luke's to negotiate higher reimbursement rates from payers and higher rates for ancillary services, all of which would be passed on to consumers.[147] Although the court stated that the "[a]cquisition was intended by St. Luke's and Saltzer primarily to improve patient outcomes," it largely accepted the FTC's arguments that benefits were not merger-specific.[148]

St. Luke's appealed the ruling to the Ninth Circuit, arguing that the district court erred in defining the relevant geographic market, because patients could use PCPs outside of Nampa to defeat a price increase.[149] St. Luke's also argued that the court incorrectly failed to credit the procompetitive benefits of the acquisition and improperly rejected the proposed conduct remedy.[150] In February 2015, the Ninth Circuit affirmed the decision of the district court, pointing to "the careful factual findings by the able district judge."[151]

Geographic market definition. The court affirmed the use of the hypothetical monopolist test (i.e., a small but significant and non-transitory increase in price (SSNIP) test) in defining the relevant geographic market. Because patients have a general preference for access to convenient, local PCPs, the court noted, "[H]ealth plans must offer Nampa Adult PCP services to Nampa residents to effectively compete."[152] Accordingly, "Nampa PCPs could band together and successfully demand a [SSNIP] (or reimbursement increase) from health plans."[153] The circuit court specifically held that there was no error in the district court concluding that a SSNIP would be profitable even though "one-third of Nampa residents travel to Boise for PCPs."[154] Here, the circuit court cautioned against committing the "silent majority fallacy," which involves mistaking the fact of some patients traveling outside a candidate market for reasons other than price for evidence that additional patients would leave the area in response to a SSNIP.[155]

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[147] *Id.* at Conclusions ¶¶ 23, 25.

[148] *Id.* at 3.

[149] Brief of Appellants at 2, Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., No. 14-35173 (9th Cir. filed June 12, 2014), www.ftc.gov/system/files/documents/cases/140612briefofappellants.pdf.

[150] *Id.* §§ II, III.

[151] Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 781 (9th Cir. 2015). The Ninth Circuit rejected the district court's findings that ancillary services prices would increase because "the district court made no findings about St. Luke's' market power in the ancillary services market" and because the "the ancillary services finding is not supported by the record." *Id.* at 787.

[152] *Id.* at 785 (quoting *St. Luke's* Findings of Fact, *supra* note 112, at Conclusions ¶¶ 71–72).

[153] *Id.*

[154] *Id.*

[155] *Id.*; Capps et al., *supra* note 7, at 679–82; Kenneth Elzinga & Anthony Swisher, *Limits of the Elzinga-Hogarty Test in Hospital Mergers: The Evanston Case*, 18 INT'L J. ECON. BUS. 133, 136–38 (2011).

Competitive effects. The circuit court credited a combination of (1) concentration evidence showing that the acquisition increased the HHI from 4612 to 6219; (2) evidence that in Nampa, Saltzer and St. Luke's PCPs were each other's closest competitor; and (3) documentary evidence from the parties indicating that they expected to gain bargaining leverage and to use the increased leverage to increase prices.[156]

Efficiencies. The circuit court opened its analysis of efficiencies by observing that the "status of the [efficiency] defense . . . remains uncertain" and "[w]e remain skeptical about the efficiencies defense in general and about its scope in particular."[157] Even so, the court examined whether evidence that "the proposed merger will create a more efficient combined entity and thus increase competition" would rebut the FTC's case.[158] Against this high bar, the circuit court determined that it was reasonable for the district court to conclude that St. Luke's "claimed efficiencies were not merger-specific."[159] Moreover, the court noted:

> But even if we assume that the claimed efficiencies were merger-specific, the defense would nonetheless fail. At most, the district court concluded that St. Luke's might provide better service to patients after the merger. That is a laudable goal, but the Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations. . . . The district court did not clearly err in concluding that . . . [St. Luke's] did not demonstrate that efficiencies resulting from the merger would have a positive effect on competition.[160]

The implication of the Ninth Circuit's approach appears to be that efficiencies cannot simply *outweigh* anticompetitive effects, they must—in addition to being merger-specific—be sufficient to *prevent* them.[161]

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[156] *St. Luke's*, 778 F.3d at 786–87. Recent economic research finds that physician acquisitions by hospitals, on average, leads to higher payments for physician services and that about 25% of the increase is attributable to billing physicians' services through the acquiring hospital (i.e., facility-based billing). Cory Capps et al., *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, 59 J. HEALTH ECON. 139 (2018).

[157] *St. Luke's*, 778 F.3d at 790.

[158] *Id.* at 790. The circuit court further explained, "The Clayton Act focuses on competition, and the claimed efficiencies therefore must show that the prediction of anticompetitive effects from the prima facie case is inaccurate." *Id.* at 791.

[159] *Id.* at 791.

[160] *Id.* at 791–92.

[161] Under this standard, if efficiencies reduce variable costs and are large enough that the profit-maximizing post-merger price is less than or equal to the pre-merger price, that could rebut the government's case. However, this approach appears to rule out a defense based on the concurrent existence of price increases *and* equally large or greater non-price benefits. The court did not address the viability of examining whether, if both quality and price increase as a result of a merger, it would be appropriate to evaluate whether quality-adjusted prices would likely increase or decrease.

Remedy. Citing *ProMedica* and other cases, the Ninth Circuit described divestiture as the "customary form of relief" in Clayton Section 7 merger cases.[162] However, St. Luke's argued against the customary approach on two grounds. First, divestiture would be "unlikely to improve competitive conditions given the weakness of a divested Saltzer."[163] Second, given that the district court had stated that the merger would create some benefits, a conduct remedy based on separate bargaining would be more efficient.[164] The Ninth Circuit rejected the first argument, in large part because St. Luke's itself had assured the district court that divestiture was feasible.[165] It also concluded that ordering divestiture was not an abuse of discretion by the district court; interestingly, the circuit court indicated that a conduct remedy might also have been acceptable.[166]

After the Ninth Circuit issued its opinion in February 2015, St. Luke's pursued no further appeals and turned to divesting Saltzer. In May 2017—more than two years after the Ninth Circuit opinion and over four years after litigation began—the district court finally approved the divestiture of Saltzer.[167] Saltzer entered a long-term agreement with Change Healthcare, a provider of health care management services owned by McKesson. Change would provide managerial, administrative, and strategic operations services while the Saltzer physicians would focus on providing clinical services.[168]

C. HERSHEY MEDICAL CENTER-PINNACLEHEALTH

In December 2015, the FTC and the Commonwealth of Pennsylvania filed a complaint for a preliminary injunction to enjoin Penn State Hershey Medical Center's proposed acquisition of PinnacleHealth System, pending an adminis-

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[162] *Id.* at 792.

[163] Brief of Appellants at 57–60, *St. Luke's*, No. 14-35173 (9th Cir. filed June 12, 2014).

[164] *Id.* at 60–62. St. Luke's did not propose separate bargaining for all contracts, but rather only for traditional, fee-for-service contracts.

[165] *St. Luke's*, 778 F.3d at 793. Recall that at the outset of litigation (first filed by St. Alphonsus, the St. Luke's rival), the district judge, largely on the basis of representations by St. Luke's, declined to issue a preliminary injunction enjoining the merger. *See supra* note 117.

[166] *St. Luke's*, 778 F.3d at 793. ("Even assuming that the district court might have been within its discretion in opting for a conduct remedy, we find no abuse of discretion in its declining to do so.").

[167] Press Release, Fed. Trade Comm'n, FTC Obtains Court Approval of Divestiture of Saltzer Medical Group by Idaho-based St. Luke's Health System (May 2, 2017), www.ftc.gov/news-events/press-releases/2017/05/ftc-obtains-court-approval-divestiture-saltzer-medical-group.

[168] Press Release, Change Healthcare, Saltzer Medical Group Chooses Change Healthcare for Practice Management Services (May 2, 2017), www.changehealthcare.com/press-room/press-releases/detail/saltzer-medical-group-chooses-change-healthcare-practice-management-services. McKesson is best known as a drug distributor and a Fortune 10 company. It also provides technology and consulting services to providers and health plans. *See* MCKESSON, *Our Businesses*, www.mckesson.com/about-mckesson/our-businesses/.

trative hearing.[169] Pinnacle and Hershey were the two largest health systems in Harrisburg, Pennsylvania, where Hershey operated an academic medical center and Pinnacle operated three "community hospitals focused on cost-effective acute care" that offered "some higher-level services."[170]

While the government presented Hershey and Pinnacle as substitutes and "vigorous competitors" whose competition "benefited local patients with lower health care costs and increased quality of care," the systems characterized themselves as complements that were used together, rather than played off one another, by payers forming insurance networks.[171] In large part, the systems' argument was based on Hershey being a major academic medical center that "offers all levels of care but specializes in high-acuity tertiary or quaternary services unavailable at most hospitals," whereas Pinnacle comprised community hospitals that did not have a comparable research and education mission.[172] Hershey drew its patients from a broad area in central Pennsylvania, while the bulk of Pinnacle's patients came from the counties surrounding Harrisburg.[173] This distinction would play a major role in the preliminary injunction hearing and ensuing appeal.

As in most litigated provider mergers, both sides agreed on a relevant product market of inpatient GAC services sold to commercial payers, but they disagreed about the definition of the relevant geographic market.[174] The government alleged that the four counties surrounding Harrisburg—the Harrisburg Metropolitan Statistical Area plus Lebanon County—constituted the relevant geographic market, arguing that the "[r]esidents of the Harrisburg Area strongly prefer to, and do, obtain GAC services locally."[175] The government's proposed market included the merging hospital systems and three other hospitals, two of which were "small community hospitals with limited service offerings."[176] The government alleged that, within the Harrisburg area, the merger would increase the HHI by 2582 points to a level of 5984 and that

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[169] Complaint for Temporary Restraining Order & Preliminary Injunction, FTC v. Penn State Hershey Med. Ctr., No. 1: 1:15-cv-2363 (M.D. Pa. filed Apr. 8, 2016) [hereinafter *Hershey* Complaint], www.ftc.gov/system/files/documents/cases/160408pinnacleamendcmplt.pdf

[170] FTC v. Penn State Hershey Med. Ctr., 185 F. Supp. 3d 552, 554 (M.D. Pa. May 9, 2016) (No. 1:15-cv-2363).

[171] *Hershey* Complaint, *supra* note 169, ¶¶ 45, 43; Brief of the FTC & the Commonwealth of Pa. at 45–46, FTC v. Penn State Hershey Med. Ctr., No. 16-2365 (3d Cir. filed June 1, 2016) [hereinafter FTC Appellate Brief].

[172] FTC Appellate Brief, *supra* note 171, at 4.

[173] *Id.* at 19–21.

[174] *Hershey* Complaint, *supra* note 169, ¶ 23; *Hershey Medical Center*, 185 F. Supp. 3d at 556– 57.

[175] *Hershey* Complaint, *supra* note 169, ¶¶ 25, 27.

[176] *Id.* ¶ 33.

the merging hospital systems would have a post-merger market share of 76 percent.[177]

To argue against the FTC's claims that patients preferred local care and that a SSNIP by just the hospitals in the FTC's alleged geographic market would be profitable, the hospital systems presented evidence that 43.5 percent of Hershey's patients and more than half of Hershey's revenue originated from outside the government's proposed geographic market.[178] At trial, the parties' economic expert proposed a significantly larger geographic market that included "19 hospitals within a 65 minute drive of Harrisburg."[179]

The district court denied the FTC's request for a preliminary injunction, holding that the government's relevant geographic market was "impermissibly narrow" and did "not assume the commercial realities faced by consumers in the region."[180] In rejecting the FTC's market, the district court relied on two major lines of argument. The first was the aforementioned high degree of patient travel into the FTC's Harrisburg area geographic market, especially among patients selecting Hershey Medical Center. The second was the court's interpretation of the relevance of contractual rate agreements between Hershey and the two largest payers in the area to the SSNIP test.

Regarding patient travel, the court stated that the systems' proposed broader market included "realistic alternative[s] that patients would utilize" and better represented the "realities of living in Central Pennsylvania, which is largely rural and requires driving distances for specific goods or services" than did the FTC's alleged geographic market.[181] Significantly, the court cited the Eighth Circuit's *Little Rock Cardiology* opinion for the proposition that the "end goal [of geographic market definition] is to delineate a geographic area where, in the medical setting, 'few patients leave . . . and few patients enter.' "[182] Although neither the district court opinion in *Hershey* nor the *Little Rock Cardiology* opinion it cited directly reference the term, this was a clear adoption by the court of the E-H method for defining geographic markets.[183]

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[177] FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 347 (3d Cir. 2016).

[178] FTC v. Penn State Hershey Med. Ctr., 185 F. Supp. 3d 552, 557 (M.D. Pa. 2016). The court also noted that half of Hershey's patients travel 30 minutes or more to reach the hospital and that 20% travel over an hour. *Id.*

[179] *Id.*

[180] *Id.* at 558.

[181] *Id.* at 557.

[182] *Id.* (internal quotation marks omitted) (quoting Little Rock Cardiology Clinic PA v. Baptist Health, 591 F.3d 591 (8th Cir. 2009); United States v. Rockford Mem'l Corp., 717 F. Supp. 1251, 1267 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990)).

[183] The forensic chain is not long: the *Little Rock Cardiology* Eighth Circuit opinion extensively cites the 1989 *Rockford Memorial* opinion, which discusses the Elzinga-Hogarty method at length. In *Rockford Memorial*, the district court not only adopted the E-H methodology, it performed its own E-H analysis. Capps, *supra* note 5, at 450–51.

After the FTC appealed, Professor Elzinga, a co-creator of the E-H method, was among the several dozen economists who submitted an amicus brief in support of the FTC's appeal that explained why "a sizeable inflow of patients into a proposed geographic market does not imply that an alleged relevant geographic market is overly narrow."[184]

In its SSNIP analysis, the district court placed significant weight on rate agreements with Capital Blue Cross and Highmark, the two largest payers in the Harrisburg area:

> [T]he Court heard hours of economic expert testimony regarding the hypothetical monopolist's ability to impose a SSNIP in the context of this proposed merger. The Court finds it extremely compelling that the Hospitals have already taken steps to ensure that post-merger rates do not increase . . . . [T]he Hospitals have executed a 5-year contract with Highmark and a 10-year contract with CBC that . . . maintain existing rate structures for fee-for-service contracts and preserve the existing rate differential between the Hospitals. The result of these agreements is that the Hospitals cannot walk away from these payors and that rates *cannot increase* for at least 5 years. The Court simply cannot be blind to this reality when considering the import of the hypothetical monopolist test advanced by the *Merger Guidelines*.[185]

The hospital systems also presented several efficiency defenses. First, they argued that Hershey faced capacity constraints and that shifting volume from Hershey to Pinnacle post-merger would improve the quality of care. Second, they argued that Hershey would avoid spending millions of dollars on the construction of a bed tower addition.[186] Lastly, the parties claimed other efficiencies, including optimizing patient site-of-service, entering more risk-based contracts, and attracting and retaining high-caliber medical students and staff.[187]

The claimed capital cost avoidance from Hershey not having to build a new 100-bed tower at a reported cost of $277 million is interesting because of the very different interpretations offered by the two sides. While the parties characterized this as an efficiency of the merger, the FTC responded that canceling the expansion was not an efficiency but rather an anticompetitive output reduction.[188] The district court sided with the merging parties, stating that "the

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[184] Consent Brief of *Amici Curiae* Economics Professors in Support of Plaintiffs/Appellants Urging Reversal at 2, FTC v. Penn State Hershey Med. Ctr., No. 16-2365 (3d Cir. filed June 8, 2016); FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 340 n.3 (3d Cir. 2016) ("*Amici* are a group of 36 economics professors—including Professor Elzinga—who argue that the District Court engaged in faulty economic reasoning, particularly with regard to geographic market definition.").

[185] *Hershey Medical Center*, 185 F. Supp. 3d at 557–58.

[186] FTC Appellate Brief, *supra* note 171, at 5–6.

[187] *Id.* at 49–50.

[188] Corrected Reply Brief of the Fed. Trade Comm'n & the Commonwealth of Pa. at 27–29, *Hershey Medical Center*, No. 16-2365 (M.D. Pa. filed June 20, 2016). *See also* Merger Guide-

merger would immediately make additional capacity available to Hershey, causing near instantaneous benefits to Hershey's patients."[189] It further noted that the "community medical center is a[n] . . . increasingly antiquated concept"[190] and that the "patients of Hershey and Pinnacle stand to gain much from a combined entity that is capable of competing" rather than hospital systems that remain independent and diminish in relevance.[191]

Based primarily on its rejection of the FTC's relevant geographic market and its acceptance of the parties' efficiency claims, the district court concluded that the "FTC failed to meet its burden to show a likelihood of ultimate success on the merits" and denied the motion for a preliminary injunction.[192] On appeal, the FTC argued that the district court erred with respect to market definition by misapplying the hypothetical monopolist test, crediting the unreliable E-H test, improperly considering rate commitments, and discounting the role of payers in price negotiations.[193] The government also argued that the district court's evaluation of efficiencies was not the "rigorous analysis needed to evaluate and verify an efficiency claim" outlined in the Merger Guidelines or the case law.[194] The Third Circuit sided with the FTC on each of these points.

Market Definition. The Third Circuit held that the district court "erred in both its formulation and its application of the proper legal test" for assessing the relevant geographic market.[195] The Third Circuit rejected the district court's use of an E-H-style assessment of patient inflows: "The Elzinga-Hogarty test was once the preferred method to analyze the relevant geographic market and was employed by many courts. . . . But subsequent empirical research demonstrated that utilizing patient flow data to determine the relevant geographic market resulted in overbroad markets with respect to hospitals."[196]

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lines, *supra* note 58, § 10. ("Cognizable efficiencies are merger-specific efficiencies that have been verified and do not arise from anticompetitive reductions in output or service.").

[189] *Hershey Medical Center*, 185 F. Supp. 3d at 560.

[190] *Id.* at 564.

[191] *Id.*

[192] *Id.*

[193] FTC Appellate Brief, *supra* note 171, at 26–28, 40 n.7.

[194] *Id.* at 28–29.

[195] FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 339 (3d Cir. 2016).

[196] *Id.* at 340. There was some debate as to whether the district court had relied on E-H, given that it had not cited it. But, the circuit court noted, the statement about few patients entering and few patients leaving was a direct quote from *Rockford*. *See also supra* note 183. Further, the "District Court relied primarily on the fact that 43.5% of Hershey's patients travel from outside of the Harrisburg area (the Government's proposed geographic market) in order to receive GAC services. This number is a measure of patient inflows—one of the two primary measurements relevant to the Elzinga-Hogarty analysis." *Hershey Medical Center*, 838 F.3d at 340.

The Third Circuit credited the Economics Professors' amicus brief as having "persuasively demonstrated [that] patient flow data—such as the 43.5% number emphasized by the District Court—is particularly unhelpful in hospital merger cases . . . ."[197] Therefore, the circuit court held that the district court had improperly relied on the E-H methodology.[198] It further criticized the district court for only examining inflow statistics when outflow statistics showed that only 9 percent of residents of the FTC's alleged Harrisburg area geographic market left that area for GAC services.[199]

The Third Circuit emphasized the district court's failure to account for the role of payers: it "completely neglected any mention of the insurers in the healthcare market" and thereby misunderstood the "commercial realities" of the health care market.[200] Pointing to the now standard two-stage model of hospital competition, the court explained:

> [W]hen we apply the hypothetical monopolist test, we must also do so through the lens of the insurers: if enough insurers, in the face of a small but significant non-transitory price increase, would avoid the price increase by looking to hospitals outside the proposed geographic market, then the market is too narrow. . . . It was error for the District Court to completely disregard the role that insurers play in the healthcare market.[201]

The Third Circuit took strong exception to the district court's reliance, in its market definition analysis, on the parties' rate agreements with the area's two largest payers: "[P]rivate contracts between merging parties and their customers have no place in the relevant geographic market analysis. The hypothetical monopolist test is exactly what its name suggests: hypothetical."[202]

The SSNIP test asks whether a "hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future seller of those products ('hypothetical monopolist') likely would impose at least a small but

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[197] *Id.* at 340. One critique of E-H is that when patients travel into an area for non-price reasons, such as to visit an academic medical center like Hershey, the fact of their travel is not a reliable indicator of patients' willingness to switch to an alternative hospital in response to a SSNIP. As the court observed, "Hershey is a leading academic medical center that provides highly complex medical services. We are skeptical that patients who travel to Hershey for these complex services would turn to other hospitals in the area." *Id.* at 341.

[198] *Id.* ("[T]he silent majority fallacy renders the test employed by the District Court unreliable even in the absence of precise thresholds. . . . [R]elying solely on patient flow data is not consistent with the hypothetical monopolist test.").

[199] *Id.* ("[C]iting only patient inflows and ignoring patient outflows creates a misleading picture of the relevant geographic market.").

[200] *Id.*

[201] *Id.* at 342–43 (citing Vistnes, *supra* note 15).

[202] *Id.* at 344; *see also id.* at 347 n.7. ([R]egardless of whether the private agreements were the sole basis for, or only a part of, the District Court's decision, we conclude that they are not at all relevant to the economic analysis. Thus, considering them, even if not relying on them, is error.").

significant and non-transitory increase in price."[203] Insofar as the district court relied on the parties' rate commitments to answer the hypothetical monopolist test, it misapprehended the purpose of the market definition exercise: to identify and include sellers whose products are close substitutes while excluding those whose products are not.[204] The circuit court went on to identify a number of illogical implications of accepting private contracts as evidence relevant to market definition analysis, but did note that such agreements "may be an effective tool for the FTC and merging parties to utilize in regulatory actions."[205]

Ultimately, the Third Circuit determined that the district court's "analysis [was] economically unsound and not reflective of the commercial reality of the healthcare market" and that "the District Court committed legal error in failing to properly formulate and apply the hypothetical monopolist test."[206] It went on to conclude that the FTC's Harrisburg area relevant geographic market was appropriate. That conclusion rested heavily on record evidence and testimony indicating that a health plan network without either of the two merging parties' hospitals would not be marketable.[207]

The circuit opinion addressed two other common issues in hospital merger cases. First, defendant hospitals often point to the bargaining leverage that payers possess as a basis for concluding that price increases are unlikely, whether as part of a SSNIP test or a direct evaluation of competitive effects. On this point, the circuit court stated that the merger (or a hypothetical monopoly) would not change payers' bargaining leverage, so the proper focus is on whether the hospitals' bargaining leverage would increase.[208] Second, the Third Circuit relied on market share and HHI evidence to conclude that the FTC had demonstrated that the merger was presumptively anticompetitive; the circuit court agreed, stating that "[m]arket concentration is a useful indicator of the likely competitive, or anticompetitive, effects of a merger" and that

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[203] Merger Guidelines, *supra* note 58, § 4.1.1.

[204] "Market definition focuses solely on demand substitution factors, i.e., on customers' ability and willingness to substitute away from one product to another in response to a price increase or a corresponding non-price change such as a reduction in product quality or service." *Id.* § 4.

[205] *Hershey Medical Center*, 838 F.3d at 344.

[206] *Id.*. The court took care, however, to not mandate that district courts use the hypothetical monopolist test. Instead, it held that all sides in the case had agreed that the hypothetical monopolist test was the appropriate framework and that, in that specific context, it was legal error to improperly implement the test. *Id.* at 344–45.

[207] *Id.* at 345–46.

[208] "No one disputes that [hospitals and insurers] both have bargaining leverage when negotiating reimbursement rates. The question here, however, is whether the merger will cause such a significant increase in the *Hospitals'* bargaining leverage that they will be able to profitably impose a SSNIP . . . . In other words, whatever leverage the payors will have after the merger, they have that leverage now." *Id.* at 346.

the FTC's concentration numbers "demonstrate that the merger is presumptively anticompetitive."[209]

Efficiencies. As did the Ninth Circuit in *St. Luke's*, the Third Circuit started by noting, "We are skeptical that such an efficiencies defense even exists," though it acknowledged that some courts and the Merger Guidelines recognize the defense.[210] Nevertheless, the circuit court examined efficiencies but applied "the demanding scrutiny that the efficiencies defense requires."[211] Under that standard, the Third Circuit sided with the FTC, holding that "Hershey's ability to forgo building the 100-bed tower is a reduction in output."[212] The court indicated that capital cost avoidance could create a creditable efficiency only if, in addition to being merger-specific and verifiable, it would "result in some tangible, verifiable benefit to consumers."[213] Moreover, it made clear that the higher the post-merger concentration, the greater must be the efficiencies:

> Even if we were to agree with the Hospitals that their ability to forego building a new 100-bed tower as a result of the merger is a cognizable efficiency that is verified, merger specific, and did not arise from any anticompetitive reduction in output, we cannot overlook that the HHI numbers here eclipse any others we have identified in similar cases. They render this combination not only presumptively anticompetitive, but so likely to be anticompetitive that "extraordinarily great cognizable efficiencies [are] necessary to prevent the merger from being anticompetitive."[214]

The Third Circuit also rejected the parties' other claimed efficiencies, largely on the grounds that they were speculative or not merger-specific, or that the parties had not established that benefits would "ultimately be passed on to consumers."[215]

Having overturned the district court on market definition, competitive effects, and efficiencies, the Third Circuit directed the district court to issue a preliminary injunction; the parties abandoned the merger several weeks later.[216]

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[209] *Id.*at 347.

[210] *Id.* at 347–79.

[211] *Id.* at 349.

[212] *Id.* at 350 (citing Merger Guidelines, *supra* note 58, § 10 ("The *Merger Guidelines* expressly indicate that the FTC will not consider efficiencies that 'arise from anticompetitive reductions in output or service.'")).

[213] *Id.* at 350.

[214] *Id.* at 350 (citing Merger Guidelines, *supra* note 58, § 10).

[215] *Id.* at 349–51.

[216] *Id.* at 353–54. Press Release, PennState Health, PinnacleHealth, Milton S. Hershey Medical Center End Integration Efforts (Oct. 14, 2016), pennstatehealthnews.org/2016/10/pinnaclehealth-milton-s-hershey-medical-center-end-integration-efforts/.

Subsequently, Pinnacle acquired four central Pennsylvania hospitals located outside the Harrisburg area from Community Health Systems and then, in turn, was acquired by the University of Pittsburgh Medical Center system.[217] In December 2017, Hershey and Highmark Health announced a strategic partnership to develop a community health care network for residents of Central Pennsylvania, anchored by the advanced services available at Hershey.[218] Although Hershey argued at trial that high occupancy rates created a need for additional capacity absent the merger, there is no indication as yet that Hershey has advanced its plan to build a new bed tower.[219] Hershey does have other, smaller expansion projects underway.[220]

D. ADVOCATE HEALTH CARE-NORTHSHORE

Roughly parallel to the challenges to the Hershey-Pinnacle and Cabell-St. Mary's mergers, the FTC and the State of Illinois sued to halt Advocate Health Care's proposed acquisition of NorthShore University HealthSystem. This marked the first hospital merger challenge in a large urban area since the unsuccessful *Sutter-Alta Bates*[221] and *North Shore-Long Island Jewish*[222] challenges at the turn of the century. The other recent challenges had all been in small and mid-size areas, like Rockford, Illinois; Toledo, Ohio; and Harrisburg, Pennsylvania.

The FTC alleged a geographic market of the North Shore Area of Chicago, corresponding to northern Cook County and southern Lake County, where the

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[217] Roger DuPuis, *PinnacleHealth Wraps Merger with UPMC, Becomes UPMC Pinnacle*, CENTRAL PENN BUS. J. (Sept. 1, 2017), www.cpbj.com/article/20170901/CPBJ01/170909988/pinnaclehealth-wraps-merger-with-upmc-becomes-upmc-pinnacle.

[218] Press Release, PennState, Penn State Health and Highmark Health Join Forces to Create Health Care Network (Dec. 15, 2017), news.psu.edu/story/498639/2017/12/15/impact/penn-state-health-and-highmark-health-join-forces-create-health-care.

[219] FTC v. Penn State Hershey Med. Ctr., 185 F. Supp. 3d 552, 561 (M.D. Pa. May 9, 2016). An upcoming three-floor addition to Penn State Children's hospital is distinct from the bed tower project at issue in the merger trial. According to one press article, "Hershey also considered constructing a 'bed tower,' [Hershey CEO] Hillemeier said, but that would take longer, so for now it's planning to add on to the children's hospital, move the departments, and see how things look in a couple of years." Heather Stauffer, *Expansion Could Increase Hershey Medical Center Capacity by up to 15 Percent*, LANCASTER ONLINE (Apr. 21, 2017), www.lancasteronline.com/news/local/expansion-could-increase-hershey-medical-center-capacity-by-up-to/article_e9d78784-2600-11e7-bd3d-6334729f1421.html).

[220] Hershey is also converting and renovating existing space to free up capacity for its general hospital. Press Release, PennState, Penn State Health on Track for More Renovations, Improved Patient Services (May 4, 2018), news.psu.edu/story/520240/2018/05/04/administration/penn-state-health-track-more-renovations-improved-patient.

[221] California v. Sutter Health Sys., 84 F. Supp. 2d 1057 (N.D. Cal. 2000), *aff'd*, 217 F.3d 846 (9th Cir. 2000), *amended by* 130 F. Supp. 2d 1137 (N.D. Cal. 2001).

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

systems were the two largest providers of inpatient services.[223] It claimed that the merger would eliminate competition between "close, if not each other's closest, competitors in the North Shore Area."[224] The combined system would have a market share of 60 percent in the North Shore Area and the HHI would increase by 1782 points to reach 3943.[225] The FTC's alleged market did not include Northwestern Memorial Hospital, located in downtown Chicago (i.e., south of "northern Cook County"), even though Northwestern Memorial was a popular choice among residents of the FTC's alleged market.[226] The area included 11 hospitals: six owned by one of the merging systems, one by Northwestern Memorial, and four that were independent or part of other systems.[227]

Once again, the merging parties disagreed strongly on the appropriate relevant geographic market. The FTC's expert constructed the candidate geographic market by including hospitals in the Chicago area that competed with *both* (rather than either) Advocate and NorthShore. He argued that, although some patients chose to travel outside of the North Shore Area, approximately 73 percent of patients residing in that area stay within it for inpatient care.[228] The FTC's geographic market—or perhaps its product market—excluded "destination hospitals," which were defined as advanced teaching hospitals located outside of the North Shore Area that offer advanced or specialized services not usually offered at community hospitals.[229] The rationale was that payers require local hospitals in order to create marketable health plan products, but "destination hospitals . . . are not located in the northern Chicago suburbs and, therefore, do not fulfill this role for commercial payers."[230] This excluded Northwestern Memorial, the University of Chicago Hospital, and several others.

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[223] Complaint ¶¶ 1, 4–5, FTC v. Advocate Health Care, No. 15-cv-11473 (N.D. Ill. filed Dec. 22, 2015). The FTC defined this as the area bounded by six hospitals. *Id.* ¶ 4.

[224] *Id.* ¶ 3.

[225] Memorandum in Support of Plaintiffs' Motion for Preliminary Injunction at 21–22, *Advocate Health Care*, No. 15-cv-11473 (N.D. Ill. filed Mar. 9, 2016).

[226] According to the merging hospitals, the FTC expert's diversion analysis showed that Northwestern Memorial was the closest substitute for two of NorthShore's four hospitals—its main Evanston location and Highland Park Hospital. Defendants' Post-Hearing Memorandum in Opposition to Plaintiffs' Motion for Preliminary Injunction at 11–12, *Advocate Health Care*, No. 15-cv-11473 (N.D. Ill. filed May 18, 2016).

[227] Amended Memorandum Opinion & Order, FTC v. Advocate Health Care, No. 15-cv-11473, 2016 U.S. Dist. LEXIS 79645, at *11 –13 (N.D. Ill. June 20, 2016), *rev'd and remanded*, 841 F.3d 460 (7th Cir. Oct. 31, 2016).

[228] Brief & Required Short Appendix of Appellants Fed. Trade Comm'n and State of Illinois at 12, *Advocate Health Care Network*, No. 16-2492 (7th Cir. filed July 15, 2016).

[229] *Advocate Health Care*, 2016 U.S. Dist. LEXIS 79645, at *12–13.

[230] *Id.* (citing to Dr. Tenn's testimony).

The merging parties countered that the government's geographic market was arbitrary and too narrow. They argued that it excluded key competing hospitals in Chicago as well as several hospitals near the perimeter of the North Shore Area.[231] As support, they pointed to the fact that the FTC expert's diversion analysis predicted that 52 percent of patients in the North Shore Area would switch to a hospital located outside the alleged geographic market if their first choice hospital was unavailable, and that 7.2 to 29.2 percent would instead go to a specific "destination hospital," Northwestern Memorial.[232] The FTC responded that, despite high diversion rates to hospitals outside of its alleged relevant geographic market, a hypothetical monopolist of all hospitals inside the government's alleged market could impose a SSNIP because payers would accede to it rather than attempt to market a plan with a network that excluded *all* North Shore Area hospitals.[233]

The merging parties offered two further critiques of the FTC's relevant market. First, they argued that the FTC's expert incorrectly included only hospitals that competed with both Advocate and NorthShore, rather than including hospitals that competed with either of the two merging systems.[234] Second, they argued that outside hospitals had opened outpatient facilities and physician offices in the North Shore Area and used those to drive patients to their hospitals.[235] After including "destination hospitals" and hospitals that compete with either one of the merging systems, the merging parties' expert concluded that the merger fell below the post-merger HHI threshold of 2500 set forth in the Merger Guidelines.[236]

Initially, the government and the hospital systems also disagreed on the relevant product market. The FTC alleged a relevant product market consisting of the cluster of general acute care inpatient services offered by both Advocate and NorthShore.[237] The hospital systems argued that the product market should also include outpatient services because the number of hospital services offered on an outpatient basis is increasing, inpatient volume is declining, and payers often negotiate inpatient and outpatient services under the

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[231] Defendants' Post-Hearing Memorandum in Opposition to Plaintiffs' Motion for Preliminary Injunction at 9–12, *Advocate Health Care*, No. 15-cv-11473 (N.D. Ill. filed May 18, 2016) [hereinafter Defendants' Post-Hearing Memo], www.appliedantitrust.com/14_merger_litigation/cases_ftc/advocate/1_13b/advocate%20ndill_postclosing_brief_def5_20_2016.pdf.

[232] *Advocate Health Care Network*, 841 F.3d at 475.

[233] Plaintiffs' Closing Statement Proposed Merger of Advocate and North Shore at 18, *Advocate Health Care*, No. 15-cv-11473 (N.D. Ill. filed May 25, 2016).

[234] Defendants' Post-Hearing Memo, *supra* note 231, at 10–11.

[235] *Id.* at 12.

[236] *Id.* at 13.

[237] Complaint ¶¶ 26–29, *Advocate Health Care*, No. 15-cv-11473 (N.D. Ill. filed Dec. 22, 2015).

same contract.[238] However, during testimony, the merging parties' economic expert accepted the relevant inpatient GAC service product market alleged by the government.[239]

Based on a merger simulation, the FTC's expert predicted an average price increase of 8 percent among the parties' North Shore Area hospitals, which would increase payments to the combined system by approximately $45 million per year.[240] The hospitals responded by criticizing the model and presenting an alternative merger simulation that indicated the merger was unlikely to result in a significant price increase for inpatient hospital services.[241] The hospital systems also argued that other competitors—including hospitals excluded from the government's relevant geographic market—and health plans would reposition to prevent post-merger price increases.[242] Two payers, one of which was Illinois' largest, testified against the merger, while four other payers testified in support.[243]

Beyond challenging the FTC's affirmative case, Advocate's and NorthShore's defense hinged on the premise that the merger would allow for the creation of a more efficient insurance product anchored by the two systems—the high performing network (HPN). The merging parties argued that the combined system's providers, covered lives, and geographic coverage were complements and were necessary for the implementation of the HPN.[244] Because, they argued, it would have premiums 10 percent below the price of Blue Cross Blue Shield of Illinois's HMO plan, the savings would outweigh any price increase attributable to greater bargaining leverage post-merger and consumers would, on net, benefit from the merger.[245] The FTC challenged the merger-specificity of the proposed HPN. Its main basis was that each system already participated in narrow networks and that Advocate had already worked with Blue Cross Blue Shield of Illinois to offer an HPN product that, the FTC claimed, was essentially the same as the HPN that the parties claimed the merger would allow them to offer.[246]

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[238] Defendants' Post-Hearing Memo, *supra* note 231, at 12.

[239] FTC v. Advocate Health Care, 2016 U.S. Dist. LEXIS 79645, at *10 (N.D. Ill. June 20, 2016) (No. 15-cv-11473).

[240] Memorandum in Support of Plaintiffs' Motion for a Preliminary Injunction at 21–22, *Advocate Health Care*, No. 15-cv-11473 (N.D. Ill. filed Mar. 9, 2016).

[241] Defendants' Post-Hearing Memo, *supra* note 231, at 18–19. The merging parties' estimates ranged from a 3.3% decrease to a 0.6% increase. Defendants' Proposed Findings of Fact & Conclusions of Law ¶ 231, *Advocate Health Care*, No. 15-cv-11473 (N.D. Ill. filed May 18, 2016) [hereinafter Defendants' Proposed Findings of Fact & Conclusions of Law].

[242] Defendants' Proposed Findings of Fact & Conclusions of Law, *supra* note 241, at 48–51.

[243] Defendants' Post-Hearing Memo, *supra* note 231, at 2.

[244] *Id.* at 23–30.

[245] *Id.*

[246] Plaintiff's Post-Hearing Brief at 19–20, 23–26, FTC v. Advocate Health Care, No. 15-cv-11473 (N.D. Ill. filed May 18, 2016) ("As Defendants have repeatedly told the Court, the HPN

The district court denied the government's request for a preliminary injunction, holding that the FTC had not met its burden to prove a relevant geographic market.[247] It criticized the FTC's expert for offering "no economic basis of the 'destination hospital' designation" and for assuming his conclusion by excluding "destination hospitals" at the outset of his market definition analysis.[248] It also rejected the expert's construction of the candidate relevant geographic market by starting with just hospitals that competed with both Advocate and NorthShore.[249] Finally, the court also dismissed, as "equivocal," evidence presented by the FTC that patients prefer to receive GAC services near their homes.[250] Having rejected the FTC's geographic market and denied the preliminary injunction, the district court noted but did not address the HPN or other efficiencies.

The government appealed to the Seventh Circuit.[251] The circuit court focused almost entirely on market definition issues, including discussions of E-H, the SSNIP test, and "destination hospitals." It began by describing three distinctive features of hospital geographic markets that the district court had disregarded. First, geographic markets are often small because "most patients prefer to go to nearby hospitals." The circuit court highlighted that "in the Commission's proposed market, 80 percent of patients drove to the hospital of their choice in 20 minutes or less."[252] Second, hospitals are differentiated and patients' preferences are varied such that the "silent majority fallacy" applies:

> [A]s Dr. Elzinga himself has explained, the Elzinga-Hogarty test will often overestimate the size of hospital markets. The test assumes that if some patients presently travel for care, more would do so to avoid a price increase, making an increase unprofitable. But in fact, often a "silent majority" of patients will not travel, enabling anticompetitive price increases.[253]

The circuit court found that the district court had committed a variant of the silent majority fallacy by focusing on "patients who leave a proposed market instead of on hospitals' market power over the patients who remain," explaining: "The geographic market question asks in essence, how many hospitals can insurers convince most customers to drive past to save a few percent on

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already exists. In its current form, the HPN offers every benefit that Defendants claim will be achieved by the merger . . . Whether or not the merger goes forward, the HPN will be available to consumers.").

[247] FTC v. Advocate Health Care, 2016 U.S. Dist. LEXIS 79645, at *21.

[248] *Id.* at *16. ("[H]is rationale for excluding such hospitals—that they are not substitutes for Advocate and NorthShore—assumes the answer to the very question the geographic market exercise is designed to elicit; that is, are the destination hospitals substitutes for the merging parties?").

[249] *Id.* at *12 n.2.

[250] *Id.* at *16–17.

[251] FTC v. Advocate Health Care Network, 841 F.3d 460, 464, 476 (7th Cir. 2016).

[252] *Id.* at 470.

[253] *Id.* (citing to Elzinga & Swisher, *supra* note 155).

their health insurance premiums? We should not be surprised if that number is very small. Plaintiffs have made a strong case that it is."[254]

Third, the Seventh Circuit observed that payers, rather than patients themselves, pay most of the cost of hospital care.[255] Appealing to the two-stage model of hospital competition, the court explained: "Insured patients are usually not sensitive to retail hospital prices, while insurers respond to both prices and patient preferences. . . . The geographic market question is therefore most directly about 'the "likely response of insurers,"' not patients, to a price increase."[256] For each of these reasons, the circuit court concluded that the district court had both misunderstood and misapplied the hypothetical monopolist test.[257]

The circuit court bolstered its conclusion with reference to payer testimony: "The insurance executives were unanimous on a second point: in the North Shore Area, an insurer's network must include either Advocate or NorthShore to offer a product marketable to employers. The record as a whole supports that testimony."[258]

Based on payer testimony and other evidence indicating that Advocate and NorthShore were necessary to have a marketable product in the North Shore Area, the Seventh Circuit concluded that the FTC's alleged market would satisfy the SSNIP test.[259] The Seventh Circuit specifically criticized the district court opinion for mistaking the iterative process of the hypothetical monopolist test as a "logical circularity."[260] As noted above, the FTC's expert constructed his candidate market by including hospitals that overlapped with both parties' hospitals and conducted a SSNIP test for that set of hospitals; the district court had concluded that this amounted to "assum[ing] the answer" instead of allowing data to determine which hospitals were in the candidate market.[261] But the Seventh Circuit observed that it is inherent in the hypotheti-

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[254] *Id.* at 476. This is a variant of the silent majority fallacy because the district court was focusing not on inflow and outflow statistics per se, but rather on the overall 52% diversion from hospitals inside the FTC's geographic market to outside hospitals as estimated by the FTC's expert.

[255] *Id.* at 475

[256] *Id.* at 471 (citing to, among others, Vistnes, *supra* note 15).

[257] *Id.* at 473. ("[T]he district court made clear factual errors. Its central error was its misunderstanding of the hypothetical monopolist test: it overlooked the test's results and mistook the test's iterations for logical circularity.").

[258] *Id.* at 474. The court noted that one insurance product does not include Advocate or North Shore but that the product's "membership is overwhelmingly individuals rather than employers. And fewer than two percent of those individual members live near NorthShore's hospitals." *Id.*

[259] *Id.* at 476, 465–66.

[260] *Id.* at 473.

[261] FTC v. Advocate Health Care, No. 15-cv-11473, 2016 U.S. Dist. LEXIS 79645, at *16, 21 (N.D. Ill. June 20, 2016).

cal market first to propose a candidate market and then evaluate it with the SSNIP test, expanding the candidate market only if the test so indicates. That iterative process, it held, "is not circular reasoning."[262]

This debate highlights an issue that may reappear in future cases in larger cities with many hospitals: there may be multiple candidate markets that would pass a SSNIP test and the concentration and presumptions may vary across candidate markets. For example, in *Advocate*, the candidate market did not include Northwestern Memorial, an academic medical center located in downtown Chicago, even though diversions indicated that patients viewed Northwestern Memorial as the closest substitute to NorthShore's largest hospital, Evanston Hospital.[263] The FTC's candidate market also excluded St. Francis, the closest hospital to Evanston Hospital. The FTC excluded the former because it was a "destination hospital" and the latter because it did not overlap with both systems' hospitals.[264]

The Merger Guidelines state that the SSNIP test must include "at least one product sold by one of the merging firms," but they do not specifically identify an algorithm or basis for determining which other products (or locations) to include in the initial candidate market to be evaluated by the hypothetical monopolist test.[265] One portion of the Merger Guidelines implies that diversions should play a significant role in determining the set of included sellers:

> When applying the hypothetical monopolist test to define a market around a product offered by one of the merging firms, if the market includes a second product, the Agencies will normally also include a third product if that third product is a closer substitute for the first product than is the second product. The third product is a closer substitute if, in response to a SSNIP on the first product, greater revenues are diverted to the third product than to the second product.[266]

This suggests that Northwestern Memorial should be included in the relevant market. However, the Seventh Circuit rejected this, because of its status as a "destination hospital." Although the district court held that the FTC's expert offered "no economic basis for the 'destination hospital' designation," the Seventh Circuit noted that market participants—including the merging parties—distinguished them from community hospitals and that "destination

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[262] *Advocate Health Care Network*, 841 F.3d at 473.

[263] *Id.* at 474–76, 475 nn.4 & 5.

[264] *Id.* fig.1, cases.justia.com/federal/appellate-courts/ca7/16-2492/16-2492-2016-10-31.pdf?ts=1477931445 (map showing Chicago Area hospitals—in slip op). The candidate hospitals in the FTC's primary relevant market was the set of hospitals with "at least a two percent share of the admissions from the same areas the parties' hospitals drew from"—a criterion that excluded St. Francis. *Id.* at 466.

[265] Merger Guidelines, *supra* note 58, § 4.1.1.

[266] *Id.*; *see also Advocate Health Care Network*, 841 F.3d at 475 n.5.

hospitals" could not satisfy insurers' business need to include local hospitals as part of marketable health plans.[267]

In that respect, the Seventh Circuit decision is broadly consistent with the proviso contained at the outset of the Merger Guidelines:

> [M]erger analysis does not consist of uniform application of a single methodology. Rather, it is a fact-specific process through which the Agencies, guided by their extensive experience, apply a range of analytical tools to the reasonably available and reliable evidence to evaluate competitive concerns in a limited period of time.[268]

On remand in March 2017, the district court ruled in favor of the government and granted the preliminary injunction.[269] Echoing the Seventh Circuit, it held that the "relevant geographic market need not include every firm that competes . . . . [I]t need only include those competitors that would 'substantially constrain'" the ability of the merged firm to raise prices.[270] The district court accepted the government's relevant geographic market, HHI calculations, and assertion that the merger would give the merged system control of 60 percent of the market.[271] It concluded that the FTC's expert had "persuasively demonstrated that the merger is likely to cause a significant price increase resulting in a loss to consumers."[272]

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[267] *Advocate Health Care Network*, 841 F.3d at 475 n.5 ("The hospitals' reliance on the diversion ratios, like the district court's, overlooks insurers' role in the marketplace. Even if we take the diversion ratios to mean that a sizable minority of patients consider Northwestern Memorial a close substitute, it does not follow that insurers could offer it as a sufficient substitute for a commercially viable insurance network."). This is a striking contrast with the outcome in DOJ's effort to block the merger of Long Island Jewish Medical Center and North Shore Health System, two hospital systems in Long Island, New York. There, the DOJ argued that the merging systems' respective flagship hospitals were "each other's closest competitor for the function of an anchor hospital . . . in a managed care plan's hospital network, for several reasons. Each offers a broad array of sophisticated services, a similarly broad and high-quality medical staff, the prestige of their academic affiliations and research programs, and a strategic location that make them the only alternatives for the anchor of a plan serving these Counties." Complaint ¶ 20, United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. June 11, 1997). The DOJ had alleged that "anchor hospitals"—the same or similar concept as "destination hospitals" in *Advocate*—were in their own relevant product market. *Id.* ¶ 30. However, the district court rejected the government's distinction, stating *inter alia* that "the plaintiff's definition is unduly restricted to 'anchor' hospitals. This definition does not comport with that applied in other hospital merger cases, namely, 'general acute inpatient services.'" United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 137 (E.D.N.Y. 1997).

[268] Merger Guidelines, *supra* note 58, § 1.

[269] FTC v. Advocate Health Care, No. 15 C 11473, 2017 U.S. Dist. LEXIS 37707 (N. D. Ill. Mar. 16, 2017).

[270] *Id.* at *23 (citing AD/SAT, a Div. of Skylight, Inc. v. Assoc. Press, 181 F.3d 216, 228 (2d Cir. 1999)).

[271] *Id.* at *27–*28.

[272] *Id.* at *37.

After expressing skepticism over the existence of the efficiencies defense, the district court also concluded that the hospital systems had not proved that efficiencies would outweigh the anticompetitive effects of the merger.[273] It found the evidence that Advocate could not expand its narrow network plan without NorthShore—that is, that the merger was necessary to grow the lower premium HPN—to be "thin."[274] Further, the district court held that "it may well be possible that the HPN will generate sufficient enrollment to offset any anticompetitive effects caused by the merger," but that the possibility was "essentially speculative."[275]

After the district court granted a preliminary injunction, Advocate and NorthShore called off the merger rather than proceed to an FTC administrative trial on the merits.[276]

In December 2017, Advocate announced plans to merge with Aurora Health Care, a multi-hospital system operating in Wisconsin, to form the tenth largest not-for-profit system in the country. The combined system would operate 27 hospitals and more than 500 outpatient locations, and employ more than 3300 physicians. The new system plans to reduce costs and invest in technology to expand access and improve quality.[277] In February 2018, Illinois regulators approved the merger, and the FTC concluded its review of the deal without a challenge. After approval by Wisconsin regulators, Advocate and Aurora Health Care finalized their merger in April 2018.[278] NorthShore has not announced any further merger plans to date; in March of 2018, it was named a Top 100 hospital by Truven Analytics for the 19th consecutive time.[279]

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[273] *Id.* at *57 ("Although the [efficiency] defense has never been sanctioned by the Supreme Court . . ."). *Id.* at *45 ("Where the merger would result in high market concentration levels, as in this case, the defendants must provide proof of 'extraordinary efficiencies' based on a 'rigorous analysis.' ").

[274] *Id.* at *49.

[275] *Id.* at *57. "[A]nalysis sheds little light on what the true level of savings generated by the HPN might turn out to be." *Id.* at *54.

[276] *Id.* at *59; Stefano Esposito, *Advocate, NorthShore Drop Proposed Merger*, CHI. SUN TIMES (Mar. 7, 2017), chicago.suntimes.com/news/federal-judge-blocks-advocate-northshore-merger/.

[277] Alex Kacik, *Advocate Health Crosses State Lines to Merge with Aurora*, MODERN HEALTHCARE (Dec. 4, 2017), www.modernhealthcare.com/article/20171204/news/171209965.

[278] Lisa Schencker, *Advocate Health Care Finalizes Merger with Wisconsin Hospital System*, CHICAGO TRIB. (Apr. 2, 2018), www.chicagotribune.com/business/ct-biz-advocate-aurora-merger-done-20180403-story.html.

[279] Press Release, NorthShore Univ. HealthSystem, NorthShore Named to the IBM Watson Health 100 Top Hospitals List for a Record 19th Time (Mar. 5, 2018), www.northshore.org/newsroom/press-releases/100-top-hospitals/.

III. LESSONS, IMPLICATIONS, AND QUESTIONS

Our discussion of the appellate cases highlights economic and legal questions that are largely closed as well as several that remain open. We begin with the former.

A. COMMON THEMES AND LARGELY CLOSED QUESTIONS

1. *The Two-Stage Model of Provider Competition Is Now the Accepted Model*

Among the common themes across the four provider merger cases, the consistent and strong recognition by the courts of the two-stage model of provider competition stands out. Even though the district courts sometimes ignored that model, the appellate decisions consistently adopted it. For example, the Ninth Circuit characterized the two-stage model of competition as the "accepted model."[280] The Seventh and Third Circuits likewise endorsed the model.[281] Overall, this has placed the analytic focus in analyses of provider mergers squarely on the bargaining between health care payers and providers.

2. *Elzinga-Hogarty Is Unlikely to Be Used in Future Hospital Merger Cases*

The courts' adoption of the two-stage model has clear implications for courts' treatment of E-H and, more broadly, using patient flow to define geographic markets. Although the district courts in *Hershey* and *Advocate* applied E-H analysis (or at least logic that echoes E-H) to define relevant geographic markets, both decisions were overturned, based in part on economic research and submissions by economist amici.[282] The reasoning behind these reversals follows from the two-stage model: hospital prices are determined in stage one, where the customers are payers, not patients. While patient choices in stage two reflect preferences among in-network hospitals, those choices are generally not made based on price. Therefore, patient travel patterns are of limited direct relevance to the SSNIP test.

One possible exception is in the Eighth Circuit, where a 2009 decision rejected an alleged relevant geographic market in a private antitrust suit because the plaintiff "alleges that a low percentage of patients leave its proposed geographic market, but does not allege that a low percentage of its patients enter

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[280] Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 784 n.10 (9th Cir. 2015).

[281] FTC v. Advocate Health Care Network, 841 F.3d 460, 465, 471; FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 342 (3d Cir. 2016).

[282] Capps et al., *supra* note 40.

its proposed geographic market."[283] Further, the court stated that "[t]he end goal in this analysis is to delineate a geographic area where, in the medical setting, 'few' patients leave . . . and 'few' patients enter."[284] That is close to, if not actually, a statement that E-H must be used to define geographic markets in health care merger cases. Even so, in December 2017, the FTC won a preliminary injunction blocking the proposed acquisition of Mid Dakota Clinic by Sanford Health, a horizontal physician merger in North Dakota.[285] The Eight Circuit has heard the appeal but has not yet issued its ruling.[286]

Despite the rejection of E-H for geographic market definition, the circuit courts have not entirely discarded the relevance of patient flow information. The Third and Seventh Circuits both accepted patient flow data, including such evidence as the percentage of patients who stayed within the relevant geographic market for care and the average travel time to chosen hospitals, as part of the basis for concluding that patients prefer local inpatient care.[287]

3. *Acceptance of the Two-Stage Model Has Increased the Importance of Payer Testimony*

Courts' adoption of the two-stage model means they focus on payers as the relevant customer when evaluating market definition and competitive effects. This has elevated the importance of payer testimony in litigated provider mergers. The analysis of payer testimony by courts, however, shows major differences between district and circuit courts.

In *Advocate,* the district court recounted testimony of hospital executives and payers regarding where patients prefer to receive care for more than a

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[283] Little Rock Cardiology Clinic PA v. Baptist Health, 591 F.3d 591, 599 (8th Cir. 2009).

[284] *Id*. at 598 (citing United States v. Rockford Mem. Hosp., 717 F. Supp. 1251 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990)).

[285] Complaint, FTC v. Sanford Health, No. 1:17-cv-00133-DLH-CSM (D.N.D. June 23, 2017), www.ftc.gov/system/files/documents/cases/1710019sanfordfedcomplaint.pdf. Public materials do not indicate whether the merging parties are using E-H or similar methods to define the relevant geographic market. The FTC did argue against using E-H to define the relevant geographic market, citing *Evanston, Advocate*, and *Hershey*. Memorandum in Support of Plaintiffs' Motion for a Preliminary Injunction §1.A.ii, FTC v. Sanford Health, No. 1:17-cv-00133-ARS (D.N.D. Oct. 10, 2017), www.ftc.gov/system/files/documents/cases/1710019sanfordfedpibrief.pdf.

[286] Bryan Koenig, *Standard Too High on ND Drs. Group Merger, 8th Circ. Told*, LAW360 (Nov. 14, 2018).

[287] FTC v. Advocate Health Care Network, 841 F.3d 460, 474–75 (7th Cir. 2016); FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 347 (3d Cir. 2016). The geographic market was undisputed in *ProMedica*, but the Administrative Law Judge also accepted these data. Initial Decision ¶¶ 328–329, ProMedica Health Sys., FTC Docket No. 9346 (Dec. 12, 2011), www.ftc.gov/sites/default/files/documents/cases/2012/01/120105promedicadecision.pdf.

page of its opinion.[288] It described that evidence as "equivocal," and concluded that it did not support the FTC's alleged geographic market.[289] However, on appeal, the Seventh Circuit disagreed, holding that payers "testified unequivocally that it would be difficult or impossible to market a network to employers in metropolitan Chicago that excludes both NorthShore and Advocate" and gave weight to the lack of insurance offerings that omitted the parties' hospitals.[290] *Hershey-Pinnacle* and *ProMedica* include similar language regarding the importance of payer testimony.[291]

4. *Courts Will Likely Continue to Rely on Structural Presumptions and HHIs*

In each FTC win, after resolving the relevant geographic market debate, courts relied, at least in part, on HHIs to conclude that a merger was presumptively anticompetitive. In *ProMedica*, the defendants challenged the applicability of HHIs in differentiated products industries.[292] As we discussed in Part II.A, the Sixth Circuit gave this argument some credit but also offered the FTC a solution. After observing that ProMedica's argument "is one to be taken seriously," the court credited additional evidence the FTC had presented to support the presumption based on HHIs.[293] Specifically, the FTC had shown that concentration was correlated with market power and, for that reason, "the HHI data speak to our 'ultimate inquiry' as directly as an analysis of substitutability would."[294]

Thus, assuming it can sustain a relevant geographic market, the FTC will likely be able to use structural presumptions in its merger challenges. That may require presenting other evidence to establish either that concentration is a reliable predictor of pricing power or that the merging parties are head-to-head competitors, but the FTC generally includes one or both types of evidence in its cases. For example, it commonly uses merger simulation or diversion analysis, along with ordinary-course-of-business documents, to argue that the merging parties are close competitors.

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[288] *See* Amended Memorandum Opinion & Order, FTC v. Advocate Health Care, No. 15-cv-11473, 2016 U.S. Dist. LEXIS 79645, at *10 –11 (N.D. Ill. June 20, 2016) *rev'd & remanded*, FTC v. Advocate Health Care Network, 841 F.3d 460 (7th Cir. Oct. 31, 2016).

[289] *Id.* at *13.

[290] *Advocate Health Care Network*, 841 F.3d at 474–75.

[291] *Hershey Medical Center*, 838 F.3d at 352; Initial Decision at 171–72, 140–45, ProMedica Health Sys., Inc., FTC Docket No. 9346 (Dec. 12, 2011), www.ftc.gov/sites/default/files/documents/cases/2012/01/120105promedicadecision.pdf.

[292] ProMedica Health Sys. v. FTC, 749 F.3d 559, 569 (6th Cir. 2014).

[293] *Id.*

[294] *Id.* at 570.

5. *The "Flailing Firm" Defense Is Unlikely to Be Persuasive*

There is mounting evidence that when hospitals abandon merger plans following agency challenges, the hospitals remain viable and often enter alternate, and unchallenged partnerships:

- After abandoning proposed mergers that were contested by the FTC, Prince William, the Surgical Institute of Reading, Mercy Hot Springs, Rockford Memorial, Pinnacle, and Advocate all entered into transactions with alternative partners that did not draw challenges from antitrust agencies.
- In *ProMedica*, through a Hold Separate agreement, the FTC monitored St. Luke's re-establishment as an independent hospital. Despite concerns raised during the adjudicative process about St. Luke's financial health, the parties ultimately informed the FTC that "St. Luke's will emerge from the divestiture with the necessary financial strength to fund capital expenditures and compete vigorously."[295] One year thereafter, St. Luke's CEO stated, "[W]e're stronger than we've been in a long time."[296]
- In *St. Luke's*, the absence of a Hold Separate agreement complicated the divestiture of Saltzer Medical Group.[297] Even so, Saltzer eventually partnered with Change Healthcare Management, a division of McKesson, and now operates as an independent medical group.[298]

One implication is that the flailing firm defense—labeled a "Hail-Mary pass of presumptively doomed mergers" by the Sixth Circuit—will likely continue to be of little avail to defendants in litigated mergers.[299] At the same time, in our experience, there are examples of non-public merger investigations in which a target hospital's financial challenges are sufficiently deep, and potential quality benefits sufficiently large, that the FTC has allowed a merger to close that it might otherwise have challenged. This may also require

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[295] Application for Approval of Proposed Divestiture of St. Luke's Hospital at 6, ProMedica Health Sys. Inc., FTC Docket No. 9326 (Apr. 25, 2016), www.ftc.gov/system/files/documents/cases/160503promedicaapplication.pdf.

[296] Lindstrom, *supra* note 109.

[297] Lisa Schencker, *Court-Ordered Break Up Is Still Hard to Do*, MODERN HEALTHCARE (July 17, 2015), www.modernhealthcare.com/article/20150717/news/150719929. ("St. Luke's argued in court documents that it needed a master 'because what may have seemed like a simple, straightforward process at the time that divestiture was ordered, has proven not to be so.'").

[298] Government Plaintiffs' Unopposed Motion to Approve the Divestiture of the Saltzer Assets and Business ¶¶ 7–8, Saint Alphonsus Med. Ctr.-Nampa, Inc., v. St. Luke's Health Sys., Ltd., No. 1:12-cv-00560-BLW (D. Idaho filed Apr. 25, 2017), www.ftc.gov/system/files/documents/cases/688_unopposed_motion_saltzer.pdf. St. Luke's apparently had to provide financial and other support to Change Healthcare. *Id.* ¶ 8.

[299] *ProMedica*, 749 F.3d at 572.

the acquired entity to establish that it made a good-faith effort to identify an alternative buyer but was not able to do so.[300]

6. *Conduct Remedies Are Likely to Remain Rare*

In the last decade, the FTC has accepted conduct remedies in several horizontal provider merger cases. Each featured a unique set of circumstances that is unlikely to apply generally. In *Evanston*, by the time litigation wound down, the merger was seven years old. The FTC declined to sunder two hospitals that, by that the end of litigation, had integrated. The FTC also accepted a conduct remedy in *Phoebe Putney*. However, it did so only after the Georgia Department of Community Health indicated that it would not issue the Certificate of Need required for a divestiture to occur.[301] More recently, the FTC accepted a conduct remedy with regard to CentraCare Health System's acquisition of St. Cloud Medical Group (SCMG).[302] That decision was due in large part to the FTC concluding that SCMG is "failing financially" and that the group's "multi-year search did not identify an alternative purchaser."[303]

Absent extenuating circumstances of these sorts, the FTC will likely continue disfavoring conduct remedies. For example, in both *ProMedica* and *St. Luke's*, the parties argued for the use of separate negotiating teams as a remedy, but in both cases this remedy was rejected.[304]

B. LARGELY OPEN QUESTIONS

1. *Hospital-Based Versus Patient-Based Market Shares*

In the *Advocate* case, the FTC adopted a hospital-based approach for calculating market shares. This approach counts only hospitals physically located in the alleged relevant geographic market as market participants and computes

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[300] Fed. Trade Comm'n, Statement of Bureau of Competition Director Richard Feinstein on the FTC's Closure of Its Investigation of Consummated Hospital Merger in Temple, Texas (Dec. 23, 2009), www.ftc.gov/sites/default/files/documents/closing_letters/scott-white-healthcare/kings-daughters-hospital/091223scottwhitestmt.pdf (explaining that another buyer was interested but ultimately decided not to acquire the hospital due to its poor financial condition and other deterioration of the hospital); Press Release, Fed. Trade Comm'n, Healthcare Provider in St. Cloud, MN Settles FTC Charges That Its Acquisition of Rival Provider Would Likely Lessen Competition for Certain Physician Services (Oct. 6, 2016) [hereinafter FTC St. Cloud, MN, Press Release], www.ftc.gov/news-events/press-releases/2016/10/healthcare-provider-st-cloud-mn-settles-ftc-charges-its (stating that the acquired physician group's "multi-year search did not identify an alternative purchaser").

[301] Fed. Trade Comm'n, *supra* note 39.

[302] Agreement Containing Consent Orders, CentraCare Health System, FTC Docket No. C-4594 (Jan. 9, 2017), www.ftc.gov/system/files/documents/cases/170109centracarecomplaint.pdf.

[303] FTC St. Cloud, MN, Press Release, *supra* note 300.

[304] *ProMedica*, 749 F.3d at 572; Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 781 (9th Cir. 2015).

market shares based on the total commercial volume of those within-market hospitals. Thus, Northwestern Memorial and neighboring-but-outside hospitals such as St. Francis did not enter into the FTC's market share calculation at all.[305] An alternative patient-based approach instead measures market shares based on the choices of patients who reside in the relevant geographic market.

These two approaches align with the distinction in the Merger Guidelines between "Geographic Markets Based on the Locations of Customers" and "Geographic Markets Based on the Locations of Suppliers."[306] In many cases, the two approaches will yield similar conclusions, although, in others, they will not. They are more likely to be similar in cases involving relatively isolated, mid-size, or small urban areas, such as Toledo, Ohio, or Rockford, Illinois, and to diverge in denser metropolitan areas.

A surface read of the Merger Guidelines seems to support the supplier-based approach used in *Advocate*: "Geographic markets based on the locations of suppliers encompass the region from which sales are made. Geographic markets of this type often apply when customers receive goods or services at suppliers' locations."[307]

This suggests that, because patients travel to hospitals, the market should be defined on the basis of hospitals' locations, and market shares computed accordingly. In contrast, the Merger Guidelines describe the alternative approach based on the locations of customers as follows: "When the hypothetical monopolist could discriminate based on customer location, the Agencies may define geographic markets based on the locations of targeted customers. Geographic markets of this type often apply when suppliers deliver their products or services to customers' locations."[308]

Hospitals do not price discriminate based on patient location in any obvious way, and they certainly do not deliver inpatient services to patients' homes, so it seems that this approach should not apply to hospitals. This conclusion,

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[305] Complaint at 15, FTC v. Advocate Health Care, No. 15-cv-11473 (N.D. Ill. Dec. 22, 2015). This stands in direct contrast to the Massachusetts Attorney General's challenge to the Partners-South Shore merger. Had Massachusetts adopted the FTC's hospital-based approach, it would have concluded that Partners had a market share of 0 percent in the alleged South Shore area relevant geographic market, which did not physically include a Partners hospital. Instead, Massachusetts adopted a patient-based approach, in which it measured market shares based on the choices of patients who reside in the relevant geographic market. This explains why Partners, with no hospitals in South Shore's service area, had a market share of 24 percent. Commonwealth of Massachusetts Health Policy Comm'n, Review of Partners HealthCare System's Proposed Acquisitions of South Shore Hospital (HCP-CMIR-2013-1) and Harbor Medical Associates at 17 (HPC-CMIR-2013-2) (Feb. 19, 2014), www.mass.gov/anf/docs/hpc/20140219-final-cmir-report-phs-ssh-hmc.pdf.

[306] Merger Guidelines, *supra* note 58, § 4.2.1.

[307] *Id.*

[308] *Id.* § 4.2.2.

however, overlooks the significance of the two-stage model of competition.[309] Because prices are determined in stage one, when insurers and providers negotiate to determine whether and under what terms providers will participate in insurers' networks, the relevant customer (the insurer) does not "receive goods or services" at the location of the hospital. Instead, the insurer is building a network, which it sells primarily to employers, who in turn offer those networks as part of their employee benefit packages. The insurer is marketing its products to employers (and their employees) where they reside. In this sense, the economic transaction aligns more closely, though perhaps not perfectly, with the language describing geographic markets based on the locations of customers (in stage one, the insurer and not the patient is the customer). It is only in stage two that the customer (patient) travels to the seller (hospital), but that is not the stage in which prices are determined and is therefore less relevant to market definition and the hypothetical monopolist test.

In practice, measuring shares under both approaches may be useful. For example, if there are only two hospitals in a relevant geographic market, the post-merger supplier-based share will be 100 percent. Assuming the relevant geographic market is appropriately defined, that reflects the important piece of information that it would be impossible for insurers to offer any local hospital at all without the merged hospitals. At the same time, if there is a somewhat distant hospital that draws a significant percentage of patients from the area, that information is also relevant to the analysis of the merger.

As a final note, this distinction is only relevant to the structural exercise of calculating market shares and drawing inferences from concentration statistics. The empirical tools that economists use to directly asses the competitive effects of mergers, such as evaluating diversions, measuring willingness-to-pay, or merger simulation, generally do not depend on market definition.

2. *Geographic Market Definition in Large Metropolitan Areas*

The FTC has won multiple cases in smaller or mid-size cities, such as Toledo, Ohio; Rockford, Illinois; Nampa, Idaho; and Harrisburg, Pennsylvania. It has only one modern case in a large metropolitan city, Chicago, Illinois (*Advocate*). It is often challenging to draw sharp geographic market lines in larger cities with dozens of hospitals. For instance, for any geographic boundaries drawn within a metropolitan area, it will usually be the case that the distance, whether measured by miles or diversions, between an excluded hospital and an included hospital will be smaller than the distance between some of the included hospitals.

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[309] *See supra* Part I.B.; s*ee also* Capps et al., *supra* note 17; Vistnes, *supra* note 15.

For example, in *Advocate*, the FTC excluded St. Francis and Northwestern Memorial hospitals from its alleged relevant geographic market. St. Francis was geographically closer to NorthShore's Evanston Hospital than to any Advocate hospital. And diversions from Evanston Hospital to Northwestern Memorial Hospital were on a par with or above diversions between the parties' hospitals. Ultimately, neither factor undermined the FTC's case in *Advocate*. However, with only one case addressing these issues, there is less certainty that the same outcome will result in the next case.

3. *The Efficiency Defense*

As discussed above, district and appellate courts have expressed strong skepticism and articulated a high bar for the efficiency defense. Yet, efficiencies feature prominently in the Merger Guidelines. This leads to the question: how high is the high bar? Without a ruling that credits the efficiency defense in allowing a challenged merger to proceed, it is not possible to provide a precise answer.

In *St. Luke's-Saltzer*, it was the FTC's expert rather than the merging parties' expert who conducted an analysis of the acquirer's past physician group acquisitions. That analysis concluded that there was no evidence of overall medical cost savings—one of the central goals of population health management and efforts to "bend the cost curve"—from St. Luke's past acquisitions and some evidence that medical expenditures had increased.[310] If the evidence had instead supported the conclusion that St. Luke's past physician group acquisitions had lowered overall medical expenditures, even if they entailed some increases in unit prices for physician services, St. Luke's may have had a convincing case that efficiencies would outweigh harms. After all, premiums are driven by total medical expenditures—price times quantity—and not just prices.[311]

As consolidation continues, more acquirers are likely to have track records that could be used to shore up, or rebut, efficiency claims.[312] In turn, this could

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[310] Plaintiffs' Demonstratives for the Testimony of Dr. Dranove at 50–51, Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 12-cv-560-BLW (D. Idaho filed Oct. 2, 2013), www.ftc.gov/system/files/documents/cases/131002stlukedemodranove.pdf.

[311] For physicians, it is not just the quantity of services they render, but the quantity and nature of services they direct. As recounted by Atul Gawande, "Physicians' after-expense incomes are a fairly small percentage of medical costs. But we're responsible for most of the spending. For the patients I see in the office in a single day, I prescribe somewhere around thirty thousand dollars' worth of medical care—in the form of specialist consultations, surgical procedures, hospital stays, X-ray imaging, and medicines." Atul Gawande, *Piecework: Medicine's Money Problem*, NEW YORKER, Apr. 4, 2005, at 44.

[312] If an acquirer consistently makes care delivery demonstrably more efficient post-acquisition, that could provide inferential evidence that the acquisition targets were unwilling or unable to so on their own, one element needed for an efficiency to be cognizable. This inferential argu-

help sharpen the lines for when the courts, or the agencies in their exercise of discretion, will credit efficiencies.

4. *Divestiture Remedies*

Only a few of the 70–100 hospital mergers that occur each year are challenged on antitrust grounds and, of late, blocked. Consequently, the industry landscape is consistently moving toward larger hospital systems, albeit with some limits imposed by antitrust enforcement. Given this, it is likely that some future challenged merger will involve systems that each own more than one hospital in the relevant market alleged by the FTC. In such cases, an FTC challenge could, perhaps, be resolved by divesting one or more hospitals in the area of competitive overlap. As yet, defendant hospitals in litigated merger cases have only proposed conduct remedies, not divestitures.[313]

Of the recent cases, only *Advocate* presented a potential for a divestiture remedy. Inspection of the map included in the Seventh Circuit opinion indicates that two NorthShore hospitals, Glenbrook and Skokie, were located in between the flagship hospitals of the two systems.[314] The public record gives no indication that the parties or the FTC ever considered divestiture, but it is at least possible that a divestiture of one or both Glenbrook and Skokie could have addressed the FTC's concerns. Given the FTC's recent wins, parties pursuing similar mergers may be more inclined to offer divestitures.

IV. LOOKING FORWARD

The growing body of case law, now including four appellate decisions, should provide reasonably clear guidance on which horizontal provider mergers are likely to draw a challenge. Even so, the industry continues to evolve, and economic research is advancing along with it. We close with a brief discussion of ongoing and potential future economic research and the implications that it may have for antitrust enforcement in the health care industry.

One area of research that has generated a lot of interest, but as yet no antitrust litigation, is cross-market mergers. A cross-market merger, as the name

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ment alone may not be sufficient to establish merger specificity, but it could provide guidance into that inquiry. Moreover, some limiting principle must apply—a successful track record of past acquisitions would not logically imply free reign over future mergers and acquisitions.

[313] Community Health System agreed to divest several hospitals as part of its acquisition of the hospital chain Health Management Associates. However, that was more akin to the divestitures in retail or banking mergers, where the merger spans many geographic markets, only a few of which have significant overlap. Press Release, Fed. Trade Comm'n, FTC Requires Community Health Systems, Inc. to Divest Two Hospitals as a Condition of Acquiring Rival Hospital Operator (Jan. 22, 2014), www.ftc.gov/news-events/press-releases/2014/01/ftc-requires-community-health-systems-inc-divest-two-hospitals.

[314] FTC v. Advocate Health Care Network, 841 F.3d 460, fig.1 (7th Cir. 2016).

suggests, combines hospitals that are geographically separate and are not viewed by patients as close substitutes. Examples could include a system expanding within a state, and a merger of two hospitals located in different portions of a large city such that few if any patients would ever choose between them. Recent research offers evidence of price increases following such mergers, but economists have not reached a consensus on the cause and mechanisms of such price increases.[315]

Gregory Vistnes and Yianis Sarafidis argue that cross-market mergers can increase bargaining leverage through the medium of employers whose employees live in the affected markets.[316] Their logic is that employers may be willing to tolerate an inferior provider network in one portion of a metropolitan area—a "hole"—but that having multiple such holes quickly becomes untenable. This implies that hospitals that are not substitutes in the eyes of individual patients can be substitutes for employers and, therefore, for the payers that sell health insurance products to those employers. As Vistnes and Sarafidis point out, similar reasoning could apply to mergers of hospitals and physicians, which are both inputs into insurers' provider networks.[317] Matthew Lewis and Kevin Pflum offer the alternative explanation that cross-market mergers can improve the overall negotiating abilities of the combined system, making the merged entity more adept at using its existing bargaining leverage.[318] If the research literature reaches a firmer conclusion that cross-market mergers can enhance market power, the question remains as to whether an agency will bring a challenge on that theory and, if so, how it will describe the relevant product and geographic markets.

Vertical mergers, especially acquisitions of physician groups by hospital systems, have also been on the rise. Hospitals may acquire physician groups to protect or expand their patient referral base, or they may do so to generate efficiencies by, for example, solving coordination problems, internalizing

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[315] Leemore Dafny, Katherine Ho & Robin Lee, *The Price Effects of Cross-Market Hospital Mergers* (Nat'l Bureau of Econ. Research,Working Paper No. 22106, 2018), www.nber.org/papers/w22106; Matthew Lewis & Kevin Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, 48 RAND J. ECON. 579 (2017).

[316] Gregory Vistnes & Yianis Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79 ANTITRUST L.J. 253, 255 (2013).

[317] In a 2014 speech, Aviv Nevo, then chief economist at the Antitrust Division, explained how similar logic could apply in other industries that feature intermediaries who assemble varying inputs into a bundle that is sold to customers. For example, smartphone sellers can replace one feature with another even if the features do not offer similar functionality; cable providers may be able to replace one channel with another having very different characteristics (e.g., CNN vs. ESPN). Aviv Nevo, Former Deputy Assistant Att'y Gen., Presentation, Department of Justice: Mergers That Increase Bargaining Leverage (Jan. 22, 2014), www.justice.gov/atr/speech/mergers-increase-bargaining-leverage.

[318] Matthew Lewis & Kevin Pflum, *Diagnosing Hospital System Bargaining Power in Managed Care Networks*, 7 AM. ECON. J.: ECON. POL'Y 243, 269–71 (2015).

negative externalities, or facilitating relationship-specific investments. These various rationales may all be present at once. Given their increasing frequency, vertical combinations could give rise to antitrust enforcement. As noted in the cross-market discussion above, hospitals and physicians are both inputs into insurers' provider networks, and their combination conceivably could be cast as a cross-market merger. Another possible basis would be a vertical foreclosure theory that one hospital system could, by acquiring sufficient physicians, deprive its rival of patients and thereby lessen hospital competition.[319] Whatever the mechanism, recent economic research has found evidence that, on average, physician prices and overall medical spending increase after hospital systems acquire physician groups.[320] Thus, another area for further study is to determine where and how hospital-physician integration is likely to change prices and medical expenditures. Even if that is resolved, the FTC and DOJ rarely seek to block a merger on a purely vertical theory of harm.[321] (DOJ's recent lawsuit seeking to block AT&T's acquisition of Time Warner is a notable exception.[322])

As the industry continues moving toward value-based payment, efficiencies also remain an open question. As discussed herein, courts apply an exacting standard to efficiency defenses and the Merger Guidelines, while less skeptical, require that efficiencies be non-speculative, verifiable, and merger-specific.[323] Public health researchers continue to investigate the characteristics of a successful Accountable Care Organization and how to make those traits

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[319] This was the basis of the private suit brought in *St. Luke's-Saltzer*. See discussion Part II. Because the court in that case ruled against the merger on horizontal grounds, it did not address the vertical theory of harm.

[320] Cory Capps et al., *supra* note 156; Laurence Baker, M. Kate Bundorf & Daniel Kessler, *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending*, 35 HEALTH AFF. 756 (2014); Laurence Baker et al., *The Effect of Hospital/Physician Integration on Hospital Care*, 50 J. HEALTH ECON. 1 (2016); Thomas Koch et al., *How Vertical Integration Affects the Quantity and Cost of Care for Medicare Beneficiaries*, 52 J. HEALTH ECON. 19 (2017).

[321] Steven C. Salop & Daniel P. Culley, Vertical Merger Enforcement Actions: 1994–July 2018 (Geo. Law Faculty Publ'ns & Other Works 1529, 2018), scholarship.law.georgetown.edu/facpub/1529. Conduct remedies are more common when the DOJ or FTC raises vertical concerns. Notably, however, the current head of the Antitrust Division expressed concern over conduct remedies generally and cautioned that "certain instances where an unlawful vertical transaction generates significant efficiencies that cannot be achieved without the merger or through a structural remedy, then there's a place for considering a behavioral remedy if it will completely cure the anticompetitive harms. It's a high standard to meet." Makan Delrahim, Assistant Att'y Gen., Antitrust Div., U.S. Dep't. of Justice, Antitrust and Deregulation: Remarks at American Bar Association Antitrust Fall Forum (Nov. 16, 2017), www.justice.gov/opa/speech/file/1012086/download.

[322] Press Release, Dep't of Justice, Justice Department Challenges AT&T/DirecTV's Acquisition of Time Warner (Nov. 20, 2017), www.justice.gov/opa/pr/justice-department-challenges-attdirectv-s-acquisition-time-warner.

[323] Merger Guidelines, *supra* note 58, § 10.

generalizable.[324] Understanding how and where horizontal and vertical integration are likely to advance the transition from volume-based to value-based care (relative to what merging parties could achieve absent a merger) is an important area for further research. There is also a role for the health care industry to develop evidence on mergers that result in lower costs, improve quality, or create additional value through cognizable and merger-specific efficiencies.[325]

State enforcement with respect to provider mergers also remains an area of enforcement and regulatory activity. Several states have taken actions to shield merging hospitals from FTC challenges.[326] Other states have launched merger challenges without being joined by a federal agency.[327] For states that shielded mergers, the underlying premise was that the mergers would yield benefits, while regulation would ameliorate the adverse effects of lessened competition. As data become available, research into the performance of systems created by state action-enabled mergers is likely to prove valuable. If such research shows real benefits, more states may follow suit, or the FTC may reconsider the viability of conduct remedies in hospital merger cases. If research shows harm with respect to prices, overall spending, or quality, then the FTC and DOJ are likely to maintain their current stance in opposition to cooperative agreements. Potentially, states that have granted cooperative agreements could modify or rescind them.[328]

This review of hospital merger enforcement makes clear that economic research has played a central role in changing how courts evaluate hospital

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[324] J. Michael McWilliams et al., *Early Performance of Accountable Care Organizations in Medicare*, 374 NEW ENG. J. MED. 2357 (2016).

[325] Leemore Dafny & Thomas Lee, *The Good Merger*, 372 NEW ENG. J. MED 2077 (2015).

[326] Coop. Agreement Decision at 79l, Cabell Huntington Hospital, Inc., No. 16-2/3-001 (W. Va. Health Care Auth. June 22, 2016), www.hca.wv.gov/About/Documents/Decision.pdf. Press Release, Tenn. Dep't of Health, Tennessee Grants Certificate of Public Advantage for Wellmont Health System, Mountain States Health Alliance (Sept. 19, 2017), www.tn.gov/health/news/2017/9/19/tennessee-grants-certificate-of-public-advantage-for-wellmont-mountain-stat.html; Va. Dep't of Health, Order & Letter Authorizing a Cooperative Agreement (Oct. 30, 2017), www.vdh.virginia.gov/content/uploads/sites/96/2017/10/Order-and-letter-authorizing-a-cooperative-agreement.pdf.

[327] Decision & Order at 2, Commonwealth of Mass. v. Partners Healthcare Sys., Inc., No. 14-02033-BLS2 (Mass. Jan. 29, 2015), www.mass.gov/ago/docs/press/2015/partners-memo-of-decision-and-order.pdf; Wash. v. Franciscan Health Sys., No. 3:17-cv-05690 (W. Wash. filed Aug. 8, 2017), agportal-s3bucket.s3.amazonaws.com/uploadedfiles//News/Press_/Filed%20redacted%20complaint.pdf.

[328] In the Mountain States-Wellmont merger, Tennessee required the systems to file a "plan of separation" that is "intended to set out the process by which the Parties would effect an orderly separation of the new, integrated health system to be created under the COPA [Certificate of Public Advantage] . . . in the event that the Department determines that it is necessary to terminate the COPA previously granted to the Parties." Revised Plan of Separation Between Wellmont Health System and Mountain States Health Alliance (Sept. 9, 2016), www.tn.gov/assets/entities/health/attachments/Revised_Plan_of_Separation_9.9.16.pdf.

mergers. Although it was issued after most of the cases described above, the Supreme Court's recent ruling in *Kimble v. Marvel Entertainment* describes a continuing role for economic research in antitrust generally.[329] There, the Supreme Court took care to distinguish antitrust from other areas of law in that antitrust law *should* change in response to new economic research:

> This Court has viewed *stare decisis* as having less-than-usual force in cases involving the Sherman Act. Congress, we have explained, intended that law's reference to "restraint of trade" to have "changing content," and authorized courts to oversee the term's "dynamic potential." We have therefore felt relatively free to revise our legal analysis as economic understanding evolves and . . . to reverse antitrust precedents that misperceived a practice's competitive consequences.[330]

Hence, we expect that economic research will continue to play a significant role in how the agencies and the courts apply the antitrust laws to health care provider mergers and, by implication, will continue to affect the types of transactions that health care providers pursue.

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[329] Kimble v. Marvel Entm't, 135 S. Ct. 2401 (2015).

[330] *Id.* at 2412–13 (citations omitted).