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EDITOR'S REPORT

Welcome to the latest edition of the ABA Antitrust Health Care Chronicle. We are pleased to present two articles for this issue, the first of the ABA's 2021-22 year. Our first article is an interview with Peter Mucchetti, partner at Clifford Chance and the former Chief of the Healthcare and Consumer Products Section for the U.S. Department of Justice's Antitrust Division. The second article reviews recent remedies by federal and state antitrust agencies in healthcare provider transactions.

If there is a topic that you would like to see covered in a Committee program or if you have any other suggestions, please contact the Committee Co-Chairs, Lauren Rackow (LRackow@cahill.com) or Amy Ritchie (aritchie@ftc.gov).

If you would like to submit an article for the Chronicle, please contact Amanda Lewis (alewis1@ftc.gov) or Andrew Hatchett (andrew.hatchett@alston.com) or Paul Wong (paul.wong@nera.com).

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ABA SECTION OF ANTITRUST LAW
Promoting Competition Protecting Consumers

ENFORCER INSIGHTS: AN INTERVIEW WITH PETER MUCCHETTI, FORMER CHIEF OF THE HEALTHCARE AND CONSUMER PRODUCTS SECTION FOR THE U.S. DEPARTMENT OF JUSTICE'S ANTITRUST DIVISION

Peter Mucchetti is a partner at Clifford Chance in Washington, D.C., specializing in antitrust and litigation matters, including in the healthcare, technology, and consumer goods sectors. He has more than two decades of antitrust litigation, investigations, and merger clearance experience. Prior to joining Clifford Chance, Peter worked at the U.S. Department of Justice ("DOJ") Antitrust Division, where he served as the Chief of its Healthcare and Consumer Products Section. While at the DOJ, among many cases, Peter oversaw the clearance of the CVS/Aetna merger, the successful challenge of the Anthem/Cigna and Aetna/Humana mergers, and multiple litigations concerning hospital system conduct, including *United States v. Carolinas Healthcare System* (W.D.N.C. 2018) and *United States v. Hillsdale* (E.D. Mich. 2018). In this issue, we discuss the antitrust landscape with Peter from his view as a recent former enforcer.

Peter Mucchetti
Partner, Clifford Chance
Former Chief of the Healthcare and Consumer Products Section for the U.S. Department of Justice's Antitrust Division

New Issues in Healthcare Antitrust

There is a lot of debate about rethinking the approach to antitrust analysis. How would you summarize the status quo and proposed changes?

Congress, the antitrust agencies, consumer groups, and the business world are devoting a tremendous amount of resources towards re-examining the appropriate scope and application of competition law. The changes being made at the Federal Trade Commission ("FTC") by Chair Lina Khan show both how antitrust policy is being reconsidered and what the future holds for many merger and conduct matters. These changes include an increased aggressiveness in antitrust enforcement and examination of concerns beyond historical consumer-welfare considerations. Spurred on by a recent Executive Order from President Biden, other agencies also are searching for new ways to promote competition.

For example, in July 2021, the FTC rescinded its 2015 policy statement concerning Section 5 of the FTC Act. That statement essentially limited the FTC's application of Section 5 to traditional consumer welfare-enhancing situations. Signaling their desire to more aggressively and expansively use Section 5, Chair Khan and Commissioners Rebecca Slaughter and Rohit Chopra said that the policy inappropriately constrained the agency's use of its authority to stop anticompetitive business tactics. Using strong language, they argued that the 2015 policy statement was "shortsighted" and "doubled down on the Commission's longstanding failure to investigate and pursue 'unfair methods of competition.'" Commissioners Noah Phillips and Christine Wilson voted against the majority, an outcome that we may well see in many future matters.

Continuing this expansive trend, a majority of the FTC Commissioners voted in September to withdraw the FTC's approval for the Vertical Merger Guidelines. The Guidelines, which had been approved by the FTC and DOJ just one year earlier, provided companies with increased transparency about the framework that the agencies use when assessing vertical mergers. DOJ has stated that, while it will currently leave the Guidelines in place, it is reviewing whether to update the Guidelines. Hopefully, the agencies will explain to the public the criteria that they are currently using to consider vertical issues as that will allow consumers, parties, and other industry participants to better engage with the agencies on these issues.

Of course, the fact that the underlying antitrust laws have not changed will limit the FTC's and DOJ's ability to successfully litigate more matters. But Congress is considering easing the standards that the agencies must meet to establish an antitrust violation. The combination of aggressive antitrust agencies and lower thresholds for proving competition violations would significantly increase the number of antitrust legal challenges.

Another important development is that DOJ and FTC are placing more emphasis on factors that go beyond traditional notions of consumer welfare to consider ESG (environmental, social, and governance) and equity factors. For example, during an ABA panel this summer, DOJ and FTC officials commented that antitrust enforcers have carefully examined certain transactions to better understand how they impact seniors and the lower-income populations. Businesses are also prioritizing ESG improvements, and the ability to explain how a transaction or policy will affect these factors is becoming increasingly important.

Finally, antitrust policy has garnered significant attention beyond the FTC and DOJ. In July, President Biden signed an Executive Order on Promoting Competition in the American Economy, a sweeping statement on the administration's focus on antitrust enforcement. The Order contains 72 initiatives and calls to action more than a dozen federal agencies in what the Order terms a "whole-of-government approach" to competition. Notably, the order highlights several markets, including labor and healthcare. DOJ and the FTC will continue to lead the administration's competition efforts, but the Department of Health and Human Services, the Department of Transportation, and other federal agencies can also be expected to significantly increase their competition advocacy and enforcement efforts.

Are their particular applications to healthcare settings?

Yes, in part because promoting competition in healthcare markets has been and continues to be a major focus of federal and state competition agencies across a variety of markets. For example, in labor markets, DOJ announced in October 2016 that it would criminally prosecute anticompetitive wage-fixing and no-poach agreements between competitors that are not reasonably related to any pro-competitive purpose. True to its word, DOJ has brought three criminal labor-market cases, all in the healthcare sector. In *United States v. Jindal*, the DOJ brought criminal charges against the former owner of a Texas healthcare staffing company for allegedly conspiring to fix wages for physical therapists and physical therapist assistants. In its second case, *United States v. Surgical Care Affiliates*, the DOJ indicted an outpatient medical care company for allegedly agreeing with competitors not to solicit each other's senior-level employees. In the last case, *United States v. Hee*, a federal grand jury in Las Vegas returned an indictment charging a health care staffing company and a former manager with conspiring to allocate employee nurses and to fix the wages of those nurses.

Federal and state antitrust agencies are also more closely considering the potential for disparate impacts on vulnerable communities when evaluating business conduct and mergers, especially in the healthcare sector. In the Hee case, for example, the DOJ noted that the alleged allocation and wage-fixing scheme was especially harmful because it targeted nurses who served medically fragile students.

Two recent merger cases also show the DOJ's and FTC's concerns about vulnerable communities. In *United States v. Aetna*, the DOJ and nine attorney general offices sued to block the merger of two of the largest health insurers in the United States—Aetna and Humana. The DOJ's case focused on competition in the sale of Medicare Advantage health plans for seniors. The DOJ emphasized that the loss of competition between the parties

would have particularly harmed seniors, who tend to have lower and fixed incomes, and who are twice as likely to visit a doctor.

And in the Jefferson-Einstein case, the FTC and the Pennsylvania Attorney General unsuccessfully challenged the proposed merger of the Jefferson Health System and Albert Einstein Healthcare Network. The government plaintiffs argued that the case was especially important in part because the largest of the acquired hospitals, Einstein Medical Center Philadelphia, was a "safety net hospital" with eighty-seven percent of its inpatients being government‐insured.

We can see how these new issues could lead to more deals being blocked. But could they also help some deals?

There are two sides to this issue. Just as agencies consider the potential for harm to vulnerable populations, they should also consider the potential benefits from efficiencies that would help vulnerable populations. For this reason, parties should be prepared to demonstrate how vulnerable populations would benefit from proposed mergers or business conduct. Mergers and business conduct may produce synergies that lower healthcare costs, improve quality, and enhance innovation. In turn, these procompetitive changes can have an outsized benefit for vulnerable populations. In the Jefferson-Einstein case, for example, the parties argued that the merger was motivated in part to improve the financial situation driven by its payor mix, which in turn would enable the hospitals to better serve government-insured patients.

Parties should also examine how past mergers or conduct improved service offerings and enhanced access to care. Evidence that past transactions and conduct benefitted consumers is one of the most effective ways to demonstrate that similar actions will help vulnerable populations and other consumers.

Analysis of Vertical Healthcare Mergers

There has been a lot of debate about the Vertical Merger Guidelines. The DOJ has, thus far, stood by the guidelines from 2020. Do you think the Guidelines reflect the DOJ's approach to vertical mergers?

Yes, the Vertical Merger Guidelines fairly reflect how the DOJ approaches vertical issues. And antitrust practitioners agree in many key respects on the analytical framework for examining vertical mergers and conduct. To the extent that the FTC intends to apply different standards for looking at vertical issues, consumers would be best served if the FTC articulates its standards and gives the public an opportunity to comment on those standards. With the 2020 Vertical Merger Guidelines and other significant policy updates, both agencies have effectively used the public-comment process to improve upon initial drafts.

To that end, what DOJ healthcare cases illustrate the approach to vertical mergers?

Two helpful examples are the DOJ's review of the CVS-Aetna and Cigna-Express Scripts mergers. In both cases, the DOJ released a public statement explaining its framework for considering vertical issues and a high-level explanation of the facts that supported its conclusion. For example, in Cigna-Express Scripts, the DOJ considered how the merger would affect Express Scripts' incentive to provide competitive PBM services to Cigna's health insurance rivals. Using a traditional framework for vertical analysis, the DOJ found that the merger likely would not enable Cigna to increase costs to Cigna's health insurance rivals because of competition from stand-alone and vertically integrated PBMs. In the CVS-Aetna merger, the DOJ considered whether the merger would raise the cost of (i) CVS/Caremark's PBM services or (ii) CVS's retail pharmacy services to Aetna's health insurance rivals. Again, applying traditional

vertical principles, the DOJ determined that the merger likely would not cause CVS to increase the price of either service to Aetna's health insurance rivals due to competition from other PBMs and retail pharmacies.

What are cases to watch going forward?

The UnitedHealth-Change Healthcare merger review is one to watch. In January 2021, UnitedHealth Group announced that it planned to acquire Change Healthcare for $13 billion. In March 2021, the DOJ issued a second request for further information to the companies. The proposed merger raises both horizontal and vertical questions, and has drawn opposition from some industry participants. Key issues to be determined are what markets the DOJ believes are affected and the scope of an acceptable remedy, if any, for any impacted markets.

Joint Ventures

The DOJ successfully challenged Geisinger's joint venture. Can you summarize that case? What is notable about it?

In February 2019, Geisinger Health and Evangelical Community Hospital agreed to a partial acquisition where Geisinger would acquire a 30 percent interest in Evangelical for $100 million. The DOJ filed a complaint challenging the transaction in August 2020. Geisinger operated 12 hospitals in Pennsylvania and New Jersey. Evangelical was an independent community hospital in nearby Lewisburg, Pennsylvania. The DOJ alleged that the transaction created significant competitive entanglements between the hospitals, reducing their incentives to compete against each other and increasing the likelihood of coordination.

In March 2021, the DOJ announced a settlement between Geisinger and Evangelical. As part of the final judgment, Geisinger's ownership interest in Evangelical was capped at a 7.5% passive interest.

What is notable about the case is that DOJ challenged a partial acquisition, which shows that companies should not expect a pass for transactions only involving the acquisition of a minority stake. The case is also notable because DOJ alleged the existence of a no-poach agreement between the two companies. As a result of the DOJ's lawsuit, a class action lawsuit was filed in February 2021 against Geisinger and Evangelical, alleging that the hospitals agreed not to recruit each other's health care professionals. This case is another example showing the increasing importance of antitrust labor issues, particularly in healthcare.

The Horizontal Merger Guidelines spell out how the agencies approach joint ventures. Is that guidance applicable heading forward? Did the Geisinger case follow that approach?

The Horizontal Merger Guidelines—and much of the other guidance provided by the antitrust agencies, such as the Guidelines for Collaboration Among Competitors—continue to provide sound guidance on how the agencies analyze mergers, partial mergers, and joint ventures that are similar in effect to mergers. And the DOJ followed those guidelines in its approach to the Geisinger case.

Is there room for joint ventures that go beyond the Geisinger settlement? For example, could a different joint venture among competitors go above 7.5 percent ownership interest? If so, what should companies consider in structuring a joint venture?

As with many antitrust issues, it all depends on the facts of the particular situation. But the considerations for a joint venture are often essentially the same as for a merger. For example, the analysis would consider how closely do the parties compete, the amount of market concentration, ease of entry, and the procompetitive effects of the joint venture.

I do not believe that the Geisinger settlement should be read to mean that the DOJ (or the FTC) will always allow a company to purchase up to 7.5 percent of a competitor. Rather, the DOJ was comfortable with this ownership percent for limited reasons. As explained in the Competitive Impact Statement, the 7.5 percent ownership interest was obtained in exchange for the approximately $20 million already paid by Geisinger to Evangelical, and Evangelical could only use the $20 million for two specified projects: improving Evangelical's patient rooms and sponsoring a local center for recreation and wellness.

Criminal Cases

We have recently seen several criminal antitrust cases brought by the DOJ. Can you summarize these cases?

In March 2020, Florida Cancer Specialists & Research Institute, LLC ("FCS") was charged with participating in a conspiracy to suppress and eliminate competition by allocating medical treatments for cancer patients between 1999 and 2016. The DOJ alleged that the parties agreed to allocate medical oncology treatments to FCS while allocating radiation oncology treatments to a competitor located in three Florida counties. FCS entered into a deferred prosecution agreement ("DPA") with the DOJ under which FCS paid $100 million in criminal antitrust penalties to resolve the federal charges and paid $20 million to the state of Florida. In addition, the founder and former President of FCS was indicted; that case remains ongoing.

In another case, the DOJ has charged seven generic drug manufacturers with per se criminal violations including conspiring to fix prices, rig bids, and allocate customers for generic drugs between May 2013 and December 2015. Five of the companies resolved the charges via DPAs, paying a combined total of more than $426 million in criminal antitrust penalties. Two additional companies await trial. In addition, four senior executives have been indicted on criminal antitrust charges, with three entering plea agreements, averting prison sentences of up to 10 years each provided that they continue to cooperate with the government.

What are some of the reasons why the DOJ uses DPAs with healthcare companies?

First, as background, a DPA is an agreement under which the government brings charges against a defendant but agrees not to move forward with its case. In exchange, the defendant agrees to abide by certain conditions, admit wrongdoing, and pay a hefty penalty. In addition, the recipient must take on certain additional burdens, such as agreeing to cooperate with the DOJ's investigation of other conspirators and even the company's employees. If the defendant abides by the terms of the DPA for a designated period (usually several years), the DOJ will ultimately drop the charges. If, however, the recipient fails to abide by the terms of the agreement, the DOJ can enforce the indictment against the company, relying on the company's admission of criminal wrongdoing to swiftly obtain a criminal conviction.

In the healthcare sector, the DOJ may be hesitant to bring a criminal case because collateral consequences may harm consumers. For example, a criminal guilty plea might—by operation of law—bar a company from participating in federal healthcare programs. In part for this reason, the DOJ may opt for a DPA.

Is recent criminal enforcement a sign of more to come?

I believe so. DOJ has placed significant emphasis on criminal enforcement in the healthcare sector over the last few years, including bringing three criminal no-poach and wage-fixing cases in the healthcare industry. These efforts squarely support President Biden's call for vigorous antitrust enforcement.

Concluding Thoughts

We have talked a lot about changes in antitrust enforcement. What are some changes you would like to see in the context of healthcare related enforcement?

One policy statement that would benefit from updating is the 1996 Statements of Antitrust Enforcement Policy in Health Care (the "Healthcare Guidelines"), which address a variety of issues concerning healthcare providers and health insurance companies. Some of the statements have aged well and provide regularly used guidance. But other statements have largely been ignored or effectively been replaced by subsequent guidance. Three areas where these guidelines can be updated concern: (1) steering restrictions in hospital-payer contracts; (2) the acceptable structure of hospital discounts to payers; and (3) lessons from the COVID-19 crisis on how competitors may collaborate to address healthcare crises. These statements would also benefit from the creation of new "safety zones" describing conduct that the agencies will not challenge under the antitrust laws absent extraordinary circumstances.

Given the shifting antitrust landscape, what advice would you have for companies navigating healthcare deals in front of the agencies?

I would recommend that the parties be prepared to affirmatively explain why the proposed transaction helps consumers. Also, companies should take an "eyes wide open" approach given the heightened level of scrutiny that mergers are receiving. Finally, companies should be realistic in what remedies might be approved, as the agencies are not likely to accept only behavioral or piecemeal remedies.

CONDUCT AND STRUCTURAL MERGER REMEDIES IN RECENT HEALTHCARE PROVIDER DEALS

Antitrust merger enforcement has been a popular topic as of late, including enforcement of hospital and healthcare provider mergers. Consolidation in the healthcare industry continues to be a focal issue, as 66% of hospitals are part of a larger system as of 2017, up from only 53% in 2005.[2] Provider mergers are often subject to review and, occasionally, challenge by federal and state authorities. Typically, the Federal Trade Commission (FTC) and state Attorneys General (AGs) are responsible for scrutinizing and then, depending on the findings of their reviews, challenging potentially anticompetitive mergers. As an alternative to an outright challenge of the transaction, however, the agencies may agree to "remedies" that allow a transaction to proceed subject to stipulations that reduce or eliminate projected anticompetitive effects.

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There are two main types of remedies that can address competitive concerns. First, there are "structural" remedies, which typically require the sale of assets of the merging firms. This process, known as divestiture, does not require long-term monitoring or ongoing enforcement.[3] Structural remedies avoid making enforcers into regulators and, as long as they are successful, maintain the competitive status-quo. However, structural remedies may not produce the desired result if the new buyer is not successful with the divested assets. For example, an agency may require a hospital system to divest outpatient assets before merging with another hospital system to maintain competition in the outpatient market post-transaction. However, if the buyer of the outpatient assets goes out of business the following year, the existing pre-merger competition in the outpatient market will not be preserved long-term.[4] Therefore, the agencies generally only agree to divestitures that seem likely to have lasting success.

The second type of remedy is a "conduct" remedy. These provisions are intended to limit the future behavior of the merging parties, allowing the transaction to proceed but preventing potential anticompetitive effects through behavioral modifications and ongoing, external enforcement and monitoring. For example, an agency may implement price caps or quality commitments for a certain number of years post-transaction. This may assuage concerns about an otherwise anticompetitive merger by suppressing consumer harm that would arise but for the remedy. However, these remedies are often more costly and complex to implement, as they require ongoing monitoring to ensure compliance with the remedy. Additionally, the conduct is often only enforced for a limited time post-transaction, which means it is possible for the merging parties to still pursue anticompetitive conduct in the long-run once they are no longer subject to the remedy's stipulations.

The FTC and the Department of Justice (DOJ) have often taken the stance that structural remedies are preferrable to conduct remedies.[5] The DOJ Antitrust Division's Merger Remedies Manual states this preference is because "[structural remedies] are clean and certain, effective, and avoid ongoing

[1] The opinions expressed represent only those of the authors, and do not represent the views or opinions of Bates White, NYU Langone Health, or of other Bates White or NYU Langone Health employees or affiliates.

[2] Karyn Schwartz, Eric Lopez, Matthew Rae, and Tricia Neuman, *What We Know About Provider Consolidation*, Kaiser Family Foundation (Sept. 2, 2020), *available at* https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation (citing *TrendWatch Chartbook 2018*, Am. Hosp. Ass'n (May 22, 2018)).

[3] Andreea Cosnita-Langlais, *Remedies: Structural, Behavioral, Both, or None? Enforcement Trade-offs for Merger and Antitrust*, CPI Antitrust Chronicle (April 2020) at 3, *available at* https://www.competitionpolicyinternational.com/wp-content/uploads/2020/04/CPI-Cosnita-Langlais.pdf.

[4] *Id.*

[5] United States Department of Justice, *Merger Remedies Manual* (Sept. 2020), *available at* https://www.justice.gov/atr/page/file/1312416/download.

government entanglement," although it also acknowledges there are "limited circumstances [when] conduct remedies may be appropriate."[6] For example, there are certain types of transactions, such as some physician group mergers, where conduct remedies may be more appropriate than a structural remedy. In a merger between two physician groups, it likely would not be possible to divest one of the physician groups as there are only two parties, and it is typically difficult to "divest" individual physicians who are employed at will. More generally, the Manual claims conduct relief is *only* appropriate when the parties specifically prove that:

(1) the transaction generates significant efficiencies that cannot be achieved without the merger;

(2) a structural remedy is not possible;

(3) the conduct remedy will completely cure the anticompetitive harm; and

(4) the remedy can be enforced effectively.[7]

The FTC also defends this focus on structural remedies by explaining that the Commission has "long known that divestiture [helps with] maintaining or restoring the competition eliminated by the merger," and that studies affirm that "buyers that acquired an ongoing business were successful."[8] Indeed, there is a long history of FTC-imposed structural remedies in hospital mergers. For example, in 1997, Tenet Healthcare Corporation and OrNda Healthcorp were allowed to merge on the condition that Tenet divested one OrNda hospital and related assets in San Luis Obispo County.[9]

In contrast to this strong preference for structural remedies, state agencies can and do depart from the federal agencies' philosophy. As we discuss below, we find numerous examples of state agencies pursuing conduct remedies for prospective transactions, even when the federal agencies' typical conditions for conduct remedies may not apply. In light of these examples, it seems that state agencies have been more willing to accept conduct remedies than the federal agencies. We explore several case studies of recent hospital transactions to show how these two remedy strategies have been applied—and where the states' approaches have differed from the preferred federal enforcement policy.

FEDERAL ENFORCEMENT POLICY

We explore four case studies that illustrate the federal policy prioritizing structural remedies and, generally, rejecting conduct remedies. We begin with a discussion of Cabell Huntington Hospital (Cabell Huntington) and Phoebe Putney-Palmyra in depth, and then we discuss Community Health Systems-Health Management Associates and St Luke's-Saltzer more briefly.

Cabell Huntington, West Virginia

In November 2014, Cabell Huntington signed an agreement to purchase St. Mary's Medical Center (St. Mary's) from Pallottine Health Services.[10] Cabell Huntington and St. Mary's are both general acute care hospitals and are only located around 3 miles apart (a 10-minute drive) in Huntington, West Virginia.[11]

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[6] *Id*. at 13.

[7] *Id.* at 16.

[8] Dan Ducore & Naomi Licker, *Looking Back (Again) at FTC Merger Remedies,* FEDERAL TRADE COMMISSION (Feb. 3, 2017, 8:46 AM), *available at* https://www.ftc.gov/news-events/blogs/competition-matters/2017/02/looking-back-again-ftc-merger-remedies. *See also* Maria Raptis, Steven C. Sunshine, & David P. Wales, *New DOJ Merger Remedies Manual: Preference for Structural Remedies and Private Equity Buyers*, SKADDEN, ARPS, SLATE, MEAGHER & FLOM LLP AND AFFILIATES (Sept. 21, 2020), *available at* https://www.skadden.com/insights/publications/2020/09/new-doj-merger-remedies-manual.

[9] Press Release, Federal Trade Commission, FTC Obtains Relief for Health Care Consumers in California County (Jan. 29, 1997), *available at* https://www.ftc.gov/news-events/press-releases/1997/01/ftc-obtains-relief-health-care-consumers-california-county.

[10] Complaint, *In re Cabell Huntington Hosp., Inc*., FTC Docket No. 9366 (Nov. 5, 2015) (hereinafter "*Cabell Huntington FTC Complaint*") ¶ 24, *available at* https://www.ftc.gov/system/files/documents/cases/151106cabellpart3cmpt.pdf.

[11] *Id.* ¶ 2.

In July 2015, Cabell Huntington and St. Mary's signed an Assurance of Voluntary Compliance (AVC) with the West Virginia AG.[12] The agreement contained several terms that the parties agreed to comply with following the transaction close. The terms included capping price increases and operating margins for seven years, maintaining St. Mary's as a freestanding hospital, committing to quality and access improvements (e.g., implementing community wellness programs in medically underserved areas), and allowing robust labor market competition (e.g., no physician non-compete clauses, exclusive privileges, etc.).[13] These terms were further updated in November 2015 in an attempt to remedy any concerns about the impacts of the transaction. In the updated agreement, the price caps were extended to ten years instead of seven.[14]

Despite this agreement with the AG, in November 2015, the FTC issued a complaint to challenge the transaction, alleging that the transaction would significantly harm competition and result in higher prices and a lower quality of care.[15] Given the geographic proximity of the hospitals, similar service offerings, and their high post-transaction market share, the FTC alleged that the combined system would create a "near monopoly over general acute care inpatient hospital services and outpatient surgical services" in the surrounding area.[16] The FTC noted that the two hospitals had a history competing as not only the only two hospitals located in the city of Huntington, West Virginia, but also as the only two general acute care hospitals within a four county area of Cabell, Wayne, and Lincoln counties in West Virginia and Lawrence county in Ohio (i.e., the region the FTC defined as the relevant geographic market).[17]

In its complaint, the FTC stated, "For mergers that may substantially lessen competition, the Supreme Court, other courts, and the federal antitrust agencies strongly prefer 'structural' remedies, such as pre-merger injunctions and post-merger divestitures, to preserve competition rather than 'conduct' remedies, which rely on courts or enforcement authorities to police post-merger behavior."[18] The FTC referred to the July 30, 2015 AVC and acknowledged that the terms in the AVC would expire after seven years, thereby creating only a temporary solution and allowing the parties to revert to anticompetitive behavior in the long term. In addition, the FTC stated that the agreements "principally consist[ed] of price controls shown by economic theory and evidence to be ineffective" and would limit incentives to improve the quality of services.[19] The FTC also referenced the recent case of *Commonwealth v. Partners Healthcare System, Inc.*, in which a Massachusetts court overturned a settlement agreement containing conduct remedies, citing that it "require[s] constant and costly monitoring" and is "temporary and limited in scope—like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is

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[12] Answer and Defenses of Respondent, *In re Cabell Huntington Hosp., Inc.*, FTC Docket No. 9366 (Nov. 25, 2015) ¶ 10, *available at* https://www.ftc.gov/system/files/documents/cases/151202cabellanswer.pdf.

[13] Civil Case Information Statement and Assurance of Voluntary Compliance, *In re Cabell Huntington Hosp., Inc.*, No. 15-C-542 (Cir. Ct. of Cabell County, W. Va., July 30, 2015), *available at* https://ago.wv.gov/Documents/Cabell%20Huntington%20Hospital%20Civil%20Statement%20and%20Assurance.PDF.

[14] Assurance of Voluntary Compliance, *In re Cabell Huntington Hosp., Inc.*, No. 15-C-542 (Cir. Ct. of Cabell County, W. Va. Nov. 4, 2015), *available at* https://mountainhealthnetwork.org/assets/Documents/Forms/AVC-11-4-15.pdf. Another amended condition consisted of a "Statement of Proposed Activities" that would outline quality and efficiency improvements such as clinical integration goals and quantitative benchmarks for quality measures. *See* Brief of Respondent, *Steel of W. Va., Inc. v. W. Va. Health Care*, No. 17-406 (W. Va. Oct. 12, 2017) at 9, *available at* http://www.courtswv.gov/supreme-court/calendar/2018/briefs/jan18/17-0406respondent-health-care.pdf.

[15] *Cabell Huntington FTC Complaint* ¶ 1.

[16] Press Release, Federal Trade Commission, FTC Challenges Proposed Merger of Two West Virginia Hospitals (Nov. 6, 2015), *available at* https://www.ftc.gov/news-events/press-releases/2015/11/ftc-challenges-proposed-merger-two-west-virginia-hospitals.

[17] *Cabell Huntington FTC Complaint* ¶ 6.

[18] *Id.* ¶ 89.

[19] *Id.* ¶ 10, 91.

taken off."[20] Therefore, in the case of Cabell Huntington, the FTC alleged that temporary conduct remedies would not prevent long-term competitive harm that could result due to the transaction and attempted to overturn the agreement that the parties had reached with the AG.

Soon after, in March 2016, the governor of West Virginia signed Senate Bill 597 which had been enacted by the West Virginia Legislature.[21] The bill gave the West Virginia Health Care Authority (the Authority) and the West Virginia AG the power to approve cooperative agreements between academic medical centers and other hospitals or healthcare providers.[22] If the cooperative agreement is approved by the aforementioned authorities, it cannot be challenged under state or federal antitrust laws.[23] After the approval of Senate Bill 597, the Authority reviewed the case and determined that the benefits of the proposed transaction offset the potential for competitive harm.[24] The Authority alleged that the transaction would have no impact on reasonable payor negotiations, healthcare provider competition, or quality, prices, or access to healthcare and stated that "to the extent there is any likely impact on any of the [aforementioned] items, the Authority finds that they are ameliorated by the terms contained in the AVC."[25] Even though the FTC still had concerns about the transaction, the FTC dropped their lawsuit in July 2016 due to the passage of Senate Bill 597 and the parties were permitted to proceed with the deal.[26] Despite this concession, in their public statement, the FTC stated that they believe "that state cooperative agreement laws such as SB 597 are likely to harm communities through higher healthcare prices and lower healthcare quality."[27] After receiving approval from the Vatican in March 2018, the deal was finally permitted to close in June 2018 following an almost four-year-long process.[28]

There are several other states that have similar legislation to Senate Bill 597 in West Virginia. For example, both Tennessee and Virginia also have laws that allow states to supersede federal decisions on hospital mergers.[29] Indeed, in Tennessee, the Mountain States Health Alliance and Wellmont Health System were initially challenged by the FTC in their pursuit of a merger, but a state law was later passed to give the deal immunity.[30] Proponents of these laws claim that rural providers are in danger of closing unless they are acquired—and states would rather have healthcare providers pursue an anticompetitive merger, rather than allowing rural populations to

[20] *Id.* ¶ 89 (quoting *Partners Healthcare Sys.*, No. SUCV2014–02033–BLS2 (Mass. Super. Ct. Jan. 30, 2015)).

[21] Decision, *In re Cabell Huntington Hospital, Inc.*, West Virginia Health Care Authority Cooperative Agreement No. 16-2/3-001 (Jun. 22, 2016) (hereinafter "*Cabell Huntington Decision*") § I, *available at* https://hca.wv.gov/About/Documents/Decision.pdf.

[22] *Id.* These types of laws are known as certificates of public advantage (COPAs). As was the case with Senate Bill 597 in West Virginia, through COPAs, states can provide mergers immunity from antitrust challenges. The idea is that state oversight and monitoring can promote efficiencies and lessen any harm of competitive effects. This is an increasing phenomenon pursed by states in recent years. *See A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets*, Federal Trade Commission (June 18, 2019), *available at* https://www.ftc.gov/news-events/events-calendar/health-check-copas-assessing-impact-certificates-public-advantage.

[23] *Cabell Huntington Decision* § I.

[24] *Id.* § VIII.

[25] *Id.*

[26] *Cabell cleared to acquire St. Mary's following dismissal of FTC antitrust lawsuit to block transaction*, Jones Day (May 2018), *available at* https://www.jonesday.com/en/practices/experience/2018/05/cabell-cleared-to-acquire-st-marys-following-dismissal-of-ftc-antitrust-lawsuit-to-block-transaction.

[27] Statement of the Federal Trade Commission, *In re Cabell Huntington Hosp., Inc.*, FTC Docket No. 9366, (July 6, 2016), *available at* https://www.ftc.gov/system/files/documents/public_statements/969783/160706cabellcommstmt.pdf.

[28] Alyssa Rege, *Vatican approves Cabell Huntington's acquisition of St. Mary's,* Becker's Hospital Review (Mar. 27, 2018), *available at* https://www.beckershospitalreview.com/hospital-transactions-and-valuation/vatican-approves-cabell-huntington-s-acquisition-of-st-mary-s.html.

[29] Samantha Liss, *As Providers Merge, States Look to Supersede FTC*, Healthcare Dive (Dec. 18, 2018), *available at* https://www.healthcaredive.com/news/as-providers-merge-states-look-to-supersede-ftc/544176/.

[30] Denise M. Gunter, *Tennessee Approves Certificate of Public Advantage for Wellmont and Mountain States*, Nelson Mullins (Sept. 21, 2017), *available at* https://www.nelsonmullins.com/idea_exchange/blogs/healthcare_essentials/corporate_and_transactional/tennessee-approves-certificate-of-public-advantage-for-wellmont-and-mountain-states.

risk going without healthcare entirely.

As summarized by several attorneys, this continues "a trend of state governments acting to exclude or limit the role of federal antitrust authorities in state healthcare markets, and demonstrate[s] the tension that can arise between state law and policy and federal antitrust enforcement."[31] The Cabell Huntington case is one notable example of the tension between state law and policy and federal antitrust enforcement in that even after the parties negotiated with the state AG and agreed on certain conduct remedies, the FTC still challenged the transaction and opposed the remedies. Although the FTC was not able to successfully challenge the merger due to Senate Bill 597, the FTC took a clear stance in this case that conduct remedies are not effective and will not prevent competitive harm, whereas the AG believed that the conduct remedies were sufficient and would alleviate competitive concerns.

Phoebe Putney Health System, Georgia

The FTC also challenged a 2011 acquisition involving Phoebe Putney Health System (Phoebe Putney) in Albany, Georgia, resulting in litigation that lasted until 2015 and focused heavily on whether local regulations can prevent federal antitrust scrutiny.[32] The challenge focused on Phoebe Putney's proposed acquisition of a rival hospital: Palmyra Park Hospital (Palmyra Park). The FTC alleged that the deal would reduce competition and allow the combined entity to substantially raise prices for general acute care hospital services.

The deal initially fell under the purview of the Hospital Authority of Albany-Dougherty County, which exists under Georgia's Hospital Authorities Law.[33] This structure allowed the parties to argue that the deal was exempt from federal antitrust oversight due to "state action." However, litigation on the deal eventually reached the U.S. Supreme Court, who ruled that the merger was not actually exempt from FTC scrutiny.[34] This decision allowed the FTC to consider structural remedies to mitigate the anticompetitive effects of the deal. After the Supreme Court decision and a public comment period, the FTC came to "believe that structural relief remains available."[35]

Initially, difficulties with Georgia's Certificate of Need laws meant that structural relief was difficult, so the FTC considered a proposed settlement with non-structural relief. However, the FTC eventually returned to administrative litigation to seek a remedy outside of this initial proposed settlement. In 2015, the FTC finally entered into a settlement agreement with Phoebe Putney.[36] The final settlement agreement required Phoebe Putney and the Hospital Authority to notify the FTC in advance of Phoebe Putney acquiring any other hospitals or healthcare providers in the Albany, Georgia area.[37] The settlement also prevented the parties from objecting to certificate of need applications from other hospitals for the next five years—minimizing obstacles for future competitors to enter the Albany hospital market. However, the parties were able to remain as a

[31] Lisl Dunlop, Ashley Antler, and Shoshana Speiser, *State Bill Seeks to Shield Hospital Mergers from Antitrust Challenge*, MANATT, (Mar. 23, 2016), *available at* https://www.manatt.com/documents/newsletters/2016-7.

[32] FEDERAL TRADE COMMISSION, *In re Phoebe Putney Health Sys., Inc.*, FTC Docket No. 9348 (Mar. 31, 2015), *available at* https://www.ftc.gov/enforcement/cases-proceedings/111-0067/phoebe-putney-health-system-inc-phoebe-putney-memorial.

[33] Press Release, Federal Trade Commission, In Phoebe Putney Hospital Merger Case, FTC Rejects Proposed Consent Agreement; Parties to Return to Litigation (Sept. 5, 2014), *available at* https://www.ftc.gov/news-events/press-releases/2014/09/phoebe-putney-hospital-merger-case-ftc-rejects-proposed-consent.

[34] *Id.*

[35] Statement of Federal Trade Commission, *In re Phoebe Putney Health Sys., Inc.*, FTC Docket No. 9348 (Sept. 4, 2014), *available at* https://www.ftc.gov/system/files/documents/public_statements/581041/140905phoebeputneystatement.pdf.

[36] *Id*.

[37] Melanie Evans, *FTC Ends Four-Year Fight with Phoebe Putney Health System*, MODERN HEALTHCARE (Apr. 1, 2015, 1:00 AM), *available at* https://www.modernhealthcare.com/article/20150401/NEWS/150409992/ftc-ends-four-year-fight-with-phoebe-putney-health-system.

merged entity, and the FTC was unable to unwind the transaction.[38]

This settlement did not require divestiture and also did not require conduct remedies that may be typical of other similar transactions. For example, the FTC did not require price caps or separate reimbursement negotiations for Phoebe Putney and Palmyra Park.[39] When discussing the lack of structural relief, the FTC explained that "such remedies are typically insufficient to replicate pre-merger competition," but also emphasized that the outcome of this case was unique to the facts of Georgia's Certificate of Need laws, and that divestures may still be sought in future hospital merger challenges.[40]

In a retrospective analysis, FTC researchers found that this transaction created a large price spike in its first post-merger year, followed by similar-to-trend prices in subsequent years.[41] Furthermore, they found that the transaction created a significant reduction in post-merger quality in the Palmyra Medical Center facility. During litigation, the parties claimed that oversight by the local Hospital Authority would be sufficient to prevent price increases and disruption to patient care, but the post-merger data appears to suggest otherwise. The FTC researchers concluded that this case may "give pause to [agencies] considering the replacement of antitrust enforcement with […] regulation" or other conduct remedies.[42]

Other cases

While the cases of Cabell Huntington and Phoebe Putney did not result in structural remedies, there are several cases where the FTC did impose a structural remedy to mitigate potential competitive harm following a merger. Two examples that we will discuss more briefly include the mergers between Community Health Systems, Inc. (CHS) and Health Management Associates, Inc. in 2014 and St. Luke's Health System (St. Luke's) and Saltzer Medical Group (Saltzer) in 2015.

Community Health Systems and Health Management Associates

In 2014, the FTC required that CHS divest hospitals and related assets in Alabama and South Carolina upon acquiring Health Management Associates, Inc.[43] The FTC's concern focused on two geographic areas that they alleged were already highly concentrated pre-transaction: Gadsden, Alabama and Hartsville, South Carolina.[44] After an investigation, the FTC concluded that the merger was likely to substantially lessen competition for general acute care services, increase prices above competitive levels, and decrease quality.[45] As a result, CHS agreed to divest Carolina Pines Regional Medical Center, Riverview Regional Medical Center, and their respective assets within 6 months to an FTC-approved buyer.[46]

St. Luke's-Saltzer, Idaho

Another federal case involving structural remedies is the acquisition of Saltzer by St. Luke's, which differs from the aforementioned CHS case as the divestiture was ordered after the completion of the merger instead of preemptively. In 2012, St. Luke's acquired Saltzer, which the FTC alleged created a dominant group of adult primary care physicians

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[38] *Id.*

[39] Stephen Wu, *U.S. Federal Trade Commission (FTC) Reaches Unique Settlement with Phoebe Putney Health System Resolving Lengthy Hospital Merger Challenge*, 3 NAT'L L.R. 238 (2013), *available at* https://www.natlawreview.com/article/us-federal-trade-commission-ftc-reaches-unique-settlement-phoebe-putney-health-syste.

[40] *Id.*

[41] Christopher Garmon and Laura Kmitch, *Health Care Competition or Regulation: The Unusual Case of Albany Georgia* (Sept. 30, 2017), *available at* https://ssrn.com/abstract=3048839.

[42] *Id.*

[43] Decision and Order, *In re Cmty. Health Sys., Inc.*, FTC Docket No. C-4427 (Apr. 15, 2014) (hereinafter "*CHS Decision*") §§ II–III, *available at* https://www.ftc.gov/system/files/documents/cases/140415chshmado.pdf.

[44] Complaint, *In re Cmty. Health Sys., Inc.*, FTC Docket No. C-4427 (Jan. 22, 2014) ¶¶ 10–14, *available at* https://www.ftc.gov/sites/default/files/documents/cases/140122chscmpt.pdf.

[45] *Id.* ¶¶ 17-18.

[46] *CHS Decision* §§ II–III.

("PCPs") in Nampa, Idaho. Between 2013 and 2015, the FTC successfully challenged this acquisition.[47] Litigation concluded with the FTC requiring St. Luke's to divest Saltzer's physicians and reestablish Saltzer as an independent PCP practice in Nampa. When reviewing the case, the Ninth Circuit court noted that divestiture was an appropriate and customary form of relief for such a merger, and, quoting the Supreme Court, noted that divestiture "should always be in the forefront of a court's mind" for similar matters.[48]

The Ninth Circuit also considered whether proposed conduct remedies would be sufficient to avoid divesting Saltzer's physicians. The proposed conduct remedy would have allowed the groups to negotiate separately with insurers. The court claimed that this remedy "risk[ed] excessive government entanglement in the market" and was not as easy or sure as a simple divestiture. The case reiterates much of what we observe in other examples: keeping with typical federal enforcement policy, the FTC has not been persuaded by conduct remedies, and divestitures are preferred when at all feasible.[49]

State Attorneys General

Next, we explore four case studies that illustrate state policies permitting conduct remedies. We begin with a discussion of the Beth Israel-Lahey Health transaction (BILH) in Massachusetts and CHI Franciscan's acquisition of The Doctors Clinic (TDC) and WestSound Orthopaedics (WSO) in Washington state in depth, and then we discuss Cedars-Sinai Health System's (Cedars-Sinai) recent acquisition of Huntington Memorial Hospital (Huntington) and Acadia's attempted acquisition of Adventist, both in California, more briefly. Each of these transactions was led by the relevant state's AG.

Beth Israel-Lahey, Massachusetts

In July 2017, Beth Israel Deaconess, Lahey Health, Anna Jaques Hospital, Mount Auburn Hospital, and New England Baptist Hospital signed a merger agreement, thereby creating the Beth Israel Lahey Health (BILH) system. The combined system now includes 12 acute care hospitals, 1 psychiatric hospital, and more than 4,000 primary care and specialty physicians.[50] Valued at $4.5 billion, the deal was the biggest hospital merger in the state in more than 20 years and created the second-largest hospital system in Massachusetts.[51] The parties aimed to "create a large, lower-cost health network that can compete with Partners HealthCare, the parent company of Massachusetts General and Brigham and Women's hospitals."[52]

The BILH transaction was reviewed extensively by the FTC, AG, and the Massachusetts's Health Policy Commission (HPC), which is an independent state agency that monitors growth in health care expenditure in Massachusetts and provides policy recommendations.[53] Although the HPC concluded that the BILH hospitals had relatively low to moderate prices compared to the

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[47] Press Release, Federal Trade Commission, FTC Obtains Court Approval of Divestiture of Saltzer Medical Group by Idaho-based St. Luke's Health System (May 2, 2017), *available at* https://www.ftc.gov/news-events/press-releases/2017/05/ftc-obtains-court-approval-divestiture-saltzer-medical-group.

[48] *Ninth Circuit Upholds Divestiture in Idaho Primary Care Provider Merger Case (St. Alphonsus Medical Center-Nampa v. St. Luke's Health System)*, American Antitrust Institute (Feb. 11, 2015), *available at* https://www.antitrustinstitute.org/work-product/ninth-circuit-upholds-divestiture-in-idaho-primary-care-provider-merger-case-st-alphonsus-medical-center-nampa-v-st-lukes-health-system/.

[49] *Id.*

[50] Tina Reed, *It's official. Beth Israel Lahey Health emerges postmerger,* Fierce Healthcare (Mar. 1, 2019, 9:14 AM), *available at* https://www.fiercehealthcare.com/hospitals-health-systems/it-s-official-beth-israel-lahey-health-emerges-post-merger.

[51] Paige Minemyer, *Beth Israel, Lahey Health finalize long-simmering merger*, Fierce Healthcare (Oct. 7, 2019, 7:00 AM), *available at* https://www.fiercehealthcare.com/special-report/beth-israel-deaconess-medical-center-lahey-health.

[52] Priyanka Dayal McCluskey, *Beth Israel and Lahey Health Sign Final Agreement to Merger*, Boston Globe (Jul. 13, 2017, 2:19 PM), *available at* https://www.bostonglobe.com/business/2017/07/13/beth-israel-deaconess-and-lahey-health-sign-final-agreement-merge/lZWtE3YWeQZyRvaWGYXxAO/story.html.

[53] Commonwealth of Massachusetts, *About the Health Policy Commission*, *available at* https://www.mass.gov/about-the-health-policy-commission-hpc.

rest of the hospitals in the area,[54] the HPC also forecasted that the merger would enable BILH to increase its bargaining leverage with commercial payors and could potentially harm competition.[55] As a result, the HPC was concerned that BILH would use its increased bargaining leverage to raise commercial prices and increase healthcare spending by $158.2 million to $230.5 million each year across inpatient, outpatient, primary care, and specialty physician services.[56] The HPC is, itself, not able to block a transaction,[57] but it referred its report to the AG "to assess whether there are enforceable steps that the parties may take to mitigate concerns about the potential for significant price increases and maximize the likelihood that BILH will enhance access to high quality care, particularly for underserved populations."[58]

Although the AG and the FTC ultimately decided against challenging the transaction outright and closed their investigations in November 2018, the AG imposed several conduct remedies that the parties agreed to abide by, including price constraints and several healthcare access commitments. First, to address the concern that BILH would increase its bargaining leverage with payors, BILH agreed to cap price increases below the Massachusetts Health Care Cost Growth benchmark for the first seven years following the transaction.[59] The benchmark is a statewide target for the annual growth rate of medical spending.[60] The constraint applied to commercial and managed Medicare unit price payments and alternative payment methods.[61] The AG's goal of the price constraint was to prevent more than $1 billion of the cost increases that the HPC predicted.[62] In addition, the parties agreed to several healthcare access commitments following the approval of the merger. Any BILH facility that was a participating MassHealth provider must continue to participate in MassHealth, and BILH must make an effort to have all licensed providers apply to participate in MassHealth within 3 years.[63] BILH must also design a program to bring in more MassHealth patients into its system by promoting access and targeting underserved populations.[64] Lastly, the settlement stipulated that the parties would need to identify a third-party to monitor BILH for 10 years following the transaction and ensure that BILH complies with the settlement.[65] The monitor is also required to produce annual reports that evaluate BILH's compliance.[66]

In the BILH transaction, the AG facilitated the resolution and designed the conduct remedies, while the FTC closed its own

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[54] Massachusetts Health Policy Commission, *Massachusetts Health Policy Commission's Review of The Proposed Merger of Lahey Health System; CareGroup and its Component Parts, Beth Israel Deaconess Medical Center, New England Baptist Hospital, and Mount Auburn Hospital; Seacoast Regional Health Systems; and Each of their Corporate Subsidiaries into Beth Israel Lahey Health; AND The Acquisition of the Beth Israel Deaconess Care Organization by Beth Israel Lahey Health; AND The Contracting Affiliation Between Beth Israel Lahey Health and Mount Auburn Cambridge Independent Practice Association (HPC-CMIR-2017-2) Pursuant to M.G.L. ch. 6D, § 13 Final Report*, (Sept. 27, 2018) [hereinafter "*CMIR Report*"] at 31, *available at* https://www.mass.gov/doc/final-cmir-report-beth-israel-lahey-health/download.

[55] *Id.* at 49.

[56] *Id.* at 52.

[57] Cory Capps, Kayuna Fukushima, Tetyana Shvydko, and Zenon Zabinski, *A Stronger Second Competitor? Analyzing the Competitive Effects of the Beth Israel Lahey Health Transaction*, CPI ANTITRUST CHRONICLE (May 2019) at 2, *available at* https://www.bateswhite.com/media/publication/178_CPI-Capps-Fukushima-Shvydko-Zabinski%20dowload.pdf.

[58] *CMIR Report* at 5.

[59] Office of Attorney General Maura Healy, *AG Reaches Settlement with Beth Israel, Lahey Health Over Proposed Merger*, MASS.GOV (Nov. 29, 2018), *available at* https://www.mass.gov/news/ag-healey-reaches-settlement-with-beth-israel-lahey-health-over-proposed-merger.

[60] Massachusetts Health Policy Commission, *Health Care Cost Growth Benchmark*, MASS.GOV, https://www.mass.gov/info-details/health-care-cost-growth-benchmark.

[61] Assurance of Discontinuance Pursuant to M.G.L. Chapters 93A, § 5 and 93, § 9, *Commonwealth vs. Beth Israel Lahey Health*, Civil Action No. 2018-3703 (Mass. Super. Ct. Nov. 29, 2018) [hereinafter "*Assurance of Discontinuance*"], *available at* https://www.mass.gov/files/documents/2018/11/29/BILH%20AOD%20Filed%202018.11.29.pdf.

[62] Alex Kacik, *Beth Israel Deaconess and Lahey Health Complete Merger*, MODERN HEALTHCARE (Mar. 1, 2019, 1:49 PM), *available at* https://www.modernhealthcare.com/mergers-acquisitions/beth-israel-deaconess-and-lahey-health-complete-merger.

[63] *Assurance of Discontinuance* ¶¶ 92-94.

[64] *Id* ¶ 96.

[65] *Id* ¶ 140-154.

[66] *Id.*

investigation after the AG approved the transaction.[67] In its closing statement, the FTC noted that "the Commission does not typically pursue behavioral remedies, such as price caps, in merger cases" but that they recognize that "this settlement seeks to satisfy two goals of critical importance to the Massachusetts AG: first, to preserve access to health care for underserved populations in Massachusetts; and second, to limit price increases for Massachusetts health care consumers."[68] The BILH transaction is a clear example of a state agency taking a different remedy approach by negotiating conduct remedies; whereas the FTC was hesitant to do so but allowed the AG to make the final decision.

CHI Franciscan, Washington

In 2017, the Washington AG's office filed a lawsuit against CHI Franciscan, alleging anticompetitive conduct among healthcare providers on Washington's Kitsap Peninsula.[69] The allegations centered on two 2016 transactions, when the CHI Franciscan health system acquired TDC and WSO, two physician groups located on the Peninsula.

The lawsuit alleged that after affiliating with TDC and WSO, CHI Franciscan raised prices for physician services, especially for primary care (at TDC) and orthopedic services (at both TDC and WSO). The lawsuit also alleged that CHI Franciscan elected to close a TDC imaging center and significantly reduced service offerings at a local Ambulatory Surgery Center (ASC). By reducing these offerings, the lawsuit alleged that the parties were able to shift care from the lower-cost ASC to higher-cost hospital-based surgery departments. Most notably, the agencies alleged that care was diverted to Harrison Medical Center, a hospital owned by CHI Franciscan.

The parties eventually settled with the AG's office, agreeing to mitigate the alleged anticompetitive effects through several policies.[70] First, CHI Franciscan was required to divest its interest in the ASC. By making the ASC an independent entity again, the AG believed competition for surgery services would be more robust. Second, CHI Franciscan paid $2.5 million dollars to the State. These funds were to be used to assist competing health providers in the region, encouraging patient services from providers outside CHI Franciscan, TDC, and WSO. Finally, this case spurred lawmakers to create a new merger approval process in Washington State for future healthcare transactions. The new legislation requires healthcare entities to notify the AG's Office 60 days in advance of any mergers, acquisitions, or affiliations of a certain size.[71] This process would have avoided the post-transaction litigation in this case, by instead forcing a pre-approval process similar to the HSR filing process at the federal level.[72]

Divestiture of the ASC and payment to the State both represent structural remedies for the CHI Franciscan transactions. By reestablishing the surgery center as a competitor, and by offering grants to assist competitors in the region, the AG is focusing on establishing a robust competitive landscape on the Kitsap Peninsula, and this competition has been supported regardless of future conduct by CHI Franciscan, TDC, and WSO.

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[67] Capps et al., *supra* note 57, at 3.

[68] FED. TRADE COMM'N, Statement of the Federal Trade Commission Concerning the Proposed Affiliation of CareGroup, Inc.; Lahey Health System, Inc.; Seacoast Regional Health System, Inc.; BIDCO Hospital LLC; and BIDCO Physician LLC, FTC File No. 171-0118 (Nov. 29, 2018), *available at* https://www.ftc.gov/system/files/documents/closing_letters/nid/1710118_bidmc_commission_closing_statement.pdf..

[69] Washington State Office of the Attorney General, *AG Ferguson sues CHI Franciscan over price-fixing and anticompetitive Kitsap deals* (Aug. 31, 2017), *available at* https://www.atg.wa.gov/news/news-releases/ag-ferguson-sues-chi-franciscan-over-price-fixing-and-anticompetitive-kitsap.

[70] Washington State Office of the Attorney General, *Attorney General Ferguson: CHI Franciscan will pay up to $2.5 million over anti-competitive Kitsap deals* (May 13, 2019), *available at* https://www.atg.wa.gov/news/news-releases/attorney-general-ferguson-chi-franciscan-will-pay-25-million-over-anti.

[71] *Id.*

[72] Federal Trade Commission Premerger Notification Office, *What is the Premerger Notification Program? An Overview* (Mar. 2009), *available at* https://www.ftc.gov/sites/default/files/attachments/premerger-introductory-guides/guide1.pdf.

Additionally, several conduct remedies were imposed on TDC during the settlement. Primary care physicians and orthopedists at TDC must separately contract with insurers, instead of relying on CHI Franciscan's allegedly higher rates, if the insurer desires a separate contract.[73] The AG describes this requirement as "restor[ing] competition and giving insurance companies an alternative" to contracting with CHI Franciscan. Additionally, the agreement required CHI Franciscan to allow value-based payments to TDC if TDC's physicians provide high quality care. Finally, physicians at TDC and CHI Franciscan are required to inform patients of alternative imagining facility options besides Harrison Medical Center—avoiding a scenario where physicians consistently steer patients to CHI Franciscan's allegedly higher-priced facilities.[74]

Other cases

There are several other more recent cases that provide evidence of states' willingness to accept conduct remedies as an acceptable means of curbing anticompetitive behavior following a merger. We discuss two additional examples more briefly, including the mergers between Cedars-Sinai Health System (Cedars-Sinai) and Huntington Memorial Hospital (Huntington) and an abandoned deal between Adventist Health Vallejo (Adventist) and Acadia Healthcare Company (Acadia).

Cedars-Sinai-Huntington, California

Another example of state enforcement comes from California, where Cedars-Sinai Health System (Cedars-Sinai) acquired Huntington Memorial Hospital in 2021. The Cedars-Sinai system included 3 hospitals in and around Los Angeles adjacent to Huntington's location in the San Gabriel Valley.[75] This transaction was reviewed by the California AG. The AG's review found that, even though the hospitals do not directly compete with each other, "cross-market effects" could lead to price increases and potentially harm competition.[76] Given the concern about cross-market effects, the AG conditionally approved the transaction in December 2020 with several conditions, including conduct remedies intended to reduce the alleged competitive impact.[77] In comparison, the FTC's review did not result in any competitive concerns relating to the merger, and the FTC closed their investigation following the initial Hart-Scott-Rodino (HSR) waiting period.[78]

In response to the AG's conditional approval, the parties filed a lawsuit in March 2021.[79] The lawsuit cited a concern that Huntington would be at a disadvantage compared to its competitor hospitals if it was required to abide by the requested stipulations.[80] Ahead of the trial, the parties negotiated revised conditions, settling on a few main remedies. First, the parties cannot engage in any all-or-nothing bargaining for ten years after the transaction, which means that the parties must allow insurers to contract with the systems' individual hospitals and not require that the contracting be for the system as a

[73] Washington State Office of the Attorney General, *Attorney General Ferguson: CHI Franciscan will pay up to $2.5 million over anti-competitive Kitsap deal* (May 13, 2019), *available at* https://www.atg.wa.gov/news/news-releases/attorney-general-ferguson-chi-franciscan-will-pay-25-million-over-anti.

[74] *Id*.

[75] Cedars-Sinai, *Huntington Hospital Signs Definitive Agreement to Join Cedars-Sinai Health System* (Jul. 16, 2020), *available at* https://www.cedars-sinai.org/newsroom/huntington-hospital-signs-definitive-agreement--to-join-cedars-sinai-health-system/.

[76] David Dahlquist and Nathan Garg, *Huntington Hospital/Cedars-Sinai Health System v. California DOJ*, American Health Law Association (Apr. 28, 2021) at 1, *available at* https://www.winston.com/images/content/2/3/v2/237717/AHLA-Bulletin-AT-Dahlquist-Garg-042821.pdf.

[77] Alia Paavola, *California Hospitals Sue Attorney General Over Conditions for Affiliation,* Becker's Hospital Review (Mar. 30, 2021), *available at* https://www.beckershospitalreview.com/legal-regulatory-issues/california-hospitals-sue-attorney-general-over-conditions-for-affiliation.html.

[78] Huntington Hospital, *Huntington Hospital and Cedars-Sinai Health System Jointly File Suit Over Attorney General's Conditions on Proposed Affiliation*, (Mar. 30, 2021), *available at* https://www.huntingtonhospital.org/in-the-news/huntington-hospital-and-cedars-sinai-jointly-file-suit/.

[79] Dahlquist and Garg, *supra* note 76, at 1.

[80] Huntington Hospital, *supra* note 78.

whole.[81] Second, the parties must maintain their existing contracts with payors and new contracts are subject to a price cap of a maximum 4.8% price increase per year for five years.[82] An appointed monitor will track compliance of these competitive impact conditions.[83] The Cedars-Sinai and Huntington merger is, thus, another case where a state agency was willing to approve a merger subject to several conduct remedies rather than structural remedies.[84]

[81] Order, *Pasadena Hosp. Ass'n Ltd. v. Cal. Dep't of Justice*, Case No. 21 STCP00978 (Calif. Super. Ct. Jul. 19, 2021) at 2, *available at* https://oag.ca.gov/system/files/media/nhft-huntington-ag-decision-071921.pdf.

[82] *Id* at 2. In the original conditional approval in December 2020, the length of the price cap was ten years. *See Attorney General's Conditions to Change in Control and Governance of Huntington Memorial Hospital and Approval of Affiliation Agreements by and between the Pasadena Hospital Association, the Collis P. and Howard Huntington Trust and Cedars-Sinai Health System* (Dec. 10, 2020), *available at* https://oag.ca.gov/sites/all/files/agweb/pdfs/charities/nonprofithosp/ag-decision-huntington-121020.pdf?.

[83] The original conditional approval required Cedars-Sinai and Huntington to maintain firewalls and separate negotiating teams for purposes of payor contracting, the settlement changed this requirement to only be required if requested by a payor in the instance of a violation by the hospital system. *See Attorney General's Conditions to Change in Control and Governance of Huntington Memorial Hospital and Approval of Affiliation Agreements by and between the Pasadena Hospital Association, the Collis P. and Howard Huntington Trust and Cedars-Sinai Health System* (Dec. 10, 2020), at Ex. 3 at 3, *available at* https://oag.ca.gov/sites/all/files/agweb/pdfs/charities/nonprofithosp/ag-decision-huntington-121020.pdf?.

[84] In the case of the Cedars-Sinai and Huntington transaction, a structural remedy was likely not possible for two main reasons: the transaction involved Cedars-Sinai acquiring only one hospital and the competitive concern was not related to direct competition between the parties.

Acadia-Adventist, California

One final example also comes from California. In 2021, the California AG conditionally approved a merger between Adventist Health Vallejo and Acadia Healthcare Company.[85] Adventist's Vallejo hospital is an acute psychiatric inpatient hospital, and the AG's concerns were related to the limited market for psychiatric services. Acadia also owns several behavioral health facilities, including San Jose Behavioral Health Hospital. Though the deal was conditionally approved, it appears to have been abandoned.

The conditional approval included several common conduct remedies.[86] First, a price freeze would forbid rate increases above 6% for commercial payors or 2.8% for Medicaid for up to eight years after the transaction. Additionally, Acadia could not have allowed Adventist to take on debt that could potentially push the facility to violate the other conditions. Quality measures would be reviewed to ensure continued quality post-transaction, and Adventist would be required to continue serving patients under 18, to prevent a shortage of pediatric psychiatric care in the region. Finally, a monitor would be appointed to ensure compliance with these remedies. Each of these stipulations is a conduct remedy—the CA AG did not pursue structural relief.

[85] State of California Department of Justice, *Attorney General Bonta Conditionally Approves Sale of Adventist Health Vallejo* (Oct. 5, 2021), *available at* https://oag.ca.gov/news/press-releases/attorney-general-bonta-conditionally-approves-sale-adventist-health-vallejo.

[86] State of California Department of Justice, *supra* note 85.

Conclusion

Overall, we use several case studies of state and federal hospital merger enforcement to show the recent prevalence of structural and conduct remedies in the merger approval process. In these examples, we see a pattern of states often willing to agree to conduct remedies, while the FTC and federal agencies typically continue to insist on structural remedies and disapprove of conduct remedies. Indeed, particularly in cases where structural remedies are not practical, such as a hospital divestiture in a transaction with only two facilities, states have been open to accepting conduct remedies instead of challenging the merger. Notably, this pattern holds true across a variety of states, with recent examples coming from Massachusetts, California, Washington, West Virginia, Georgia, and Idaho.

Interestingly, some cases we reviewed included a federal challenge to state authority, or vice versa. In Cabell Huntington, the FTC disapproved of initial conduct remedies pursued by the state.

However, they eventually backed down after legislation clarified the state could supersede federal enforcement. Meanwhile, in Phoebe Putney, the Supreme Court ruled that Georgia could not prevent FTC scrutiny solely by relying on local regulators' oversight. It is true that, in most cases, merger enforcement is a joint, cooperative effort at the state and federal levels. But these examples show how, sometimes, the strategies of enforcement can vary and even disagree with each other, even within the very same case.

Looking forward, it seems unlikely that this debate will resolve anytime soon. The FTC and federal agencies are clear in its preference for structural remedies. But states have shown a willingness to accept conduct remedies in certain cases, seeming to agree that conduct remedies can provide better results than simply approving or denying a merger entirely. This may be particularly salient for rural providers, as approval with a conduct remedy may prevent a hospital from closing, whereas a challenge might ultimately cause a hospital to close, hindering consumers' access to care. However, these remedies are still new, require ongoing monitoring, and such an enforcement approach may not be sustainable in all cases or for more a long enough time period. As Chris Garmon, a former economist with the FTC, summarized: "That's a conversation we all need to have, which is best: competition or active state regulation?"[87] From these recent examples, we see that the federal and state agencies may sometimes disagree on the answer to that question.

[87] Samantha Liss, *As providers merge, states look to supersede FTC*, HEALTHCARE DIVE (Dec. 18, 2018), *available at* https://www.healthcaredive.com/news/as-providers-merge-states-look-to-supersede-ftc/544176/.

Appendix

Comparison of Remedies in Hospital Merger Enforcement

Examples Discussed	Structural Remedies		Conduct Remedies			
	Divestiture	Legislation	Price Caps	Payouts	Monitoring	Other
Federal Cases						
Cabell-Huntington (WV)		Approval by state now allowed	10 years; received FTC objection			Several; received FTC objection
Phoebe Putney (GA)		Advance notice to state now required				5 years without contesting entry
Community Health and Health Management Associates (various)	2 hospitals divested					
St. Luke's-Saltzer (ID)	Physicians divested					
State Cases						
Beth Israel-Lahey (MA)			7 years		10 years	Quality and access commitments
CHI Franciscan (WA)	ASC divested	New approval process now required		$2.5 million		Separate contracting; value-based payments; alternatives
Cedars-Sinai-Huntington (CA)			5 years		10 years	No all-or-none bargains (10 years)
Acadia-Adventist (CA)			8 years		5 years	Debt rules; must serve <18; quality checks

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