Hospital Mergers and Joint Ventures: Antitrust Developments and Best Practices for Getting the Deal Through

Greater New York Hospital Association
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Overview and analysis of the current antitrust enforcement climate in the provider sector

Recent leadership changes at the FTC and their probable effect on healthcare antitrust policy and law enforcement

Understanding the market characteristics and competitive conditions that drive antitrust scrutiny of hospital mergers

Identifying, substantiating and presenting to agency staff the efficiency and quality benefits of hospital mergers

The antitrust framework for ACOs and other non-merger collaborations to achieve hospital cost and quality goals

State action antitrust immunity after the Supreme Court's February 2013 ruling in FTC v. Phoebe Putney
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Current Antitrust Enforcement Climate

- AHIP-sponsored study in 2011 – as of 2009, hospital ownership was “highly concentrated” (above 2,500) measured by HHIs in 80% of metropolitan statistical areas (MSAs)

- Increase in hospital and health system M&A activity in response to mandates of health reform
  - DOJ reported that HSR filings increased 50% from 2009 to 2010
  - Independent analyst reported number of hospital mergers increased in 2010, 2011, and 2012 from previous year; 2013 predicted to be active

- Most hospital mergers do not raise antitrust concerns
  - Approx. 330 hospital mergers between 2007-2011
  - Approx. 110 of those were HSR-reportable
  - Second requests issued for 11 (and also conducted non-public investigations of at least some hospital mergers that were not HSR-reportable)
Current Antitrust Enforcement Climate

- In 2011-2013, the FTC filed six administrative complaints seeking to enjoin hospital mergers or hospital acquisitions of physician groups
  - *In the Matter of ProMedica Health System, Inc.*
  - *In the Matter of Phoebe Putney Health System, Inc., et al. (amended complaint filed 2013)*
  - *In the Matter of OSF Healthcare System and Rockford Health System*
  - *In the Matter of Reading Health System*
  - *In the Matter of Renown Health*
  - *FTC v. St. Luke’s Health System*

- Unprecedented level of hospital merger or acquisition challenges
Recent FTC Hospital Merger/Acquisition Investigations - Administrative Complaints

- **ProMedica/St. Luke’s (Toledo, OH)**
  - FTC filed administrative and federal complaints January 6 and 7, 2011, respectively, challenging the consummated transaction
  - Alleged 4 to 3 (3 to 2 for obstetrics) controlling 60% (patient days) of the general acute care inpatient hospital services market and 80% of the market for obstetrics services
  - Dominant hospital system
  - Two product markets – one very narrow (OB/GYN), allowed FTC to claim was a merger to duopoly
  - Weakened firm defense not compelling to FTC
  - Preliminary injunction granted, FTC ruled the transaction unlawful and hospitals appealed to the Sixth Circuit (pending)
Recent FTC Hospital Merger/Acquisition Investigations - Administrative Complaints

- **Phoebe Putney/Palmyra (Albany, GA)**
  - FTC filed an administrative complaint and federal complaint challenging the transaction April 20, 2011
  - Alleged 2 to 1 in the county; alleged will control 86% (discharges) of the general acute care inpatient hospital services market in surrounding six counties
  - Federal court denied FTC’s petition for an injunction based upon the state action defense and 11th Circuit affirmed
  - Supreme Court reversed 11th Circuit – held that state action immunity did not apply
  - FTC filed amended complaint on April 9
OSF Healthcare System/ Rockford Health System (Rockford, Illinois)

- FTC filed administrative and federal complaints November 18, 2011
- Alleged 3 to 2 controlling 64% (patient days) of the general acute care inpatient hospital services market and 37% of the market for primary care physician services post-closing
- Health reform driven merger rationale not important to FTC
- Parties abandoned the transaction following federal court’s issuance of preliminary injunction
Recent FTC Hospital Merger/Acquisition Investigations - Administrative Complaints

**Reading Health System (Reading, PA)**

- FTC filed an administrative complaint challenging the transaction November 16, 2012; sought preliminary injunction in federal court
- Reading proposed to acquire a 15 bed surgical specialty hospital
  - “Safety zone” ignored by FTC
- FTC alleged four markets with market shares ranging from 49 to 71 percent:
  - inpatient orthopedic/spine surgical services;
  - outpatient orthopedic/spine services;
  - outpatient ENT surgical services; and
  - outpatient general surgical services
- Relevant markets built on specific DRGs
- Federal court granted FTC’s petition for preliminary injunction
- Parties abandoned the transaction
Recent FTC Hospital Merger/Acquisition Investigations - Administrative Complaints

- **Renown Health (Reno, NV)**
  - FTC filed an administrative complaint August 3, 2012
  - Through a series of transactions between 2010 and 2011, Renown acquired the majority of cardiologists in the area
  - Alleged Renown employed 97% of the cardiologists serving private patients at the time of the last transaction (at the time of the complaint was 88%)
  - Employment agreements with cardiologists contained non-compete clauses
  - Consent decree reached, releasing cardiologists from non-compete agreements, allowing up to 10 of them to join competing cardiology practices in the Reno area
Recent FTC Hospital Merger/Acquisition Investigations - Administrative Complaints

**FTC v. St. Luke’s Health System (Boise, ID)**

- FTC filed an administrative complaint March 12, 2013
- Challenged St. Luke’s acquisition of Idaho's largest independent, multi-specialty physician practice group
- Alleged combined entity would have nearly 60% share of market for adult primary care physician services in the area
- Private complaint also filed by competing hospital
- Cases have been consolidated; set for trial beginning Sept. 16, 2013
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Changes at FTC

- Chairman Leibowitz stepped down Feb. 15
- New Chairwoman – Edith Ramirez
  - well-respected patent litigator
  - rumored candidate for 9th Circuit
  - has always voted with staff on hospital merger challenges
- New Commissioner – Joshua Wright sworn in Jan. 11
  - Wants FTC to issue a policy statement on §5
  - PhD in economics as well as JD

Voting out of Complaints pertaining to healthcare sector expected to continue at Commission level
Changes at FTC

- Bureau of Competition Director
  - Richard Feinstein rumored to be leaving, replacement unknown

- Mergers IV (responsible for hospital mergers)
  - Jeff Perry – approaching one year anniversary as Assistant Director
  - Recently filed complaints/amended complaints in Idaho (St. Luke’s Health System), Phoebe Putney
  - Waiting for 6th Circuit opinion in ProMedica

Heavy scrutiny of healthcare sector expected to continue at staff/front office level
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Transaction Characteristics Likely to Attract Scrutiny

- One or more of the health system’s top payors has used the merging health system as leverage in contract negotiations
- Top payors have historically needed only one of the two merging health systems in their networks – but not both
- There are few or no reasonable alternatives to the merging health systems within the geographic area
Transaction Characteristics Likely to Attract Scrutiny

- The local business community is unlikely to support the transaction
- The health system’s strategic planning documents identify the merging health system as one of its primary competitors
- The health system’s transaction documents identify a purpose of the transaction is to eliminate competition or raise rates
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Presenting Efficiency and Quality Benefits

- **2010 Horizontal Merger Guidelines – Key Principles**
  - Must be likely to reverse the merger’s anticompetitive effects
  - The greater the likely anticompetitive effects, the greater must be the efficiencies
  - Certain efficiencies “more likely to be cognizable and substantial”
    - Lower incremental costs from shifting production among facilities
  - Others are less likely to be persuasive
    - Related to procurement, management, capital cost

- **Treatment of Efficiencies Under Case Law**
  - High legal standard, especially in § 13(b)/PI proceedings
    - “No court in a 13(b) proceeding … has found efficiencies sufficient to rescue an otherwise illegal merger.” *ProMedica* (N.D. Ohio 2011)
    - *See also H&R Block* (D.D.C. 2011) – proposed efficiencies were either “not merger-specific or not verifiable”
Cost reduction from service line consolidations
   - Elimination of redundancies (staff, equipment)
   - But how concrete and definite is consolidation plan?

Capital expenditure avoidance
   - Merger unites complementary assets
   - How certain that but for the merger, the capital would have been spent?

Purchasing economies
   - Would a joint purchasing program do the same thing? Merger specific?

Acquiring system will bring synergy to seller (better cost & quality)
   - Can buyer show that system synergies improved quality and cost structure at the last hospital buyer acquired?
Potential Efficiencies / Issues of Proof

- A single IT system saves cost; more clinical data aid benchmarking
  - Do you need your competitor’s data to benchmark? (merger-specificity)

- Combined service lines will become “centers of excellence”
  - Wholly dependent on execution of the consolidation plan
  - Aren’t the service lines excellent now? How will they improve?

- Higher volumes will help recruit better doctors
  - How has recruitment been lacking?

- Higher volumes = more repetition = more experience = better quality
  - The FTC disputes this as lacking empirical support
What Are The Agencies Looking For?

- In general
  - Look for cognizable efficiencies under Merger Guidelines
  - See also related analytical frameworks: Statements of Antitrust Enforcement Policy in Health Care; “ACO Antitrust Enforcement Statement”; Guidelines for Collaborations Among Competitors

- In provider transactions/collaborations
  - Quality improvements or halting deterioration
  - Cost savings enabling new or expanded services/facilities, providing existing services at lower cost
  - Other efficiencies that benefit patients

- Key is that efficiencies flow through to consumers
Efficiencies – OSF/Rockford Health System

- Parties’ efficiency, quality claims
  - Annual recurring cost savings based on clinical consolidation
  - One-time capital avoidance savings
  - Improved quality of care, other community benefits
  - Efficiencies will outweigh any anticompetitive effects

- FTC disputed efficiency claims
  - Claims “fall well short of the substantial, merger-specific, well-founded, and competition-enhancing efficiencies that would be necessary to outweigh the [ ] significant competitive harm”
  - Claims made for litigation, outside of regular business planning

- N.D. Ill. ordered PI; found efficiencies fell short
  - Noted high legal standard, particularly in § 13(b) context
  - Consolidation savings uncertain, speculative; conflicting experts
  - Capital avoidance savings “not sufficiently certain at this time”
  - Clinical effectiveness best practices not certain, merger-specific
Successful efficiencies claims:

- Non-public investigation of hospital merger in northeast
  - Hospitals were closest geographically; strong competitors
  - B hospital had beds; A hospital needed beds: avoids new tower
  - B hospital in financial trouble; A hospital to invest >$100M in B
  - A hospital presented plans for consolidation of services, timeline
  - A hospital agreed to provide charitable care, financial assistance
  - Key: strong, early case for efficiencies, quality, and other factors
  - Investigation closed after Second Request issued
  - “Court is persuaded that the proposed merger would result in significant efficiencies” (CapEx avoided, operating efficiencies)
Essential Transaction Planning for Efficiencies

- As soon as possible after identifying the transaction vision, goals and rationale, assess the benefits of the transaction to the community
  - quality improvements
  - cost reductions
  - new or expanded services
  - new or expanded locations
- Identifying community benefits is key for demonstrating both the exercise of fiduciary duties by the governing bodies of the parties as well as the pro-competitive efficiencies of the transaction
Essential Transaction Planning for Efficiencies

- Articulate the community benefits of the transaction to key stakeholders
- Garner community support for the transaction from key stakeholders
- Don’t speculate about the effects of the transaction on competition, prices and profitability
  - Contemporaneous documents should be consistent with proposed efficiencies (or be aware of those that are not)
- Consider outside consultant at outset
  - Avoids gun-jumping and competitive information sharing risks
  - Demonstrates efficiency study not done only because of an agency investigation
- Even if agency staff is never convinced that efficiencies will be realized, a robust efficiencies analysis can affect prosecutorial discretion
Best Practices for Presenting Efficiencies

- Focus on specific, concrete, real-world, verifiable benefits of merger
- Document efficiencies diligence, deliberations, and plans
- Seek health plan and constituent “buy in” for efficiencies
- Solidify (as many) efficiency plans (as possible)
- Raise efficiency claims early with staff
- Show efficiencies were key deal driver, not just ancillary
- Explain how efficiencies benefit consumers, not parties
- Compare deal with what could do alone/with another
- Demonstrate past success in achieving efficiencies
- Tie efficiency claims to any financial condition arguments
- Identify what will be achieved shortly after close (Yr 1, 2)
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October 2011 – FTC/DOJ issued a final Statement of Antitrust Enforcement Policy Regarding ACOs Participating in the Medicare Shared Savings Program (MSSP)

All MSSP-participating ACOs deemed to be sufficiently integrated within the meaning of the antitrust laws

ACOs in commercial market get rule of reason treatment if:

– Use the same governance and leadership structure and
– Use the same clinical and administrative processes that it uses to qualify for and participate in the MSSP
FTC/DOJ Policy Statement (2011) – Safety Zone

- Safety zone generally
  - ACO comprised of independent ACO participants that provide a common service
  - Where the ACO’s combined share of the common service is 30% or less in each ACO participant’s primary service area (PSA)
    - PSA is “the lowest number of contiguous zip codes from which” the ACO participant “draws at least 75% of its” patients

- Exclusivity
  - Any hospital or ASC participating in an ACO must be non-exclusive to the ACO to qualify for the safety zone, irrespective of its PSA share
  - Physicians and other providers may be non-exclusive or exclusive to the ACO, subject to the rural provider and dominant provider exceptions
FTC/DOJ Policy Statement (2011) – Safety Zone

- Rural provider exception
  - An ACO may include one physician per specialty from each rural county and still qualify for the safety zone so long as that physician is non-exclusive to the ACO
    • Applies even if inclusion of that physician causes the ACO’s share of any common service to exceed 30% in any ACO participant’s PSA for that service
  - An ACO may include a critical access hospital or a sole community hospital and still qualify for the safety zone so long as that hospital participates on a non-exclusive basis
    • Applies even if inclusion of a rural hospital causes the ACO’s share of any common service to exceed 30% in any ACO participant’s PSA for that service
Dominant provider exception

- To fall within the safety zone, any ACO that includes a participant with greater than a 50% share (dominant provider) in its PSA of any service that no other ACO participant provides must be non-exclusive to the ACO.

- In addition, an ACO with a dominant provider cannot require a payor to contract exclusively with the ACO or otherwise restrict the payor’s ability to contract with other ACOs or provider networks.
Voluntary Agency Antitrust Review

- “Newly formed” ACOs may seek voluntary expedited antitrust review
- ACOs that, as of 3/23/2010, “had not yet signed or jointly negotiated any contracts with private payors” and have not yet participated in the MSSP
- Must seek expedited review prior to participation in the MSSP
- Must submit request to both the FTC and DOJ
- Agencies will determine which Agency reviews
- Expedited review is 90 days
- Both an ACO’s request letter and the Agency’s response will be made public consistent with confidentiality provisions
Earlier this month, the FTC/DOJ ACO Working Group issued a summary of activities:

- Fielded 33 questions under the Policy Statement, mostly pertaining to PSA calculation
- 2 requests for voluntary expedited review
  - Both subsequently withdrawn by the requestor
ACO Conduct To Avoid

- If outside safety zone, agencies recommend avoiding:
  - Sharing among ACO participants competitively sensitive information that could give rise to an unlawful agreement (irrespective of PSA shares)
  - Preventing or discouraging commercial payors from steering patients to other providers
  - Tying sales of the ACO’s services to the payor’s purchase of other services from providers outside the ACO
  - Contracting with ACO participants on an exclusive basis
  - Restricting a payor’s ability to disclose to its beneficiaries cost and quality data
Applicability

- Policy Statement applies to all MSSP-participating ACOs, irrespective of formation date
  - Does not apply to ACOs whose programs are substantially similar to ACOs participating in the MSSP but who provide services in the commercially-insured market only
  - Such organizations do not have the guaranty of rule of reason treatment or the safe harbor available to them
  - Nevertheless, analytical framework of the Policy Statement should be instructive for ACOs participating only in the commercial marketplace
  - Also, Policy Statement analytical principles apply to CMS Innovation Center ACO programs “as long as those ACOs are substantially clinically or financially integrated”
Non-Merger Collaborations

- Joint conduct and collaborations still focus of FTC

- Guidance from the Agencies:
  - Antitrust Guidelines for Collaborations Among Competitors – FTC/DOJ 2000
  - Statements of Antitrust Enforcement Policy in Health Care – FTC/DOJ 1996
  - FTC Advisory Opinions (http://www.ftc.gov/bc/healthcare/industryguide/opinionguidance.htm)

- ACO Policy Statement’s “conduct to avoid” also good advice for physician collaborations
Non-Merger Collaborations

- Independent, competing providers who participate in a clinically or financially-integrated venture may jointly negotiate managed care rates that are ancillary to the joint venture (so long as they do not exercise market power)

- Key Questions:
  - Formational
    - Will the provider participants collectively be able to exercise market power?
  - Operational
    - Are the provider participants sufficiently integrated through their participation in the clinical integration program?
    - Is joint managed care contracting reasonably necessary to achieve the efficiencies of the clinical integration program?
Formational

- **Antitrust Safety Zones**
  - Statement 8 of the 1996 DOJ/FTC Healthcare Statements
  - Apply currently only to physician networks, not to multi-provider networks
  - 20% or less of providers in an exclusive network
  - 30% or less of providers in a non-exclusive network

- **Exclusivity**
  - Whether the network allows the provider participants to contract independently of the network, on their own or through other networks
  - Whether provider participants have the practical ability – and do – contract outside of the network
  - Three favorable advisory opinions address non-exclusive networks
  - One unfavorable advisory opinion addresses an exclusive network
  - Free-riding issue
Operational

- Are the provider participants sufficiently integrated through their participation in the clinical integration program?
  - Whether the network has implemented an active and on-going program to evaluate and modify the practice patterns of all participating physicians and create a high degree of interdependence and cooperation among the physicians to control costs and achieve quality

- Is joint managed care contracting reasonably necessary to achieve the efficiencies of the clinical integration program? Such as:
  - Improve outcomes
  - Deliver services for efficiently
  - Reduce practice variances
  - Enhance practitioner knowledge base
  - Realize benefits of clinical data exchange
Key Elements for Sufficient Integration

- Implement mechanisms to monitor and control utilization of healthcare services that are designed to control costs and assure quality of care
  - Care management programs
    - Smoking cessation
    - Diabetes
    - Asthma
    - Generic prescribing
Key Elements for Sufficient Integration

- Clinical protocols
  - Clinical practice guidelines that address utilization and quality goals for various diagnoses
  - Addressing the diagnoses most prevalent in the participating physicians’ practices
Key Elements for Sufficient Integration

- Select network physicians who are likely to further the network’s efficiency objectives
  - Monitor performance to improve outcomes and control costs
- Invest substantial capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies
  - Common software, electronic medical records systems, and data warehousing to permit shared access to patient records
FTC/DOJ Healthcare Report

- Joint Agency report in 2004 titled “Improving Health Care: A Dose of Competition”

- Six questions the FTC/DOJ are likely to ask when analyzing the competitive implications of a contracting network that jointly contracts on the basis of clinical integration
1. What do the physicians plan to do together from a clinical standpoint?
   - What specific activities will (and should) be undertaken?
   - How does this differ from what each physician already does individually?
   - What ends are these collective activities designed to achieve?
2. How do the physicians expect actually to accomplish these goals?

- What infrastructure and investment is needed?
- What specific mechanisms will be put in place to make the program work?
- What specific measures will there be to determine whether the program is in fact working?
3. What basis is there to think that the individual physicians will actually attempt to accomplish these goals?

– How are individual incentives being changed and realigned?

– What specific mechanisms will be used to change and re-align the individual incentives?
4. What results can reasonably be expected from undertaking these goals?
   
   - Is there any evidence to support these expectations, in terms of empirical support from the literature or actual experience?
   
   - To what extent is the potential for success related to the group’s size and range of specialties?
5. How does joint contracting with payors contribute to accomplishing the program’s clinical goals?
   - Is joint pricing reasonably necessary to accomplish the goals?
   - In what ways?
6. To accomplish the group’s goals, is it necessary (or desirable) for physicians to affiliate exclusively with one IPA or can they effectively participate in multiple entities and continue to contract outside the group?

– Why or why not?
Non-Merger Collaborations

  - 5th Circuit affirmed Commission decision that an association of independent physicians engaged in horizontal price fixing regarding fees they would charge health insurers

- No less than 12 Complaints brought by FTC alleging illegal agreements on price by physician groups between 2006 and Feb. 2013
  - All ended in consent agreements
Non-Merger Collaborations

Norman PHO (2013) – most recent advisory opinion

- PHO in Oklahoma
- 280 PCPs & specialists in 38 areas
- Non-exclusive clinical integration program
- Favorable opinion
- Collects & analyzes physician data to assess high-prevalence, high-cost & high-risk chronic conditions & has identified 9 conditions for practice guidelines
- Clinical protocols covering as many as 50 disease-specific conditions
- Electronic platform including a clinical decisions support system, e-prescribing, an electronic medical records system and an electronic health interface system
- Physicians required to pay initial & annual dues, withholds on reimbursements for CIP activities, acquire & maintain certain IT, participate on 1 CIP committee & adhere to other CIP requirements
- Comprehensive review processes & ability to financially penalize & terminate any physician who does not comply with CIP requirements
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State Action Immunity

- Judge-made doctrine immunizes certain entities from antitrust liability
  - states acting as sovereigns;
  - acts of political subdivisions when acts are taken pursuant to a *clearly articulated and affirmatively expressed* state policy to displace competition and the anticompetitive effects are a *foreseeable result* of the state’s authorization of the policy;
  - private actors if political subdivision test met and actively supervised by the state.

- Disfavored by FTC and DOJ

- Recent Supreme Court decision resolved Circuit Split
Unanimous decision by Supreme Court in February 2013

FTC challenge of a Georgia governmental hospital authority’s purchase of a competing hospital

– Alleged 2 to 1 controlling 86% (discharges) of the general acute care inpatient hospital services market

11th Circuit ruled that hospitals were immune under state action doctrine
Supreme Court held:

- Hospital Authorities Law permitted the Authority to acquire hospitals, but “it does not clearly articulate and affirmatively express a state policy empowering the Authority to make acquisitions of existing hospitals that will substantially lessen competition.”

- Conceded that the anticompetitive result need not be stated explicitly by the legislature but held that a state policy to displace federal antitrust law is sufficiently expressed only where “the displacement of competition was the inherent, logical, or ordinary result” of the act of delegation by the state legislature.

- Power to merely acquire other hospitals was not enough for state action immunity
FTC v. Phoebe Putney Health System, Inc.

- Ruling arguably narrows scope of state action immunity
  - Not a sweeping change
  - But, the grant of general corporate powers to merge or acquire will not be enough for immunity

- Battle over state action immunity may now turn to state legislatures
  - State Legislatures will need to pass more explicit regulations authorizing or approving anticompetitive conduct
  - Need to ensure legislative history reflects intent to displace competition with regulation

- Cannot exclude possibility that FTC will challenge deals by government owned hospitals in states/Circuits that previously supported state action immunity
State Action Immunity

- Multi-step analysis
  - Determine whether hospital is a political subdivision or private actor
  - Determine whether displacement of competition is a “clearly articulated” and “affirmatively expressed” policy
    - Cannot be merely a grant of general powers
    - Authorization of *some* anticompetitive conduct does not mean authorization of *all* anticompetitive conduct – need to examine scope of statute(s)
  - Determine whether the anticompetitive effect is the “foreseeable result” of what the state authorized
    - Does not have to be explicitly stated, but must be “inherent, logical, or ordinary result” of the laws
    - Supreme Court held power to acquire does not ordinarily produce anticompetitive effects
  - If private actor, determine whether actively supervised by the state/political subdivision
    - “[S]ufficient systematic state involvement such that the challenged activities can be fairly attributable to the state itself.” (Supreme Court in *Midcal* case)
New York State Action Immunity Legislation

- March 2011 - New York legislature passes COPA legislation
  - Encourage cooperative and integrative arrangements, including mergers and acquisitions among health care provider that may be competitors
  - Expressly displaces competition:
    - “the intent of the state is to supplant competition … and to provide state action immunity under the state and federal antitrust laws … where the benefits of such active supervision, arrangements and actions of the commissioner outweigh any disadvantages likely to result from a reduction of competition”

- Law requires “active supervision” by the Department of Health
  - Requires DOH to promulgate regulations to implement the legislation, including:
    - standards for determining which proposed collaborations, integrations, mergers or acquisitions are covered by the legislation
    - manner by which the interests specified in the law will be advanced through regulatory oversight
  - No regulations adopted as of April 2013
Thank You

Questions?