Federal Trade Commission Staff Submission to Indiana Health Department Regarding the Certificate of Public Advantage Application of Union Health and Terre Haute Regional Hospital

Pursuant to Indiana Code 16-21-15

PUBLIC VERSION (REDACTED)
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Bureau of Competition
Bureau of Economics
Office of Policy Planning

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The staff of the Federal Trade Commission's ("FTC") Bureau of Competition, Bureau of Economics, and Office of Policy Planning (collectively, "FTC staff")[1] respectfully submits this public comment regarding the Certificate of Public Advantage application ("COPA Application") submitted by Union Hospital, Inc. ("Union Health") and Terre Haute Regional Hospital, L.P. ("THRH") (collectively, the "Parties") to the Indiana Department of Health ("IN DOH")[2] pursuant to Indiana Code 16-21-15.[3] We appreciate the opportunity to present our views on Union Health's proposed acquisition of THRH (also referred to as "proposed merger") in connection with the IN DOH's review of their COPA Application.

I. Executive Summary

FTC staff submits this comment to express our concern that the proposed merger presents substantial risk of serious competitive and consumer harm in the form of higher healthcare costs, lower quality, reduced innovation, reduced access to care, and depressed wages for hospital employees. Applying the standard of the Indiana COPA Act, there is insufficient evidence to conclude that the potential harms from a reduction in competition are likely to be outweighed by the potential benefits of the merger and thus the COPA should not be granted. Furthermore, it is doubtful that the regulatory conditions imposed by the IN DOH would effectively mitigate all of the potential anticompetitive harms to patients in the Terre Haute area – both in the near term and in the decades to come. In short, FTC staff believes the proposed merger is likely to lead to higher costs and worse healthcare outcomes for Indiana consumers, as well as lower wage growth for hospital workers.

The Indiana state legislature passed the Indiana COPA Act to allow hospital mergers that "may benefit the public by maintaining or improving the quality, efficiency, and accessibility of health care services offered to the public."[4] Here, allowing for anticompetitive consolidation in a highly concentrated market undermines the laudable goal of improving healthcare services. As discussed below, competition has proven to be a more reliable and effective mechanism for controlling healthcare costs while preserving quality of care.

In recent years, multiple organizations in Indiana have engaged in statewide policy initiatives to reduce healthcare costs stemming, in part, from consolidation among competing

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[1] These comments express the views of the FTC's Bureau of Competition, Bureau of Economics, and Office of Policy Planning. These comments do not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

[2] Application for Certificate of Public Advantage Submitted by Union Hospital, Inc. [hereinafter Union Health] and Terre Haute Regional Hospital, L.P. to Indiana Department of Health (Sept. 14, 2023). The Parties have since submitted additional materials to the IN DOH in response to multiple requests for information. Redacted versions of these materials are publicly available at https://www.in.gov/health/cshcr/certificate-of-public-advantage/pendingapproved-copas/.

[3] Indiana Public Health Law, Title 16, Article 21, Chapter 15 §§ 0.05-11, Certificate of Public Advantage of Hospital Mergers [hereinafter Indiana COPA Act]. *See also* Indiana Department of Health, *Indiana Certificate of Public Advantage (COPA) Application Checklist* (Apr. 1, 2022), https://www.in.gov/health/cshcr/files/COPA-application-final-3.22.pdf [hereinafter IN DOH COPA Checklist]; Indiana General Assembly, Title 410 Indiana Department of Health Emergency Rule LSA Document #22-9(E) (expired), http://iac.iga.in.gov/iac/irdin.pdf?din=20220119-IR-410220009ERA.

[4] Indiana COPA Act § 16-21-15-0.5(a)(1).

healthcare providers in Indiana. Empirical studies have found that hospital consolidation is a key driver of higher healthcare prices in Indiana without any improvements to quality of care and suggest that policymakers should consider strengthening antitrust enforcement in Indiana. The Indiana state legislature formed a task force in January 2022 aimed at lowering the state's escalating healthcare costs. Among the issues the task force considered was the effect of provider concentration and what factors have contributed to it. In its final report, the task force recommended that the state require merging healthcare entities to provide at least six months' notice of mergers and acquisitions to the state so that they can be reviewed appropriately. The Indiana state legislature recently adopted this recommendation by passing legislation broadening the Indiana Attorney General's authority to monitor the consolidation of healthcare providers, which became effective in July 2024.[5]

FTC staff's concerns detailed in this submission are based on our assessment to date of the proposed merger, applying the Clayton Act's analytical framework described in the *Merger Guidelines* issued by the FTC and U.S. Department of Justice.[6] We have conducted evaluations of both the potential harm to Indiana patients and employees from the loss of competition as well as the potential benefits, including clinical quality benefits and cost savings, that the Parties claim they will be able to achieve through the proposed merger. We have also evaluated the Parties' financial conditions. The IN DOH considers these same factors when reviewing COPA applications. Thus, the goals of our analysis are closely aligned with the analysis that the IN DOH will undertake. For ease of reference, we present our analysis using the specific review factors contained in the Indiana COPA Act.[7]

Existing competition between Union Health and THRH benefits area patients and employers by enabling health insurers to negotiate lower hospital reimbursement rates (i.e., prices) on behalf of their customers. This competition ultimately reduces the prices that Indiana patients must pay in premiums, copayments, deductibles, and other out-of-pocket expenses. Furthermore, competition between the Parties likely improves healthcare quality in Indiana, as well as the availability of services and new healthcare technologies, as the hospitals compete to attract patients to their respective systems. This competition likely also results in improved wages and benefits for hospital employees.

Conversely, FTC staff has obtained evidence that the proposed merger between Union Health and THRH will likely lead to higher prices and reduced quality of care in Indiana, as well as reduced access to healthcare services.[8] It will also likely result in worse working conditions and lower wage growth for hospital employees. Some stakeholders and academics have

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[5] *See* Indiana Senate Enrolled Act No. 9, *AN ACT to amend the Indiana Code concerning health*, Second Regular Session of the 123rd General Assembly (2024).
[6] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, MERGER GUIDELINES (2023), https://www.ftc.gov/system/files/ftc_gov/pdf/P234000-NEW-MERGER-GUIDELINES.pdf.
[7] Indiana COPA Act § 16-21-15-4, https://iga.in.gov/laws/2022/ic/titles/16#16-21-15-4.
[8] As described in Section IV, FTC staff have conducted interviews with market participants and stakeholders; performed economic analyses using hospital discharge data, as well as a labor market analysis using American Hospital Association data; and reviewed public information. Our assessment is also supported by non-public documents, data, and information that we have obtained and reviewed.

expressed these concerns publicly.[9] Indeed, we have learned that the IN DOH has received over 200 public comments, and that the vast majority expressed concerns about or are opposed to the proposed merger.[10]

FTC staff's quantitative economic analyses confirm that Union Health and THRH are each other's closest, most direct competitor, and that the proposed merger will result in reduced competition. Indeed, staff's analysis predicts that 77.7% of THRH's patients view Union Health as their next best choice, and 47.6% of Union Health's patients view THRH as their next best choice. Figures of this magnitude indicate that the proposed merger would likely lead to significant price increases in Indiana, as well as reduced business incentives to maintain or improve quality.[11] The proposed merger would also result in high market shares for the merged firm. In Vigo County, where the effects of the proposed merger likely would be felt most acutely by patients, the Parties would have a combined share of nearly 74% of commercially insured inpatient hospital services.[12] To put this figure in context, mergers resulting in a combined share of 30% or more are presumptively unlawful under the antitrust laws. The proposed merger far surpasses that bar.

The Parties assert that their merger initiatives "will reduce health care costs, will improve the quality of care provided by the Combined Clinical Platform, and will significantly improve the health status of the residents of Vigo County and the other counties of the Wabash Valley Community."[13] The Parties, however, have not provided sufficient information to substantiate many of these claims, nor have they demonstrated that the claimed benefits and cost savings would offset the merger's substantial harm to competition. Moreover, the proposed merger does not appear necessary to achieve many of these claimed benefits, which may be realized through arrangements that are less restrictive to competition.

FTC staff also performed a labor analysis, and determined that the proposed merger would likely depress wage growth for registered nurses due to increased employer consolidation.[14] The proposed merger will reduce competition for healthcare employees, despite the Parties' claims to the contrary.[15] This reduction in labor market competition could lead to

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[9] *See, e.g.*, Samantha Liss, *Indiana weighs hospital monopoly as officials elsewhere scrutinize similar deals*, KFF Health News (Jun. 14, 2024), https://kffhealthnews.org/news/article/indiana-copa-hospital-monopoly-scrutiny/; Caitlin Hunt, *"Once you become a one hospital town, that's it!" Concerns raised about Union and Regional Hospital merger*, WTHI-TV News 10 (Dec. 6, 2023), https://www.wthitv.com/news/once-you-become-a-one-hospital-town-thats-it-concerns-raised-about-union-and-regional/article_0e8b7f9a-9477-11ee-bb6b-c32d70c9c103.html; Sue Loughlin, *Questions raised about hospital merger under COPA*, Tribune-Star (Jan. 16, 2024), https://www.tribstar.com/news/local_news/questions-raised-about-hospital-merger-under-copa/article_d77db760-b09c-11ee-b389-776de077acfc.html.

[10] *See* Section VII for a summary of the main concerns raised by patients and hospital employees.

[11] *See* Section VI.A.3 for further discussion of diversion ratios.

[12] *See* Section VI.A.4 for further discussion of market shares and concentration analyses.

[13] COPA Application at 19.

[14] *See* Section VII.E for further discussion of wage effects.

[15] In the COPA Application, Union Health claims it is committed to protecting THRH employees post-merger and that cutting costs by reducing workforce is not a goal of the merger. *See* COPA Application at 18. However, as we discuss in Section VII.E, this commitment appears vague and unenforceable. Furthermore, even if this commitment

reduced wages and benefits for healthcare employees, which could further exacerbate the current challenges of recruiting and retaining healthcare professionals in this region.

The Parties claim the statutory COPA framework provides for active supervision by the IN DOH that will protect against competitive harms resulting from the merger, particularly the limitation on hospital rate increases, the annual reporting of price and quality information by the hospital, and the authority of the IN DOH to issue a deficiency notice and require the hospital to adopt a plan of correction.[16] Moreover, the Parties claim that price transparency requirements "will serve as a further check on Union Hospital's ability to increase rates."[17] However, COPA frameworks in other states have proven unwieldy and difficult to manage and have failed to protect local communities from the harmful effects of anticompetitive hospital mergers. The Parties' COPA Application does not include sufficient evidence that the statutory framework would ameliorate these problems, and FTC staff is unaware of additional terms or conditions that the IN DOH may impose pursuant to COPA approval that would mitigate any anticompetitive effects of the merger.[18]

Based on the foregoing reasons which are fully supported below, we urge the IN DOH to deny the Parties' COPA Application.

II. FTC's Interest and Experience

The FTC's mission includes promoting fair competition in healthcare markets that will benefit patients, hospital employees, and the public at large. To carry out this mission, Congress has charged the FTC with enforcing the Clayton Act, which prohibits mergers and acquisitions that may substantially lessen competition or tend to create a monopoly.[19] In addition, the FTC enforces the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[20] Pursuant to its statutory mandate, the FTC seeks to identify mergers and acquisitions, business practices, laws, and regulations that may lessen competition.

Vigorous competition among healthcare providers in an open marketplace provides patients with the benefits of lower prices, higher quality, greater access, innovation for goods and services, and improved wages and benefits for employees.[21] Anticompetitive mergers and

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were enforceable, there would still be a reduction in employment options for hospital workers in Terre Haute as a result of this merger.

[16] COPA Application at 59.

[17] COPA Application at 60.

[18] *See* Section VIII for further discussion of the Parties' proposed conditions and conduct remedies more generally. In merger challenges, the FTC prefers "structural remedies" (*i.e.*, an injunction preventing consummation of a merger or a divestiture of assets) rather than "conduct remedies" (*i.e.*, restrictions intended to regulate the conduct of a merged firm).

[19] *See* Clayton Act, 15 U.S.C. § 18; Federal Trade Commission Act, 15 U.S.C. § 45.

[20] *Id*.

[21] *See* Nat'l Soc. of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978) (The antitrust laws reflect "a legislative judgment that, ultimately, competition will produce not only lower prices, but also better goods and services. . . .

conduct in healthcare markets have long been a focus of FTC law enforcement, research, and advocacy.[22] A critical part of the FTC's role in protecting the public is reviewing proposed mergers and acquisitions in the healthcare industry. The FTC has considerable experience in evaluating proposed hospital, outpatient facility, and physician group mergers, to determine whether they may substantially lessen competition or tend to create a monopoly.[23]

The FTC has a long history of advocating against the use of COPAs through comments and testimony submitted to state legislators and other stakeholders due to concerns that COPAs may enable activity that would substantially reduce competition.[24] In 2017, the FTC announced a policy project to assess the impact of COPAs on prices, quality, access, and innovation for healthcare services.[25] This project has included empirical research of past COPAs, a public workshop highlighting practical experiences with COPAs and related policy considerations, and an ongoing study of recently approved COPAs.[26]

In 2022, FTC staff released a paper, *FTC Policy Perspectives on Certificates of Public Advantage*, and a brief information sheet, *Key COPA Facts*, which summarize empirical research on COPAs approved in other states and findings from our COPA assessment policy project.[27] In particular, we have learned that COPAs can be difficult to monitor and regulate over a long period, and that COPA oversight regimes are often unsuccessful in mitigating price and quality

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The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain – quality, service, safety, and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[22] *See, e.g.*, FED. TRADE COMM'N, *The FTC's Health Care Work*, https://www.ftc.gov/news-events/topics/competition-enforcement/health-care-competition; FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2024), https://www.ftc.gov/system/files/ftc_gov/pdf/Overview-Healthcare.pdf.

[23] *See* FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, *supra* note 22, at Section III.

[24] *See, e.g.*, FTC Staff Submission to New York State Department of Health Regarding the Certificate of Public Advantage Application of State University of New York Upstate Medical University and Crouse Health System, Inc. (Oct. 7, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/FTC-NY-COPA-Comment-10-7-2022-PUBLIC.pdf; FTC Staff Comment to Texas Health and Human Services Commission Regarding Certificate of Public Advantage Applications (Sept. 11, 2020), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhsccopacomment.pdf; FTC Staff Submissions Regarding the Proposed Merger and COPA Applications of Mountain States Health Alliance and Wellmont Health System, https://www.ftc.gov/enforcement/cases-proceedings/151-0115/wellmont-healthmountain-states-health.

[25] *See* FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments (Nov. 1, 2017), https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa_assessment_public_notice_11-1-17_revised_3-27-19.pdf.

[26] *See* FTC Public Workshop, *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets* (Jun. 18, 2019), https://www.ftc.gov/news-events/events/2019/06/health-check-copas-assessing-impact-certificates-public-advantage-healthcare-markets [hereinafter FTC COPA Workshop]; FTC Press Release, *FTC to Study the Impact of COPAs* (Oct. 21, 2019), https://www.ftc.gov/news-events/press-releases/2019/10/ftc-study-impact-copas.

[27] *See* Federal Trade Commission, *FTC Policy Perspectives on Certificates of Public Advantage* (Aug. 15, 2022) and *Key COPA Facts*, both available at www.ftc.gov/copa (Attachment A).

harms resulting from a loss in competition. Indeed, several COPAs have resulted in substantial price increases for patients, as well as declines in quality of care. Furthermore, when COPA oversight is removed, the risk of price and quality harms increases significantly.

Following release of the FTC's COPA Policy Paper, FTC staff has learned of several developments concerning COPAs. In 2023, hospitals seeking a COPA in New York abandoned a proposed merger while it was still being reviewed by the New York Department of Health, and after the FTC opposed their COPA application.[28] We also learned that Maine repealed its COPA law, primarily due to the findings in the FTC's COPA Policy Paper.[29] We are also aware of several concerns raised by citizens and stakeholders about the Ballad Health COPA that was approved in Tennessee and Virginia in 2018.[30]

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[28] *See* FTC Press Release, *Statement of Elizabeth Wilkins, Director of the FTC's Office of Policy Planning, on the Decision of SUNY Upstate Medical University and Crouse Health System, Inc. to Drop Their Proposed Merger* (Feb. 16, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/02/statement-elizabeth-wilkins-director-ftcs-office-policy-planning-decision-suny-upstate-medical; James Mulder, *SUNY Upstate, Crouse hospitals call off merger plan*, Syracuse.com Health News (Feb. 16, 2023), https://www.syracuse.com/health/2023/02/suny-upstate-crouse-hospitals-call-off-merger-plan.html; Dave Muoio, *FTC Celebrates after SUNY Upstate, Crouse Health System scrap merger plans*, FIERCE HEALTHCARE (Feb. 17, 2023), https://www.fiercehealthcare.com/providers/ftc-celebrates-after-suny-upstate-crouse-health-system-scrap-merger-plans.

[29] *See, e.g.*, FTC Press Release, *FTC Policy Director Issues Statement Commending Maine's Repeal of Certificate of Public Advantage Law* (Jun. 13, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/06/ftc-policy-director-issues-statement-commending-maines-repeal-certificate-public-advantage-law.

[30] *See, e.g.*, Adam Friedman, *With Ballad Health under new scrutiny, Tennessee to hold yearly hearing on monopoly agreement*, Tennessee Lookout (Jul. 1, 2024), https://tennesseelookout.com/2024/07/01/with-ballad-health-under-new-scrutiny-tennessee-to-hold-yearly-hearing-on-monopoly-agreement/ (summarizing public's concerns with the Ballad Health COPA); Jeff Keeling, *COPA monitor: Ballad underspending on capital upkeep*, WJHL News Channel 11 (May 10, 2024), https://www.wjhl.com/news/local/copa-monitor-ballad-underspending-on-capital-upkeep/ (quoting the state's COPA monitor: "'Since Ballad does not have inpatient competition, it is not subject to the normal market pressures to maintain quality and updated property, plant, and equipment (PPE),'. . . Fitzgerald, who just retired from the COPA Monitor position he'd held since Ballad's inception, said if that trend continued, Ballad would 'struggle to meet the objectives of the TOC.' He specifically listed consistent high-quality patient care, appropriate physician, employee and patient satisfaction, improved population health, expanded access to care, particularly in rural areas, and maintaining modern diagnostic and therapeutic equipment."); Brett Kelman and Samantha Liss, *These Appalachia hospitals made big promises to gain a monopoly. They're failing to deliver.*, USA Today (Sept. 29, 2023), https://www.usatoday.com/story/news/nation/2023/09/29/ballad-health-hospitals-fall-short-quality-and-charity-care/70975091007/; Elisabeth Rosenthal, *Your Exorbitant Medical Bill, Brought to You by the Latest Hospital Merger,* New York Times Essay (Jul. 25, 2023), https://www.nytimes.com/2023/07/25/opinion/health/health-system-hospital-monopolies.html (citing examples of Ballad Health reducing services and increasing prices to insurers and patients). *See also* Dani Cook Public Comments at FTC Open Commission Meeting (Jan. 18, 2024), https://www.ftc.gov/media/open-commission-meeting-january-18-2024 (beginning 29 minutes and 35 seconds into the video, 29:35), FTC Open Commission Meeting (Mar. 21, 2024), https://www.ftc.gov/media/open-commission-meeting-march-21-2024 (beginning 14 minutes and 5 seconds into the video, 14:05), and FTC Open Commission Meeting (May 23, 2024), https://www.ftc.gov/media/open-commission-meeting-may-23-2024 (beginning 11 minutes and 12 seconds into the video, 11:12); Leslie Taylor Public Comments at FTC Open Commission Meeting (May 23, 2024), https://www.ftc.gov/media/open-commission-meeting-may-23-2024 (beginning 17 minutes and 28 seconds into the video, 17:28).

III. Recent Studies and Policy Efforts to Address High Healthcare Costs in Indiana

In recent years, multiple organizations in Indiana have engaged in statewide policy initiatives to reduce healthcare costs stemming, in part, from consolidation among competing healthcare providers in Indiana.[31] For example, the Employers' Forum of Indiana collaborated with RAND Corporation to study hospital prices and design a price transparency initiative for Indiana employers. This series of studies found that hospital price increases are a key contributor to rising healthcare costs, and that variation in prices in Indiana and other states is largely driven by provider consolidation that increases hospitals' negotiating leverage with payors. Despite causing higher prices, "hospital consolidation has not been linked to improved quality outcomes or to operating efficiency."[32]

Another study conducted by the Petris Center on Health Care Markets and Consumer Welfare similarly found that hospital consolidation is an important contributor to the higher healthcare costs in Indiana, which "lead to higher health insurance premiums paid by employers, causing a reduction in wages."[33] Furthermore, this study "found no evidence that mergers produced higher quality. At the same time, the major hospital systems have amassed significant financial reserves, far higher than most hospitals in the rest of the country."[34] Notably, the Terre Haute Metropolitan Statistical Area ("MSA") was shown to be highly concentrated, with Union Health and THRH being the largest hospitals in that area.[35] The study suggested policies that prevent further market consolidation in light of its effects on prices, health spending, and quality. Indeed, the study recommends that "policymakers should consider enhancing antitrust enforcement and state merger notification and reviewing authority to scrutinize proposed mergers."[36]

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[31] *See, e.g.*, Employers' Forum of Indiana, *Improving the Value of Healthcare*, https://employersforumindiana.org/; Hoosiers for Affordable Healthcare, *Mission Statement*, https://www.h4ahc.com/about/.

[32] Christopher Whaley, Brian Briscombe, Rose Kerber, Brenna O'Neill & Aaron Kofner, PRICES PAID TO HOSPITALS BY PRIVATE HEALTH PLANS: FINDINGS FROM ROUND 4 OF AN EMPLOYER-LED TRANSPARENCY INITIATIVE, RAND Corporation Research Report at 2-3 (2022), https://www.rand.org/pubs/research_reports/RRA1144-1.html. *See also* Chapin White, HOSPITAL PRICES IN INDIANA: FINDINGS FROM AN EMPLOYER-LED TRANSPARENCY INITIATIVE, RAND CORPORATION RESEARCH REPORT (2017) https://www.rand.org/pubs/research_reports/RR2106.html.

[33] James Godwin, Brent Fulton, Daniel Arnold, Ola Abdelhadi & Richard Scheffler, INDIANA'S SOARING HOSPITAL PRICES AND UNAFFORDABLE INSURANCE PREMIUMS: CAUSES AND POTENTIAL SOLUTIONS, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health University of California, Berkeley at 5 (Oct. 6, 2022), https://petris.org/wp-content/uploads/2022/10/Petris-Center-Report-on-Indianas-Hospital-Prices-and-Insurance-Premiums-10.06.22.pdf.

[34] *Id.* at 6.

[35] *See Id.* at 15 (Figure 2.2 showing Union Health and THRH as the only hospitals in Vigo County and the largest hospital systems in the Terre Haute MSA), 20 (Table 2.2 showing concentration increased significantly in the Terre Haute MSA between 2009 and 2019, due mostly to increased market share amassed by Union Health via internal growth), 51 (Table 3.2 showing the share of primary care physicians vertically integrated with a hospital or health system increased significantly in the Terre Haute MSA from 2010 to 2018, from 16.4% to 36.2%, an increase of 19.8%).

[36] *Id.* at 7-8, 82-84.

In January 2022, the Indiana state legislature created a task force aimed at lowering the state's escalating healthcare costs.[37] The task force was asked to "[s]tudy and make recommendations concerning the market concentration of health care providers and contributing factors." Several witnesses testified during public hearings and provided evidence that hospital consolidation is a driving factor of higher healthcare costs in Indiana, and some recommended strengthening antitrust enforcement to prevent anticompetitive mergers.[38] The task force recently issued its final report with various recommendations, including to "[r]equire an Indiana health care entity seeking to merge or acquire another health care entity to provide a notice, not less than six months prior to the date of the merger or acquisition" to certain members of the Indiana General Assembly and for the Assembly.[39] This recommendation has now been adopted through legislation that broadens the Indiana Attorney General's authority to monitor the consolidation of healthcare providers, which went into effect in July 2024.[40]

All of these policy and legislative efforts are laudable and demonstrate that anticompetitive consolidation among competing providers can be a cause of the healthcare spending problem in Indiana. FTC staff urges the IN DOH to carefully consider all of this evidence – along with the evidence of the anticompetitive harms of this particular transaction – when determining whether the benefits of the proposed merger outweigh the disadvantages.

IV. FTC Evaluates Healthcare Mergers Similarly to the Approach Outlined in the Indiana COPA Act

The FTC's goal to promote fair competition in healthcare markets for patients, employees, and the public at large is aligned with the IN DOH's mission to "promote, protect, and improve the health and safety of all Hoosiers."[41] Likewise, the approach that the IN DOH must use to review a COPA application is similar to the approach FTC staff uses to review hospital mergers.

The Indiana COPA Act states that the IN DOH shall approve COPA applications when it determines that "under the totality of the circumstances . . . [t]here is *clear evidence* that the proposed merger would benefit the population's health outcomes, health care access, and quality of care in the county" (emphasis added) and "[t]he likely benefits resulting from the proposed merger agreement outweigh any disadvantages attributable to a potential reduction in

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[37] *See* Indiana General Assembly 2023 Session, *Health Care Cost Oversight Task Force* (Authority: IC 2-5-47), https://iga.in.gov/2023/committees/interim/health-care-cost-oversight-task-force.
[38] *See Id.*, Testimony and Presentations by Brent Fulton (Oct. 19, 2023), Maureen Hensley-Quinn (Oct. 19, 2023), Gloria Sachdev (Sept. 29, 2023), Nir Menachemi (Aug. 23, 2023), and Michael Hicks (Aug. 23, 2023), *available at* https://iga.in.gov/2023/committees/interim/health-care-cost-oversight-task-force.
[39] *See* Health Care Cost Oversight Task Force, FINAL REPORT (Nov. 13, 2023), https://s3.us-east-2.amazonaws.com/iga-publications/committee_report/2023-11-14T15-04-52.043Z-Final%20Report%20-%20Health%20Care%20Cost%20Oversight%20Task%20Force.pdf.
[40] *See* Indiana Senate Enrolled Act No. 9, *AN ACT to amend the Indiana Code concerning health*, Second Regular Session of the 123rd General Assembly (2024).
[41] Indiana Department of Health, *Mission & Vision*, https://www.in.gov/health/directory/office-of-the-commissioner/about-the-agency/mission-and-vision/ (last accessed Nov. 20, 2023).

competition that may result from the proposed merger."[42] The Indiana COPA Act also lays out several factors to be considered by the IN DOH when reviewing COPA applications, including: the quality and price of healthcare services; preservation of healthcare resources and public access to acute care; the cost efficiency of services, resources, and equipment; the ability of healthcare payors to negotiate payments and service agreements with the merging hospitals; employment; and economic impact.[43] In addition, the IN DOH issued guidance regarding the review of COPA applications indicating that it will consider: the financial condition of the hospitals, the healthcare needs of the community, the competitive dynamics in the relevant geographic area, the potential benefits and disadvantages of the COPA, whether projected benefits could be achieved without approval of the COPA, and proposed terms and conditions that may ensure the potential benefits of the COPA while mitigating the potential disadvantages.[44]

The FTC and U.S. Department of Justice ("DOJ") have jointly issued *Merger Guidelines* that outline the analytical framework used by the antitrust agencies to evaluate the competitive impact of a proposed merger. These guidelines reflect the agencies' experience in analyzing a wide variety of mergers – including many hospital and other healthcare-related mergers, both proposed and consummated – and economic and other relevant research. Ultimately, as discussed in the *Merger Guidelines*, the FTC and DOJ seek to identify and challenge harmful anticompetitive mergers.[45]

When reviewing a proposed hospital merger, FTC staff devotes significant resources to understand the merging parties' arguments about potential efficiencies and other benefits (e.g., lower costs, improved quality, capacity expansion, entry into new treatment areas), arguments that the firm would otherwise fail, as well as its potential competitive harm (e.g., higher prices, reduced quality, less access to care, and depressed wages). Merging hospitals often contend that their proposed merger will yield meaningful clinical quality improvements, cost savings, and other benefits that might not be possible without the merger. Taking this into account, FTC staff's merger analysis typically includes a thorough assessment of the potential efficiencies and other benefits asserted by the merging hospitals, as well as the disadvantages and harms resulting from a reduction in competition.

FTC staff has an ongoing investigation of the proposed merger. As is customary in our investigations of hospital mergers, a team of attorneys, economists, and financial analysts has interviewed market participants and stakeholders, including health insurers, employers, professional and labor trade groups, and other affected entities. We have performed economic analyses using hospital discharge data and a labor market analysis. We have requested additional information from the Parties so that we could consider the financial condition of the hospitals, as well as some of the potential clinical quality benefits and cost savings that the Parties claim they

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[42] Indiana COPA Act § 16-21-15-4(c).
[43] Indiana COPA Act § 16-21-15-4(b).
[44] *See* IN DOH COPA Checklist.
[45] *See Merger Guidelines* § 3.

will be able to achieve through the proposed merger.[46] Although our investigation is ongoing and the FTC is prohibited from disclosing confidential information obtained during an investigation, we are nonetheless able to provide an assessment of the proposed merger based on public sources. Our assessment – including all of the findings we describe below – is also supported by non-public documents, data, and information that we have obtained and reviewed.

With this context in place, we next present FTC staff's assessment of the factors that the IN DOH must consider under the Indiana COPA Act.

V. The Parties Are Financially Stable and Could Continue Operating Without the Proposed Merger

FTC staff analyzed the Parties' financial statements and related audit reports for the last five years that were included in the COPA Application, as well as additional information we obtained from the Parties. Based on that analysis, FTC staff determined that Union Health and THRH both appear financially stable. [redacted] Importantly, THRH is owned by HCA Healthcare, Inc. ("HCA"), one of the most profitable hospital groups in the country. [redacted]

The FTC's financial analysts rely on a comprehensive approach when assessing an entity's financial condition and viability, which includes a review of standard documentation that is customary for such an analysis, as well as any additional materials that may provide adequate support for assertions made by the Parties. Such documentation typically includes, but is not limited to, audited financial statements for the past several years including all notes and attachments, year-to-date unaudited financial statements, operating and capital budgets/projections, valuation and liquidation analyses, synergy/efficiencies analyses, reorganization/restructuring plans, closure or service reduction plans, loan documents, intercompany and related-party transactions, correspondence with creditors including any applicable covenant compliance certificates and waivers, and all relevant documentation regarding any recent efforts undertaken to divest or sell assets, issue debt and obtain funding from investors, establish strategic partnerships and find alternative (less anti-competitive) purchasers than the proposed merger. Follow-up requests for additional information and meetings or calls to discuss such materials are a typical part of the review process. The FTC often utilizes formal requests such as Civil Investigative Demands to obtain these materials and any additional documentation needed for its investigations.

In this matter, the FTC's financial analyst reviewed financial materials provided by the Parties in the COPA Application and subsequent submissions to the IN DOH. Union Health

[46] FTC staff issued Civil Investigative Demands to the Parties and requested information that would allow us to assess the proposed merger and the claims they make in their COPA Application.

provided audited consolidated financial statements for Union Health System, Inc.[47] for the years 2018-2023,[48] but did not provide unaudited financial statements for year-to-date 2024. THRH provided unaudited consolidated financial statements for Terre Haute Regional Hospital[49] for the years 2018-2023,[50] and year-to-date April 2024.[51] Based on a thorough review of these materials, as well as additional information obtained through the FTC's investigation of the proposed merger, we have concluded that the Parties (and in particular, THRH) have been profitable each year during 2018-2023 and are financially stable.

While FTC staff have closely analyzed THRH as a standalone hospital and determined that it is financially stable, it cannot be ignored that THRH is also part of the largest hospital system in the country with tremendous financial resources. HCA generated net income of over $6 billion during 2023 and had cash of over $900 million as of December 31, 2023.[52] As a system, HCA finished 2023 "better than expected" with billions in revenue gains. HCA's guidance for 2024 predicted 3-4 percent continued growth in demand for its hospital services, as well as 2-3 percent revenue growth.[53] This progress continued into Q1 2024, when HCA's CEO reported "strong financial results that were driven by broad-based volume growth, improved payer mix and solid operating margins."[54] HCA's financial strength is also reflected in its

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[47] Union Health System, Inc. includes UHI and its subsidiaries, as well as Union Associated Physician's Clinic. [redacted]

[48] [redacted] Public versions of Union Health's consolidated financial statements provide information for the years 2017-2023. *See* Union Health System Consolidated Financial Statements and Supplementary Information for Dec. 31, 2023 and 2022 (https://www.in.gov/health/cshcr/files/2023-UNION-HEALTH-SYSTEM-150023-AFS.pdf); Union Health System Consolidated Financial Statements and Supplementary Information for Dec. 31, 2022 and 2021 (https://www.in.gov/health/cshcr/files/Union-Health-System-CFS-YE12312022-and-2021.pdf), Dec. 31, 2020 and 2019 (https://www.in.gov/health/files/Union-Health-System-CFS-YE12312020-and-2019.pdf), Dec. 31, 2019 and 2018 (https://www.in.gov/health/files/2019-Union-Health-System-AFS.pdf), Dec. 31, 2018 and 2017 (https://www.in.gov/health/files/2018-Union-Health-System-AFS.pdf).

[49] [redacted]

[50] [redacted]

[51] [redacted]

[52] *See* HCA 2023 Form 10-K at F-5 and F-7, https://www.sec.gov/ix?doc=/Archives/edgar/data/860730/000095017024016524/hca-20231231.htm. In fact, according to its publicly available Form 10-Ks, HCA (and its predecessor HCA, Inc.) have generated net income during every year since at least 2005.

[53] David Muoio, *Strong Demand, Higher Per-Patient Revenues Propel HCA Healthcare in Q4 2023*, Fierce Healthcare (Jan. 30, 2024), https://www.fiercehealthcare.com/providers/strong-demand-higher-patient-revenues-propels-hca-healthcare-q4-2023.

[54] HCA Healthcare, *HCA Healthcare Reports First Quarter 2024 Results* (Apr. 26, 2024), https://investor.hcahealthcare.com/news/news-details/2024/HCA-Healthcare-Reports-First-Quarter-2024-Results/default.aspx. *See also* HCA Healthcare Q1 2024 Earnings Call Transcript (Apr. 26, 2024), https://www.fool.com/earnings/call-transcripts/2024/04/26/hca-healthcare-hca-q1-2024-earnings-call-transcrip/.

executives' compensation – for example, its CEO received $21.3 million in overall compensation in 2023.[55]

Notably, the Parties did not represent in their initial COPA Application that the COPA is necessary for either hospital to remain viable due to financial distress. Indeed, as far back as 2021, Union Health's CEO stated in a public hearing that he does not believe THRH would exit the market absent the merger.[56] [redacted]

Table 1: Terre Haute Selected Financial Indicators
Dollars in Thousands
(Source: Unaudited Financial Statements)

[redacted]

As shown in Table 1, THRH has had positive pre-tax income during every year from 2018 to 2023, including [redacted]

[55] Alan Condon, *Executive Compensation at HCA, CHS, Tenet and UHS: 7 Things to Know*, Becker's Hospital Review (Apr. 16, 2024), https://www.beckershospitalreview.com/compensation-issues/executive-compensation-at-hca-chs-tenet-and-uhs.html.

[56] *See* Testimony by Steve Holmen of Union Health at Indiana General Assembly 2021 Session, Health and Provider Services Committee Hearing on SB 416 (Feb. 10, 2021), https://iga.in.gov/session/2021/video/committee_health_and_provider_services_3900.

[57] [redacted]

[58] [redacted]

[59] [redacted]

[redacted]

Any financial difficulties attributable to the pending sale should not be allowed to justify the merger. [redacted]

[redacted]

60 [redacted]

61 [redacted]

62 [redacted]

63 [redacted]

[redacted]

Finally, it should also be noted that FTC staff routinely considers the financial condition of merging hospitals during investigations. [redacted]

VI. Competitive Dynamics of the Primary Service Area: Proposed Merger Is Likely to Result in Significant Disadvantages Due to a Reduction in Competition Between Union Health and THRH

In this section, FTC staff describes our economic analyses of the proposed merger, which includes information about how the merger is likely to affect the availability of healthcare services and the level of competition in the Parties' primary service area ("PSA"), as well as entry conditions.[67] FTC staff has evaluated the competitive dynamics in the PSA, which includes portions of six counties within the state of Indiana, because this is the geographic area specifically referenced in the COPA Application and the IN DOH COPA Checklist.[68] In addition, FTC staff has evaluated the competitive dynamics in Vigo County separately from the PSA, as this is the locus of the merger's effects and likely satisfies the hypothetical monopolist test – meaning it is potentially a relevant antitrust market.

Our preliminary analyses suggest that the proposed combination of Union Health and THRH would eliminate close competition between the hospital systems for patients residing in

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[64] [redacted]

[65] *See Merger Guidelines* § 3.1.

[66] More specifically, the Parties have not demonstrated that all three criteria of such a defense have been met: 1) THRH faces the grave possibility of business failure; 2) THRH's prospects of reorganization are dim or nonexistent; and 3) Union Health is the only available purchaser. Although merging parties sometimes argue that a poor or weakening position should serve as a defense even when it does not meet these criteria, the Supreme Court has "confine[d] the failing company doctrine to its present narrow scope." *Citizen Publ'g*, 394 U.S. at 139. The FTC evaluates evidence of a failing firm consistent with this prevailing law. *See Merger Guidelines* § 3.1.

[67] FTC staff also completed an empirical analysis of the potential impact of the proposed merger on the labor market. This analysis is included in Section VII.E.

[68] *See* COPA Application at 10-13; IN DOH COPA Checklist at 2. FTC staff have defined the PSA using the generally accepted definition of the lowest number of zip codes from which a hospital (or set of hospitals) draws at least 75 percent of its patients. In the COPA Application, the Parties defined the PSA as the zip codes where 80 percent of hospital volume originates from, which is broader than the commonly accepted definition. *See* COPA Application at 12-13. FTC staff does not believe the PSA necessarily represents a "relevant geographic market" under the *Merger Guidelines* or antitrust case law, which analyze how insurers (and in turn, their members) would respond to price increases imposed by a hypothetical monopolist.

the combined PSA, and particularly in Vigo County. Evidence obtained by the FTC confirms that THRH competes directly with Union Health on price, quality, innovation, and patient experience for inclusion in health insurer networks and to attract patients to their respective hospital system for inpatient, outpatient, and physician services. Union Health and THRH are considered to be each other's closest competitor. That competition benefits Indiana patients by reducing healthcare costs and improving services.

As the Parties acknowledge in the COPA Application, Union Health and THRH offer similar facility locations, service offerings, and quality of care.[69] At the time the COPA Application was filed, each system operated acute care hospitals that provide inpatient services and Level III trauma centers,[70] as well as outpatient facilities and physician services across a number of specialties. There is significant geographic overlap between these hospitals' facilities in the areas from which they draw patients.[71] Indeed, Union Health Hospital and THRH are located just 5.5 miles from one another.[72] [redacted][73]

[69] *See* COPA Application at 4-6, 10-12, 43. *See also* Table 6 depicting the vast majority of all patients treated at Union Health are treated for conditions that are also treated at THRH, and vice-versa.
[70] We understand that THRH has discontinued its trauma services as of August 1, 2024.
[71] *See generally* COPA Application at 4-6, 43. *See also* PSA Analysis and Diversion Ratio Analysis, *infra* Sections VI.A.2-3; FTC Map: Union Health and THRH Individual and Combined Primary Service Areas (Attachment C).
[72] Compare this to the distance of other hospitals the Parties claim as competitors in the Wabash Valley region – Ascension St. Vincent Clay located 17 miles from Terre Haute, Sullivan County Community Hospital located 24 miles from Terre Haute, and Greene County General Hospital located 33 miles from Terre Haute. *See* COPA Application at 60. We note the distances of each of these hospitals to Union Health and THRH, respectively, according to mapping software: Ascension St. Vincent Clay is 17 miles from Union Health and 23 miles from THRH; Sullivan County Community Hospital is 26 miles from Union Health and 21 miles from THRH; Greene County General Hospital is 44 miles from Union Health and 39 miles from THRH.
[73] [redacted]

Consistent with our economic analyses, empirical research indicates that mergers among hospitals in close proximity are likely to result in particularly significant price increases.[74] By eliminating this competition, the proposed merger would substantially increase the combined system's ability to exercise its market power, enabling it to extract higher prices in negotiations with health insurers, which in turn would likely lead to higher healthcare costs for employers and patients. The proposed merger also would reduce the combined system's business incentives to maintain or improve the quality or availability of healthcare services for Indiana patients.

The Parties claim the "proposed Merger will result in higher quality and improved access to health care without any undue increase in health care costs because it will not result in meaningful reduction in competition for inpatient and outpatient services in the region."[75] This statement is not supported by the available evidence. Contrary to what the Parties claim, there is *substantial* risk of competitive harm from the merger due to a significant reduction in competition for inpatient and outpatient services, and insufficient evidence to demonstrate the harm would be outweighed by any potential benefits. Moreover, the regulatory conditions imposed by the COPA are unlikely to mitigate this harm, or do so in a timely fashion.

The bases for FTC staff's assessment of the competitive effects of the proposed merger are described in the following subsections. Subsection A describes the geographic areas and service lines in which the Parties currently compete for patients, and characterizes the likely effects of the post-merger reduction in competition for residents of the Parties' combined PSA, as well as Vigo County. Subsection B explains that entry of new healthcare providers in the geographic area is not likely to occur.

A. Level of Competition in the Primary Service Area and Availability of Healthcare Services

We first describe the generally accepted economic framework for analyzing hospital competition in subsection A.1, followed by our assessment of the competitive effects of the proposed merger. Using the approach outlined in the IN DOH COPA Checklist, we describe the Parties' combined PSA in subsection A.2.[76] In subsection A.3, we present the diversion ratio analysis using 2019 patient discharge data obtained from the IN DOH's Hospital Discharge Data Files ("IN Discharge Data").[77] In subsection A.4, we present market share and concentration

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[74] *See, e.g.*, WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., RESEARCH SYNTHESIS REPORT NO. 9: HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? 7 (2006), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1 ("Mergers among hospitals that are close together geographically generate greater price increases than do mergers among distant hospitals.").

[75] COPA Application at 58.

[76] *See* IN DOH COPA Checklist at 2 (requesting a description of each party's primary service area). *See also* COPA Application at 10-13.

[77] Diversion ratios estimate the extent to which patients view Union Health and THRH as substitutes, and are calculated to measure the degree of lost competition likely to result from the proposed merger. *See* Indiana Department of Health Office of Data and Analytics, *Hospital Discharge Data*, https://www.in.gov/health/oda/hospital-discharge-data/. To account for the influence of Illinois-based hospitals in

analysis using the IN Discharge Data, [redacted] Finally, in subsection A.5, we present an analysis of service overlaps using the IN Discharge Data. Collectively, these analyses demonstrate that the Parties are each other's closest competitor, and that the proposed merger would substantially reduce competition for hospital services in Indiana.

1. Economic Framework for Analyzing Hospital Competition

The FTC and healthcare economists use a two-stage framework for analyzing competition in hospital markets. In the first stage, hospitals compete for inclusion in health insurers' networks. Health insurers – on behalf of their customers (employer and individual patients) – use competition between hospitals as leverage to negotiate better reimbursement rates (i.e., prices). This, in turn, results in lower premiums, copayments, deductibles, and other out-of-pocket expenses for (i) employers who purchase health insurance for their employees, (ii) employees who receive health insurance as a benefit, and (iii) consumers who purchase their own health insurance. This first-stage competition benefits all commercially insured individuals as well as plan sponsors (employers and unions) and insurers. In the second stage, hospitals compete to attract patients. Competition between hospitals to attract patients and physician referrals leads to increased quality and availability of healthcare services. This second-stage competition benefits all commercially insured patients as well as those covered by Medicare, Medicaid, and other forms of government pay.

Thus, hospital systems compete on both price and quality. When competing hospitals merge, two different kinds of adverse effects may occur: higher prices charged to insurance companies (which are then passed on to employers and patients in the form of higher insurance costs) and non-price effects such as reduced quality and availability of services.[78] These anticompetitive effects are larger when the merging hospitals are closer (*i.e.*, more intense) competitors, and when non-merging hospitals are less significant competitors.

This framework is consistent with a large and growing body of empirical research finding that mergers between close competitors in concentrated healthcare provider markets are likely to

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the Terre Haute area, we supplemented the IN Discharge Data with Illinois claims data that the FTC obtained from several commercial payers in an ongoing study of physician group and healthcare facility mergers. *See* FTC Press Release, *FTC to Study the Impact of Physician Group and Healthcare Facility Mergers* (Jan. 14, 2021), https://www.ftc.gov/news-events/news/press-releases/2021/01/ftc-study-impact-physician-group-healthcare-facility-mergers. Using this study data, we separately estimated diversion ratios and market shares for Illinois-based hospitals in the Parties' PSA, and then adjusted the estimates from the IN Discharge Data to obtain the results reported in Tables 1 through 5. For example, using the Illinois claims data, we first estimated that Illinois hospitals have a combined market share of 7.9% in the Parties' PSA. Next, we calculated Indiana hospital market shares based solely on the IN Discharge Data. Those Indiana hospital shares were then multiplied by (1-0.079)=0.921, which deflates their size to account for the influence of Illinois hospitals. A similar approach was employed to deflate the Indiana hospital diversion ratios to account for any diversion to Illinois hospitals.

[78] *Merger Guidelines* §§ 1, 2.

result in substantial consumer harm, without offsetting improvements in quality.[79] For example, one paper discussing several studies of hospital mergers concludes that "the magnitude of price increases when hospitals merge in concentrated markets is typically quite large, most exceeding 20 percent."[80] Notably, this empirical finding holds for both for-profit and not-for-profit hospitals.[81] In other words, non-profit hospitals can and do exercise market power and raise prices, similar to for-profit hospitals.[82] Thus, as most courts have recognized, the non-profit status of merging hospitals does not mitigate the potential for anticompetitive harm.[83]

2. Primary Service Area

The IN DOH requested information about the Parties' primary service areas, therefore we analyzed the competitive effects of the proposed merger within these areas. In our experience,

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[79] *See, e.g.*, Zack Cooper, Stuart Craig, Martin Gaynor & John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q.J. ECON. 51 (2019), https://healthcarepricingproject.org/sites/default/files/Updated_the_price_aint_right_qje.pdf; Nancy Beaulieu, Leemore Dafny, Bruce Landon, Jesse Dalton, Ifedayo Kuye & J. Michael McWilliams, *Changes in Quality of Care after Hospital Mergers and Acquisitions*, 382 NEW ENG. J. MED. 51 (Jan. 2, 2020), https://www.nejm.org/doi/pdf/10.1056/NEJMsa1901383?articleTools=true. For surveys of the research literature, *see, e.g.*, MARTIN GAYNOR & ROBERT TOWN, THE IMPACT OF HOSPITAL CONSOLIDATION – UPDATE (Robert Wood Johnson Found., The Synthesis Project, Policy Brief No. 9, 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; Martin Gaynor, Kate Ho & Robert Town, *The Industrial Organization of Health-Care Markets*, 53 J. ECON. LITERATURE 235 (2015), https://www.researchgate.net/publication/278676719_The_Industrial_Organization_of_Health-Care_Markets.

[80] GAYNOR & TOWN, *supra* note 79, at 2.

[81] *See, e.g.*, Robert Town, *The Economists' Supreme Court Amicus Brief in the Phoebe Putney Hospital Acquisition Case*, 1 HEALTH MGMT. POL'Y & INNOVATION 60 (2012), http://www.hmpi.org/pdf/HMPI-%20Town,%20Phoebe%20Putney.pdf; Gaynor, Ho & Town, *supra* note 79.

[82] *See, e.g.*, Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. INDUS. ECON. 63 (2001), http://onlinelibrary.wiley.com/doi/10.1111/1467-6451.00138/epdf (finding substantial price increases resulting from a merger of non-profit, community-based hospitals, and determining that mergers involving non-profit hospitals are a legitimate focus of antitrust concern); Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter–Summit Transaction*, 18 INT'L J. ECON. BUS. 65, 79 (2011), http://www.tandfonline.com/doi/full/10.1080/13571516.2011.542956 (finding evidence of post-merger price increases ranging from 28%-44%, and concluding that "[o]ur results demonstrate that nonprofit hospitals may still raise price quite substantially after they merge. This suggests that mergers involving nonprofit hospitals should perhaps attract as much antitrust scrutiny as other hospital mergers.").

[83] *See, e.g.*, Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1081 (N.D. Ill. 2012) ("[T]he evidence in this case reflects that nonprofit hospitals do seek to maximize the reimbursement rates they receive."); Fed. Trade Comm'n v. ProMedica, No. 3:11 CV 47, 2011 WL 1219281, at *22 (N.D. Ohio Mar. 29, 2011) (finding that a nonprofit hospital entity "exercises its bargaining leverage to obtain the most favorable reimbursement rates possible from commercial health plans."); United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1284-87 (7th Cir. 1990) (rejecting the contention that nonprofit hospitals would not seek to maximize profits by exercising their market power); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1213-14 (11th Cir. 1991) ("[T]he district court's assumption that University Health, as a nonprofit entity, would not act anticompetitively was improper."); Hospital Corp. of America v. Fed. Trade Comm'n, 807 F.2d 1381, 1390-91 (7th Cir. 1986) (rejecting the contention that nonprofit hospitals would not engage in anticompetitive behavior). *See also* DOSE OF COMPETITION REPORT, *supra* note 22, ch. 4, at 29-33 (discussing the significance of nonprofit status in hospital merger cases, and concluding that the best available empirical evidence indicates that nonprofit hospitals exploit market power when given the opportunity and that "the profit/nonprofit status of the merging hospitals should not be considered a factor in predicting whether a hospital merger is likely to be anticompetitive.").

the generally accepted definition of PSA is the lowest number of zip codes from which a hospital draws at least 75 percent of its patients. Other state health authorities and hospitals define the PSA in the same or similar manner. We calculated the combined 75 percent PSA for the Parties (i.e., the lowest number of zip codes from which Union Health and THRH combined draw 75 percent of their patients) using 2019 IN Discharge Data supplemented with claims data from Illinois.[84] We rely on 2019 data to avoid aberrations in the normal course of hospital operations caused by the COVID-19 pandemic and to precede the initial merger discussions that occurred in the 2020-2021 timeframe, which could also have an impact on the normal course of hospital operations. Using this definition, the Parties' PSA consists of portions of six counties in western Indiana: Vigo, Clay, Greene, Parke, Sullivan, and Vermillion; and two counties in eastern Illinois: Edgar and Clark. The geographic extent of the combined PSA is shown in Attachment C and described in Table 2 below. It should be noted that in the COPA Application, the Parties defined the PSA as the zip codes where 80 percent of hospital volume originates from, which is broader than the generally accepted definition.[85] The Parties' slightly larger definition of the PSA would of course understate their actual competitive significance in the area that they serve.

Table 2: Union Health-THRH Combined PSA Geographic Coverage (Based on 2019 IN Discharge Data)[86]

County	# Zip Codes in PSA	# Discharges in PSA	Parties' Share of Discharges in PSA (per County)
Vigo	6	11,673	79.6
Greene	2	1,649	40.0
Clay	1	2,069	67.4
Parke	1	680	58.0
Sullivan	1	967	54.3
Vermillion	1	1,242	80.3
Clark (IL)*	1	173	58.4
Edgar (IL)*	1	356	20.5
Total	14	18,809	77.5

Table 2 demonstrates the significance of Vigo County within the PSA, as Vigo County accounts for most of the zip codes in the Parties' combined PSA (and therefore the most patients residing in the PSA) and more than half of all patient discharges in the PSA. Furthermore, the Parties account for a large percentage of total patient discharges in each individual county in the PSA. Overall, Union Health and THRH account for about 73% of all patient discharges from zip

[84] *See supra* note 77. In the COPA Application, the Parties also refer to a 6-county area as the "Wabash Valley Community" and assert that the Parties serve the residents in this area. COPA Application at 3. FTC staff does not believe this broad of an area constitutes either the PSA or a relevant geographic market for antitrust purposes.
[85] *See* COPA Application at 12-13.
[86] Shares are adjusted to account for the influence of Illinois-based hospitals, as described in footnote 77. *In Clark and Edgar Counties, "Discharges in PSA" and "Parties' Share of Discharges in PSA" are for commercially insured patients and are derived from payer claims data. These shares are not adjusted using the method described in footnote 77, as the payer claims data already includes Illinois-based hospitals.

codes within the combined PSA, demonstrating significant overlap of patients served by the Parties.

In addition to the combined PSA, we separately calculated the individual PSAs for Union Health and THRH. A map of the zip codes included in the combined PSA, in Union Health's individual PSA, and in THRH's individual PSA is included as Attachment C to this comment.[87] We find that THRH's individual PSA is very similar to Union Health's PSA. THRH's individual PSA includes 16 zip codes, 10 of which overlap with the Union Health PSA. Union Health's individual PSA contains 12 zip codes.

While there are other hospitals located within the area of the Parties' combined PSA, these hospitals are generally smaller, located farther away from Terre Haute,[88] and do not draw patients from a wide area. As we describe below, patients are not likely to not consider these other hospitals to be close substitutes for Union Health or THRH, and these hospitals have little or no competitive significance for Union Health and THRH. Likewise, although the Parties claim they routinely face competition from hospitals and healthcare providers in Indianapolis,[89] our analysis shows that patients do not consider them to be close substitutes for Union Health and even less so for THRH. During the FTC investigation, we learned that patients are less likely to travel to Indianapolis for services they can receive locally in Terre Haute and are more willing to travel to Indianapolis for high acuity services, including some that may not be offered by Union Health or THRH.

3. Diversion Ratio Analysis Confirms that Union Health and THRH Are Close Competitors

To directly measure the degree of competition between the merging hospitals, FTC staff performed a diversion ratio analysis – a commonly accepted tool to evaluate a merger's potential harm to competition.[90] This analysis calculates what would happen if, hypothetically, one of the merging hospital systems were removed from an insurer's network and was no longer an option for that insurer's patient members. The patients who would have used their preferred hospital system must now use another. The fraction of a hospital's former patients who would now go to

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[87] *See* FTC Map: Union Health and THRH Individual and Combined Primary Service Areas (Attachment C).
[88] *See supra* note 72 for approximate distances of other hospitals from Terre Haute.
[89] COPA Application at 52.
[90] To calculate diversion ratios, we estimate a patient choice model using IN Discharge Data for commercially insured patients covering calendar year 2019. We focus on the hospital choices of commercially insured patients because they determine the negotiated prices between hospitals and insurers. We also focus on general acute care services (mental health and addiction services, for example, may be negotiated separately and also have different market dynamics with different sets of providers). For a discussion of the underlying methodology used to calculate diversion ratios, see Joseph Farrell, David J. Balan, Keith Brand & Brett W. Wendling, *Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets*, 39 Rev. Indus. Org. 271 (2011), http://link.springer.com/content/pdf/10.1007%2Fs11151-011-9320-x.pdf; Devesh Raval, Ted Rosenbaum & Steve Tenn, *A Semiparametric Discrete Choice Model: An Application to Hospital Mergers*, 55 Econ. Inquiry 1919 (2017), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3026754.

another particular hospital is the diversion ratio from the first hospital to the second.[91] The estimated diversion ratio between two hospitals accounts for patients' geographic location (as determined by the 5-digit zip code of the patient), health condition (as determined by the diagnosis-related-group ("DRG") codes used for the patient), and other patient characteristics such as gender and age. All hospitals in the state of Indiana are included in FTC staff's diversion ratio analysis as possible alternatives for patients. The diversion ratio calculation reflects the importance of geographic proximity for patients' choices within an area relevant for hospital pricing and planning decisions.[92]

The diversion ratio is a useful measure of the degree of patient overlap between merging hospitals, the directness of competition between the hospitals, and the relative bargaining positions of the hospital systems and insurers. If a significant fraction of the patients "diverted" from Union Health would choose THRH or vice versa, then the two merging parties are considered close competitors and close substitutes for inclusion in an insurer's network.

Before the merger, according to bargaining theory, the presence of THRH in the insurer's network constrains the reimbursement rate that Union Health can obtain in negotiations with the insurer and vice versa. The merger would remove this competitive constraint on negotiated prices, and likely cause prices to rise. The degree of the price increase depends on the diversion ratio – a higher diversion ratio likely means a larger anticompetitive price increase post-merger. FTC staff's diversion ratio analysis is presented in Table 3. The first column represents the percentage of Union Health's patients that are predicted to choose each of the alternative hospitals if Union Health were removed from an insurer's network and was no longer an option for that insurer's patient members. The second column represents the percentage of THRH's patients that are predicted to choose each of the alternative hospitals if THRH were removed from an insurer's network and was no longer an option for that insurer's patient members.

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[91] *See Merger Guidelines* § 4.2. ("The diversion ratio from one product to another is a metric of how customers likely would substitute between them. The diversion ratio is the fraction of unit sales lost by the first product due to a change in terms, such as an increase in its price, that would be diverted to the second product. The higher the diversion ratio between two products made by different firms, the stronger the competition between them."). Unilateral price effects refer to the ability of a merged firm to raise prices on its own, without colluding with other competitors.

[92] One advantage of considering diversion ratios compared to the market share and concentration estimates in the following section is that the diversions do not require constraining the analysis to a particular geographic area.

Table 3: Diversion Ratio Analysis
(Based on 2019 IN Discharge Data)[93]

	Diversion Ratios (in %)	
To Hospital / Health System	**From Union Health**	**From THRH**
Union Hospital		**75.5**
Union Hospital Clinton		**2.2**
Terre Haute Regional Hospital	**47.6**	
St. Vincent Carmel	1.3	0.4
St. Vincent Clay	2.0	0.9
St. Vincent Heart Center	1.7	0.6
St. Vincent Indianapolis	4.5	2.3
Franciscan Health Mooresville	1.2	0.5
Greene County General Hospital	1.0	0.5
Hendricks Regional Health	6.8	1.2
Indiana University Health Methodist Hospital	4.8	2.1
Indiana University Health University Hospital	2.1	1.6
Riley Hospital for Children at Indiana University Health	2.1	1.4
OrthoIndy Hospital	2.1	1.2
Sullivan County Community Hospital	5.4	1.9
All Others, including IL Hospitals (<0.4% share)	17.4	7.7
Total	100.00	100.00

The diversion analysis confirms that Union Health and THRH are close substitutes from the perspective of patients and payers. FTC staff calculates that if Union Health were no longer an option for area residents, 47.6% of the patients who currently use Union Health would seek care at THRH. Conversely, if THRH were no longer an option for area residents, 77.7% of the patients who currently use THRH are predicted to seek care at one of Union Health's hospitals.[94]

These high diversion ratios are unsurprising, given that Union Health and THRH serve patients from a similar geographic area with similar health conditions, and there are very few nearby third-party hospitals. These diversion ratios indicate that a merger between Union Health and THRH would eliminate direct head-to-head competition and likely lead to significant price increases, as well as reduced business incentives to maintain or improve quality. These diversion

[93] Diversion ratios are adjusted to account for the influence of Illinois-based hospitals, as described in footnote 77.
[94] These diversion ratios are estimated using the observed choices of patients within the combined PSA. The same analysis can be performed using a wider geographic area. We estimated the same statistical model for the combined 90 percent PSA for the Parties and find somewhat lower, but still quite high, diversion ratios from Union Health to THRH of 37.0%, and from THRH to Union Health of 68.2%. In other words, the calculated diversion ratios are not particularly sensitive to the geographic area used to estimate the model.

ratios far exceed many recent hospital merger cases where courts found the proposed mergers to be anticompetitive.[95]

The pattern of estimates in Table 3, with higher diversion from THRH to Union than the other way around, suggests that Union Health is more of a competitive constraint on THRH than THRH is on Union Health. The estimated diversion of Union Health and THRH patients to any other particular hospital in Indiana ranges from 0.4% to 6.8%. (Note that our estimate of diversion toward Illinois hospitals appears in the "All Others" category.) These diversion ratios strongly indicate that a merger between Union Health and THRH would reduce the number of general acute care ("GAC") inpatient options available for most of their patients from two to one. After the acquisition, health insurers would have only one hospital option to include in a provider network for Terre Haute area patients, and those patients would only have one local hospital system providing GAC inpatient services.

4. High Market Shares and Concentration Levels Confirm that the Proposed Merger Is Likely to Result in Significant Disadvantages

General principles of antitrust law and economics indicate that mergers between close competitors in highly concentrated hospital markets are likely to result in significant harm to competition, resulting in higher prices, lower quality care, or reduced wages for employees.[96] For this reason, market shares and concentration are also important tools for assessing the potential for adverse competitive effects resulting from a merger. Consistent with the diversion ratio analysis discussed above, the proposed merger would create a system with a high market share and lead to a highly concentrated market, likely resulting in substantial harm to patients due to lost competition.

Courts and antitrust agencies often use a standard measure, the Herfindahl-Hirschman Index ("HHI"), to gauge a merger's effect on market concentration.[97] As the *Merger Guidelines* explain, mergers resulting in a post-merger HHI above 1,800 and an increase in HHI of more

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[95] *See, e.g.*, Complaint in the Matter of Advocate Health Care Network, Advocate Health and Hospitals Corporation, and NorthShore University HealthSystem ¶ 41, Docket No. 9369 (Dec. 18, 2015) https://www.ftc.gov/system/files/documents/cases/151218ahc-pt3cmpt.pdf (diversion ratios were 20-25%); Complaint in the Matter of Penn State Hershey Medical Center and PinnacleHealth System ¶ 46, Docket No. 9368 (Dec. 14, 2015) https://www.ftc.gov/system/files/documents/cases/160408pinnacleamendcmplt.pdf (diversion ratios were 30-40%); Fed. Trade. Comm'n Proposed Findings of Fact and Conclusions of Law in the Matter of Hackensack Meridian Health and Englewood Healthcare Foundation ¶ 100, Civil Action No. 2:20-cv-18140-JMV-JBC (D.N.J. Jun. 4, 2021) (diversion rations were 17-45%), https://www.ftc.gov/system/files/documents/cases/337_2021.06.04_ftc_fof_redacted.pdf.

[96] *See, e.g.*, *Merger Guidelines* § 2.10; United States v. Phil. Nat'l Bank, 374 U.S. 321, 363-66 (1963) ("Specifically, we think that a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market, is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects.").

[97] HHI measures are calculated by summing the squares of the individual firms' market shares. For hospital mergers, they are based on the market shares of all hospitals (or systems) deemed to be in the market.

than 100 points are presumed likely to enhance the merged firm's market power and to be anticompetitive.[98]

The concentration analysis is most appropriate when applied to a properly defined relevant antitrust market. The generally accepted definition of a "relevant antitrust market" is a set of substitute products over which a hypothetical monopolist could exercise market power by negotiating a small but significant non-transitory increase in price. This test for whether a set of substitute products constitutes a relevant antitrust market is sometimes called the "hypothetical monopolist test."[99] The geographic boundaries of a relevant antitrust market for the analysis of hospital competition are not necessarily the same as those of a PSA.

In merger investigations, defining the relevant antitrust market is a fact-intensive exercise involving interviews with market participants and reviewing confidential documents, in addition to data analyses. Here, we instead focus on the combined PSA, because this is the geographic area requested by the IN DOH in the COPA Checklist. While we have not formally defined a relevant antitrust market in this comment, the diversion analysis – which shows that Union Health and THRH are close substitutes for one another (whereas no other hospitals are) – suggests that Vigo County likely constitutes a relevant antitrust market.

Below, we report the results of our concentration analysis for the combined PSA, as well as for the set of GAC hospitals within Vigo County. We also report the results of our concentration analysis for all patient discharges as well as limited to discharges of commercially insured GAC patients. Because commercial hospital rates are negotiated with insurance companies, a merger's effect on hospital prices for commercially insured patients is often a helpful proxy for the degree of competition between the merging hospitals. Of course, the benefits of hospital competition, including improved patient experience and investment in innovation, accrue to all patients, not only to the commercially insured.

Table 4 contains the results of our concentration analysis for hospitals serving patients residing in the combined PSA. The post-merger HHI for all discharges is 5,434 and the increase in HHI is 2,206. The combined Union Health-THRH hospital system would have a share of

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[98] *Merger Guidelines* § 2.1. *See also, e.g.*, ProMedica Health Sys., Inc. v. Fed. Trade Comm'n, 749 F.3d 559, 570 (6th Cir. 2014) ("[T]he Commission is entitled to take seriously the alarm sounded by a merger's HHI data."); *id.* ("These two aspects of this case – the strong correlation between market share and price, and the degree to which this merger would further concentrate markets that are already highly concentrated – converge in a manner that fully supports the Commission's application of a presumption of illegality."); Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1079 (N.D. Ill. 2012) ("High levels of concentration raise anticompetitive concerns, and the HHI calculation provides one way to identify mergers that are likely to invoke these concerns."); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1211 n.12 (11th Cir. 1991) ("The most prominent method of measuring market concentration is the Herfindahl-Hirschman Index (HHI)."); *id*. at 1218 n.24 ("Significant market concentration makes it easier for firms in the market to collude, expressly or tacitly, and thereby force price above or farther above the competitive level.") (quotation marks omitted); United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990) ("The defendants' immense shares in a reasonably defined market create a presumption of illegality.").

[99] *See Merger Guidelines* § 4.3. Agencies typically consider a "small but significant price increase" to be five percent. *Id.*

73.1% of inpatient hospital services for patients living in the combined PSA.[100] These metrics are somewhat lower when looking specifically at commercially insured GAC patients, with a post-merger HHI of 4,471, an increase in HHI of 1,365, and a combined share for Union Health and THRH of 65.5%. The combined share and HHI calculations far exceed the thresholds that would create a presumption of illegality under the *Merger Guidelines* and the relevant case law,[101] and also exceed the levels in past hospital mergers that courts have found to be anticompetitive and blocked.[102] As with the diversion ratio analysis, all hospitals in the state of Indiana are included in the shares and concentration analysis for patients residing in the combined PSA, and an adjustment has been made to the calculated shares to account for the draw of Illinois-based hospitals (which appears in the "All Others" category).

Table 4: Shares and Concentration Analysis
Hospitals Serving Patients Residing in the Combined PSA
(Based on 2019 IN Discharge Data)[103]

Hospital / System	Share of All Discharges	Share of Commercially Insured GAC Discharges
Union Hospital	**49.8**	**51.2**
Union Hospital Clinton	**1.9**	**1.3**
Terre Haute Regional Hospital	**21.3**	**13.0**
Indiana University Health Methodist Hospital	2.7	3.3
St. Vincent Indianapolis	2.2	3.9
Greene County General Hospital	1.9	2.0
Indiana University Health University Hospital	1.9	2.7
Sullivan County Community Hospital	1.5	2.2
Riley Hospital for Children at Indiana University Health	1.2	2.0
Hendricks Regional Health		1.4
St. Vincent Carmel		1.2
OrthoIndy Hospital		1.0
All Others, including IL Hospitals (<1.0% of Discharges)	15.7	14.8
Combined Union Health-THRH	**73.1**	**65.5**
Pre-merger HHI	3,228	3,106
Post-merger HHI	5,434	4,471
Change in HHI	2,206	1,365

We note the combined PSA is likely broader than a market properly defined for antitrust purposes, meaning the shares listed in Table 4 likely overstate the competitive significance of hospitals outside of Terre Haute and understate the likely anticompetitive impact of the proposed

[100] This includes Union Health's other hospital in Clinton, Vermillion County.
[101] *See supra* note 98.
[102] *See* Table B1: Market Shares and HHIs in Prior Healthcare Merger Cases (Attachment B).
[103] Shares and HHIs are adjusted to account for the influence of Illinois-based hospitals, as described in footnote 77.

merger. Indeed, the combined PSA contains hospitals that do not appear to be reasonable alternatives for most Vigo County residents. Even in this overly broad area, however, the market shares and apparent competitive impact of the merger is deeply concerning. These concerns are heightened when assessed at the more local level of Vigo County. For completeness and to illustrate the robustness of our competitive analysis, FTC staff report the results of the concentration analysis for Vigo County in Table 5 below. As we have explained, this potential relevant antitrust market definition likely satisfies the hypothetical monopolist test.

Table 5: Shares and Concentration Analysis
Hospitals Located in Vigo County
(Based on 2019 IN Discharge Data)

Hospital	Share of All Discharges	Share of Commercially Insured GAC Discharges
Union Hospital	67.9	78.4
Terre Haute Regional Hospital	32.1	21.6
Combined Union Health-THRH	**100**	**100**
Pre-merger HHI	5,644	6,613
Post-merger HHI	10,000	10,000
Change in HHI	4,356	3,387

The results for all discharges and GAC services for commercially insured patients are similar. The combined Union Health-THRH hospital system would have a share of 100% of GAC inpatient hospital services for commercially insured patients seeking care in Vigo County. For commercially insured GAC discharges, the post-merger HHI is 10,000 and the increase in HHI is 3,387.

Finally, we performed the same share and concentration analysis for all patients residing in Vigo County, regardless of which hospital they chose (as opposed to all hospitals located in Vigo County, regardless of the origin of the patients, as shown above in Table 5). The results of this analysis are shown in Table 6 below, and also show high concentration for a combined Union Health-THRH hospital system.

Table 6: Shares and Concentration Analysis
Hospitals Serving Patients Residing in Vigo County
(Based on 2019 IN Discharge Data)[104]

Hospital	Share of All Discharges	Share of Commercially Insured GAC Discharges
Union Hospital	**55.9**	**58.9**
Union Hospital Clinton	**0.1**	**
Terre Haute Regional Hospital	**23.6**	**14.6**
Indiana University Health Methodist Hospital	2.4	2.9
St. Vincent Indianapolis	1.7	3.4
Indiana University Health University Hospital	1.9	2.8
Riley Hospital for Children at Indiana University Health	1.2	1.9
St. Vincent Carmel		1.1
OrthoIndy Hospital		1.1
All Others, including IL Hospitals (<1.0% of Discharges)	13.2	13.3
Combined Union Health-THRH	**79.6**	**73.5**
Pre-merger HHI	3,757	3,833
Post-merger HHI	6,398	5,558
Change in HHI	2,640	1,724

a) Evaluation of the Parties' Market Share Analysis

[redacted]

[104] Union Hospital Clinton had fewer than 10 discharges; its share was added to the "All Others" category and excluded from the "Combined Union Health-THRH" category. Shares and HHIs are adjusted to account for Illinois-based hospitals, as described in footnote 77.

[redacted] FTC staff believes it is appropriate to analyze full-year data from 2019 because it avoids any data anomalies associated with the COVID-19 pandemic and precedes the Parties' consideration and announcement of the proposed merger. We are aware that the proposed merger was initially considered by the Parties as far back as 2020-21 and officially announced in September 2023. [redacted]

Using full-year 2022 IN Discharge Data, FTC staff estimates market shares of all GAC patient discharges as 59.7% for Union Health and 14.2% for THRH, for a combined market share of 73.9%. This results in a post-HHI increase of 1,694, for a post-merger HHI of 5,558. [redacted] The main takeaway is that regardless of which time period is used, the proposed merger leads to an increase in concentration levels of a magnitude likely to result in antitrust concerns.

In Table 7 below, FTC staff calculates 2022 market shares and HHI concentration using the generally accepted definition of a combined 75 percent PSA for the Parties (i.e., the lowest number of zip codes from which Union Health and THRH combined draw 75 percent of their patients).[107] We have included shares for all patient discharges and all GAC patient discharges. [redacted]

105 [redacted]

106 [redacted]

107 [redacted]

Table 7: Shares and Concentration Analysis
Hospitals Serving Patients Residing in the Combined PSA
(Based on 2022 IN Discharge Data)[108]

Hospital / System	Share of All Discharges	Share of All GAC Discharges
Union Hospital	**53.8**	**57.2**
Union Hospital Clinton	**2.4**	**2.5**
Terre Haute Regional Hospital	**16.1**	**14.2**
Indiana University Health Methodist Hospital	2.9	3.1
St. Vincent Indianapolis	2.3	2.5
Indiana University Health University Hospital	1.7	1.8
Bloomington Meadows Hospital	1.7	
Riley Hospital for Children at Indiana University Health	1.5	1.6
Sullivan Community Hospital	1.1	1.5
Green County General Hospital	7.9	1.2
All Others, including IL Hospitals (<1.0% of Discharges)	15.1	14.4
Combined Union Health-THRH	**72.2**	**73.9**
Pre-merger HHI	3,507	3,863
Post-merger HHI	5,312	5,558
Change in HHI	1,805	1,694

5. Analysis of Service Overlaps Confirms that Union Health and THRH Are Close Competitors

In addition to the diversion ratio and concentration analyses described above, FTC staff also performed an analysis of the 2019 IN Discharge Data to evaluate the overlap in the Parties' services. We find that, consistent with the Parties' statements that they are similarly situated,[109] the patient conditions they treat (and hence the services they provide) are very similar. This is further indication that competition between the Parties is direct and substantial.

Using the 2019 IN Discharge Data, FTC staff measured service overlaps as the DRG codes that are common to both hospitals.[110] DRG codes are used to classify patients according to diagnosis and medical complexity and are a common way to classify sets of services offered by

[108] We assume that shares of Illinois hospitals remain constant from 2019, as we do not have Illinois payer claims data for 2022. In our previous tables using 2019 data, shares and HHIs are adjusted to account for the influence of Illinois-based hospitals, as described in footnote 77. Also, [redacted] the FTC's analysis is based on all payers because we are not able to separately identify commercial patients due to missing data in the 2022 IN Discharge Data.

[109] *See* COPA Application at 4-6, 10-12, 43.

[110] *See* CMS Guidance, *Design and development of the Diagnosis Related Group* (DRG), https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf.

hospitals. Any DRG code that appears in the data for both hospitals for at least X inpatient events is included in the overlap set, where X is equal to 1, 3, or 5 patients. Table 8 reports the number of DRG codes in each overlap set along with the percentage of all patients treated at both Union Health and THRH that are in the overlap set.

Table 8: Union Health and THRH Patients with Overlapping DRGs (Based on 2019 IN Discharge Data)

DRG Overlap Set	DRG Codes in Overlap Set	Patients in Overlap Set (%)	
		Union	THRH
>= 1	460	97.2	97.1
>= 3	290	91.5	92.6
>= 5	218	87.3	88.5

Table 8 shows that the vast majority of all patients treated at Union Health are treated for conditions that are also treated at THRH, and vice-versa. For example, the 290 DRGs for which both Union Health and THRH treated at least three patients account for 91.5% of all Union Health patients and 92.6% of all THRH patients. The 218 DRGs for which both Union Health and THRH treated at least five patients account for 87.3% of all Union Health patients and 88.5% of all THRH patients.[111] In other words, Union Health and THRH treat similar types of patients with similar health conditions.[112] This suggests that most patients view Union Health and THRH as competing options for the treatment of their health conditions. The proposed merger would leave those patients with one fewer competing option.

B. Entry of Other Healthcare Providers Would Not Be Timely, Likely, or Sufficient to Replace the Competition Lost as a Result of the Proposed Merger

Another factor that the IN DOH may consider when evaluating the COPA Application is the likelihood that other healthcare providers will enter or exit the PSA in response to likely anticompetitive effects of the merger. As the *Merger Guidelines* explain, the FTC considers whether entry by a new competitor would be timely, likely, and sufficient to alleviate the harm to competition caused by the proposed merger.[113] Such entry – if it would be timely, likely, and

[111] In principle, any threshold number of patient visits for each DRG can be used to define the "overlap set," and there is no reason to prefer "at least 3" to "at least 5," or vice-versa. Any threshold risks understating the degree of overlap in the services provided by Union Health and THRH, because one hospital system may fall just above the threshold while the other falls just below the threshold due only to chance. For example, a DRG that is treated 6 times at Union Health and 4 times at THRH would not be included in the "at least 5" overlap set, despite the fact that both hospitals treat patients who received the same diagnosis code.

[112] FTC staff also evaluated the degree of overlap in Major Diagnostic Categories ("MDCs") treated by each hospital. Union Health and THRH both treat patients with conditions that fall within each MDC.

[113] *Merger Guidelines* § 3.2.

sufficient – could offset or reduce concerns in years to come from the elimination of competition between Union Health and THRH.

However, here, new entry appears to be unlikely, and even if it were to occur, it would not be timely or sufficient to offset the competitive harm of the proposed merger. Although Indiana does not have certificate of need laws, construction and operation of new acute care hospitals involve significant capital investment and take many years from the initial planning stage to opening. It is unlikely that any firm could overcome the entry barriers necessary to build a new acute care hospital in the Terre Haute area in the foreseeable future. Unsurprisingly, FTC staff's investigation to date has revealed no such plans for new entry by acute care hospitals.

VII. Benefits of the Proposed Merger Are Unlikely to Outweigh the Disadvantages Resulting from a Reduction in Competition and Less Restrictive Arrangements May be Available

Under the Indiana COPA Act, the IN DOH must consider whether the proposed COPA is likely to generate sufficient public benefits to offset the likely harm to consumers. In conjunction with conducting our standard analysis under the *Merger Guidelines*, FTC staff also evaluated the proposed merger applying the benefits and disadvantages factors that the IN DOH must consider when reviewing the COPA Application.[114] Based on the information we have obtained to date, the Parties' claimed benefits of the COPA appear unlikely to outweigh the significant disadvantages that would result from a reduction in competition between Union Health and THRH. Furthermore, there may be alternative arrangements that are less restrictive to competition and could achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition.

For cost savings and quality benefits to be recognized as cognizable efficiencies under the case law, "the estimate of the predicted saving must be reasonably verifiable by an independent party."[115] Factors to consider when assessing the verifiability of efficiency claims may include the likelihood and magnitude of each asserted efficiency, how and when each would be achieved, and any costs of doing so. Rigorous substantiation of efficiency claims is critical because efficiencies are difficult to verify and quantify, in part because much of the information is in the hands of the Parties, and because efficiencies may not be realized.[116] Efficiency claims also must be "merger-specific" – meaning they can only be achieved by this particular merger and not through other means having the same or lesser anticompetitive effects.[117] Additionally, to the extent efficiencies merely benefit the merging firms, they are not cognizable; they must be

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[114] Indiana COPA Act 16-21-15-4(b)(1)-(6).
[115] *See United States v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 89 (D.D.C. 2011); *Merger Guidelines* § 3.3 ("These benefits are verifiable, and have been verified, using reliable methodology and evidence not dependent on the subjective predictions of the merging parties or their agents.").
[116] Indeed, legal cases indicate that efficiency claims based on "speculation and promises about post-merger behavior" are not sufficient. United States v. H&R Block, Inc., 833 F. Supp. 2d 36, 89 (D.D.C. 2011) (quoting Fed. Trade Comm'n v. H.J. Heinz, 246 F.3d 708, 720-721 (D.C. Cir. 2001)).
[117] *See United States v. H & R Block, Inc.*, 833 F. Supp. 2d 36, 89 (D.D.C. 2011); *Merger Guidelines* § 3.3.

"passed through to consumers."[118] As elaborated in the *Merger Guidelines*, "cognizable efficiencies must be of a nature, magnitude, and likelihood that no substantial lessening of competition is threatened by the merger in any relevant market."[119]

The Parties list several goals of the COPA, including most notably the Post-Merger Initiatives, which they claim will reduce health care costs, improve quality of care, and improve the health status of residents in Vigo County and the Wabash Valley Community.[120] These initiatives include adopting a Health Equity Plan, Population Health Improvement Plan, and Virtual Nursing Program.[121] Also included is expanding Union Health's Service Line Model of Care at THRH facilities, which will involve implementing Union Health's electronic medical record system and primary care services at THRH.[122] Union Health also intends to increase its number of psychiatric beds to treat the community as a follow-on project to THRH's recent expansion of its inpatient psychiatric unit,[123] and will share its "expertise in, and commitment to, the provision of high-quality hospital services" with THRH.[124] While these stated initiatives may be laudable, it appears that many of them could likely be accomplished absent the merger.

The Parties go on to state that although they "will be on alert for efficiencies and cost savings that may be realized Post-Merger, substantially reducing the operating costs of the Combined Enterprise is not a primary goal of the Merger – *instead, the primary goal of the Merger is to significantly improve the health status of the residents of Vigo County and the other counties of the Wabash Valley Community*."[125] They claim that they have no plans to reduce the healthcare services currently provided or to close any facility currently in operation.[126] However, these statements are vague and do not appear to be enforceable should the Parties decide to reduce services or close facilities post-merger.

The Parties state that their Integration Plan "remains fluid and subject to revision due to the evolving nature of the information-gathering, planning, collaboration, and execution processes," and that formal integration planning will begin upon the closing of the merger.[127] In other words, they are waiting to offer specifics about their plans to consolidate services and facilities until *after* they obtain COPA approval. Yet, the Parties identify several clinical service areas and facilities that are targeted for consolidation post-merger, as well as redundant "Back

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[118] *United States v. Anthem, Inc.*, 855 F.3d 345, 362 (D.C. Cir. 2017); *Merger Guidelines* § 3.3 ("[t]he merging parties must demonstrate through credible evidence that, within a short period of time, the benefits will prevent the risk of a substantial lessening of competition. . . .").
[119] *Merger Guidelines* § 3.3. *See also ProMedica*, 2011 WL 1219281, at *57 ("Efficiencies must be 'extraordinary' to overcome high concentration levels") (quoting Fed. Trade Comm'n v. H.J. Heinz, 246 F.3d 708, 721 (D.C. Cir. 2001)); *OSF Healthcare Sys*., 852 F. Supp. 2d at 1089 ("'[h]igh market concentration levels require proof of extraordinary efficiencies'") (quoting *H&R Block*, 833 F. Supp. 2d at 89).
[120] COPA Application at 19.
[121] *See* COPA Application at 20-31, Section III.b.1.A.(i)-(iii).
[122] *See* COPA Application at 31-35, Section III.b.1.B.
[123] *See* COPA Application at 35-36.
[124] *See* COPA Application at 36-37.
[125] COPA Application at 19.
[126] COPA Application at 19.
[127] COPA Application at 20. *See also id.* at 43 ("A thorough understanding of these redundant services, and the cost savings that may be realized by virtue of the Combined Enterprises, cannot be obtained until after the Merger.").

Office" operations. Duplicative clinical service lines and facilities that appear to be targeted for consolidation or repurposing include: trauma, wound care, women's services (outpatient mammography), mother-baby/NICU/pediatrics, oncology, intensive care unit, morgue, cardiac catheterization labs, laundry/linens, lab, endoscopy suite, ophthalmology, dental, pain, sterile processing, ICU at Regional Hospital, and the physician office building at Regional Hospital.[128]

As we discuss in more detail below, the Parties have not provided enough information to evaluate any potential cost savings and efficiencies that could result from the proposed merger. Even after the IN DOH requested additional information from the Parties, their responses still did not provide sufficient detail to support their claims.[129] FTC staff has reviewed all of their additional submissions and we still have serious questions about how they will achieve cost savings and efficiencies. That is, their claimed efficiencies and cost savings remain unsubstantiated and the available record does not mitigate FTC staff's concerns that the proposed merger will substantially lessen competition – which in turn will raise prices, reduce quality, and suppress wages. The IN DOH may wish to understand this better, as studies show that mergers often do not achieve projected cost savings and efficiencies – even with significant planning and efforts.[130] And despite the Parties' statements in the COPA Application, in the FTC's experience, hospitals frequently project cost savings premised on facility consolidation, the elimination of services, and job reductions.

We also note the importance of more than 200 public comments received by the IN DOH, the majority of which expressed concerns about or are opposed to the proposed merger. In particular, many patients and employees of both hospitals raised the following concerns:

- The proposed merger would eliminate the only alternative option for healthcare services in the Terre Haute/Vigo County/Wabash Valley region, and many patients do not want a hospital monopoly.
- Many patients have had negative experiences with Union Health, in terms of quality, customer service, and pricing, and they do not want to lose THRH as their preferred alternative. They believe quality is better at THRH and that this will be lost as a result of the proposed merger.
- Many patients are concerned about the loss of existing competition between Union Health and THRH in terms of prices, quality, and access for healthcare services, as well as the long-term impact of higher healthcare costs and reduced quality when the COPA conditions are no longer in effect.
- Some patients and hospital employees are concerned that the consolidation of services and facilities will result in increased patient travel and wait times, particularly for patients who reside in the south side of Terre Haute.
- Many hospital employees are concerned about the negative impact the proposed merger would have on their wages and benefits, morale, and alternative employment options, as

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[128] COPA Application at 38-40.
[129] *See* COPA Application Supplemental Responses, Initial Response and Subsequent Submission, available at https://www.in.gov/health/cshcr/certificate-of-public-advantage/pendingapproved-copas/.
[130] *See infra* note 197.

well as the quality of care and patient access to healthcare services. Several employees also expressed concerns about the noncompete clauses imposed by Union Health.
- Some patients and hospital employees noted that the proposed merger is unnecessary, and that both hospitals are financially sound and operational.
- Some patients and hospital employees would prefer a different purchaser of THRH, so that there continues to be an alternative hospital option in the area.

A. Proposed Merger Likely Would Have a Substantial Adverse Impact on the Quality and Price of Health Care Services in the Terre Haute Area

Indiana COPA Act 16-21-15-4(b)(1): *The quality and price of hospital and health care services provided to Indiana residents, including the demonstration of population health improvement of the region serviced and the extent to which medically underserved populations have access to and are projected to use the proposed services.*[131]

ASSESSMENT: As described above, our analysis indicates that Union Health and THRH are close competitors and that the geographic service area is already highly concentrated. As a result, the proposed merger would give the combined hospital system increased bargaining leverage with insurers to negotiate significantly higher reimbursement rates, because insurers would no longer be able to credibly threaten (either implicitly or explicitly) to temporarily terminate one competitor from in-network status during negotiations. These price increases typically are passed through from insurers to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses.[132] Thus, contrary to the statements by the Parties that the proposed merger would not result in "any undue increase in health care costs"[133] and [redacted][134] the proposed merger likely would have a substantial adverse impact on Indiana patients by increasing the prices of healthcare services. As described in Section VIII, the Parties have not proposed any enforceable terms or conditions that would mitigate this harm.

The elimination of competition between Union Health and THRH would also diminish the Parties' business incentives to maintain or improve current levels of quality, patient experience, and access to services and innovative technology, because the combined hospital system would no longer risk losing patients to its pre-merger rival. These non-price dimensions of competition greatly benefit Indiana patients and are among the factors by which employers and consumers evaluate the desirability of a provider network. Today, these hospitals know that patients can choose to seek care at, and physicians can send their referrals to, another system if they are not satisfied with the quality, patient experience, or services offered by one of the

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[131] *See also* IN DOH COPA Checklist at 4, Factor A ("The availability, access, quality and price of hospital and health care services provided to Indiana residents, including the demonstration of population health improvement of the relevant services areas and the extent to which medically underserved populations have access to and are projected to use the proposed services").
[132] *See infra* Section VII.D, for further discussion of this dynamic.
[133] COPA Application at 58.
[134] [redacted].

hospital systems. That threat of losing patients and physician referrals to a rival system incentivizes each system to provide the best possible quality and patient experience, to add new services and technology, and to enhance the availability and convenience of care. Thus, the proposed merger could reduce the quality of care in Indiana. Importantly, a reduction in quality of care can have an adverse effect on patient outcomes such as mortality, readmissions, and length of stay. Reduced availability of services may result in decreased patient access, increased travel time to receive services, increased emergency room wait times, and other negative consequences.

In the COPA Application, the Parties argue that the merger generally would lead to improved availability and quality of care, as well as enhanced clinical coordination throughout the merged entity.[135] Assessing potential quality improvement claims from merging parties has long been a central element of FTC hospital merger investigations. We often analyze the clinical quality effects likely to occur as a result of consolidation with guidance from leading academic and policy experts in healthcare quality. We also evaluate how the merger affects the hospitals' business incentives to deliver higher quality care, and whether changes brought about by the merger would enable the combined hospitals to provide higher quality care more cheaply or efficiently than they could achieve individually.

Empirical literature evaluating the relationship between competition and various measures of hospital quality of care does not support the conclusion that hospital consolidation generally improves clinical quality of healthcare services. Rather, studies demonstrate the net effect of mergers of competing hospitals on quality is often negative, and increased competition is associated with better quality.[136] Based on the available evidence, we cannot presume that any given hospital merger is likely to improve quality or reduce costs by enough to offset a price increase.

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[135] *See, e.g.*, COPA Application at 33-35 (describing how Union Health plans to expand primary care services to THRH), 35-36 (describing how Union Health plans to expand inpatient psychiatric services), and 19-35 (describing the Post-Merger Initiatives that the Parties claim will reduce healthcare costs and improve quality of care provided by the Combined Clinical Platform). The Post-Merger Initiatives appear to include deploying the Health Equity Plan that will soon be adopted by Union Health at THRH; deploying Union Health's existing Population Health Improvement Plan to THRH; deploying the Virtual Nursing Program [redacted] to THRH; and deploying Union Health's existing Service Line Model of Care to THRH. *See also* COPA Application Subsequent Submission for details about these plans.

[136] *See* Romano & Balan, *supra* note 147; Gaynor, Ho & Town, *supra* note 79; GAYNOR & TOWN, *supra* note 79; Beaulieu, Dafny, Landon, Dalton, Kuye & McWilliams, *supra* note 79, at 56 (finding "no evidence of quality improvement attributable to changes in ownership. Our findings corroborate and expand on previous research on hospital mergers and acquisitions in the 1990s and early 2000s and are consistent with a recent finding that increased concentration of the hospital market has been associated with worsening patient experiences."); Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, Medical Care Research and Review 1-18, at 14 (2019), https://journals.sagepub.com/doi/pdf/10.1177/1077558719828938 (finding "increased hospital market concentration is strongly associated with reduced quality across multiple measures. With this result in mind, regulators should continue to focus scrutiny on proposed hospital mergers, take steps to maintain competition, and reduce counterproductive barriers to entry.").

Based on FTC staff's deep experience in evaluating these types of quality justifications, it appears that many of the Parties' claims about the likely quality benefits from the merger are unsubstantiated or the benefits appear modest in scope. Furthermore, it appears that many of the claimed quality enhancements may be achieved through less restrictive alternatives that would not eliminate the valuable competition between the Parties – either by the Parties independently, through another form of collaboration between the Parties, or through an alternative merger or affiliation with a different partner that would not meaningfully reduce competition.

1. Consolidation of Clinical Services Is Uncertain and Could Reduce Patient Access

Although the Parties contend that they have no plans to reduce the services currently provided by Union Health and THRH as a result of the proposed merger,[137] the COPA Application includes numerous examples of planned consolidation of clinical services. Union Health acknowledges that it has "already identified, on a preliminary basis, some facility spaces that could be reasonably repurposed for cost and/or clinical reasons."[138] Clinical service lines that appear to be targeted for consolidation include: trauma, wound care, outpatient mammography, mother-baby/NICU/pediatrics, oncology, intensive care unit, morgue, cardiac catheterization labs, endoscopy, ophthalmology, dental, pain, and sterile processing.[139] This proposed consolidation of clinical services likely would require considerable effort, money, and time. The Parties have not provided sufficiently detailed information in the COPA Application or subsequent submissions to the IN DOH, so it remains unclear whether the merged entity could successfully consolidate clinical services so as to improve patient outcomes, or when the merging hospitals might expect to realize any purported quality benefits.

The Parties claim that "the primary goal of the Merger is to significantly improve the health status of [area] residents," and therefore they do not intend to cut costs by reducing workforce and services, or by closing facilities.[140] Despite these promises, it is entirely possible that consolidation could reduce the availability of, and patient access to, healthcare services – for example, due to the closure of hospital facilities or a reduction in hospital staff. Indeed, the Parties acknowledge that they "will be alert for efficiencies and cost savings that may be realized post-Merger"[141] and that the post-merger integration plan "remains fluid and subject to revision."[142] Thus, they have left open the possibility for reductions in workforce and services, as well as facility closures. If this were to occur, then the consolidation of clinical services could be more harmful to patients than beneficial.

Consolidation may already be happening as a result of the pending merger. FTC staff's understanding is that THRH recently made the decision that it will not seek recertification of its

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[137] *See* COPA Application at 18-19.
[138] COPA Application at 38.
[139] COPA Application at 38-40.
[140] COPA Application at 18-19.
[141] COPA Application at 19.
[142] COPA Application at 20.

Level III trauma centers and has eliminated its trauma services as of August 1, 2024.[143] [redacted] It is unclear whether THRH would have discontinued its trauma services absent the proposed merger. [redacted] For three years Union Health and THRH have been engaged in merger discussions. [redacted]

The Parties generally suggest that "increased [patient] volume will operate to improve the quality of care provided by Post-Merger Union Hospital."[146] The research literature shows that a "volume/outcome" relationship exists only for a limited set of procedures and services, including trauma and certain other complex procedures.[147] Any quality benefits from the Parties' proposed clinical consolidation would, therefore, be confined to those services for which there is a demonstrated volume/outcome relationship. Notably, the Parties do not identify any specific examples of procedures or services that will have improved outcomes as a result of increased volumes.

Moreover, even for procedures where there is a volume/outcome relationship, consolidation that might improve clinical quality outcomes would only be merger-specific if it would enable the merged hospital system to surpass certain volume thresholds that the hospitals could not otherwise meet independently. Further, even if the merging hospital systems were able to obtain substantiated, merger-specific volume/outcome related improvements in clinical outcomes by consolidating services, those benefits must be weighed against any potential disadvantages that could result from the consolidation.[148] For example, if closing some facilities reduced patient access to services, this consolidation could have an adverse impact on some patients.

Finally, to consolidate clinical services, the Parties must be able to integrate successfully and this involves achieving sufficient cultural compatibility. Indeed, the difficulty of unifying organizational cultures has been identified as a significant challenge to integrating facilities and a

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[143] *See* COPA Application Subsequent Submission at 5.

[144] [redacted]

[145] [redacted]

[146] COPA Application at 62.

[147] *See* Patrick Romano & David Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Hospital*, 18 INT'L J. ECON. BUS. 45 (2011), http://www.tandfonline.com/doi/abs/10.1080/13571516.2011.542955.

[148] *See* Kenneth Kizer, Independent Assessment of the Proposed Merger between Mountain States Health Alliance and Wellmont Health System 17-19 (Nov. 21, 2016), https://www.vdh.virginia.gov/content/uploads/sites/96/2016/11/Kennith-KIZER-INDEPENDENT-ASSESSMENT-MSHA-WHS-MERGER.pdf.

primary reason that anticipated benefits of hospital mergers may fail to materialize.[149] Based on evidence obtained by the FTC, it appears this could be an issue with the proposed merger.

2. Hospitals Can Pursue Clinical Standardization without the Proposed Merger

The Parties claim that the priority throughout the merger process "will be to remain patient-focused while optimizing and coordinating the delivery of health care services."[150] They maintain there is currently no opportunity for them to coordinate service lines, but that "following the Merger, the Combined Clinical Platform, operating as a single organized system of health care, will be able to coordinate the provision of health care services, and the utilization of health care resources, to address the area's health care needs."[151] Yet beyond such general statements, the Parties do not identify any specific areas targeted for quality improvement or detailed plans for achieving improvements. A hospital merger may generate overall quality improvements when the merging hospitals have very different clinical quality levels if the merger allows the clinically inferior hospital to come under the management, and adopt the practices, of the clinically superior hospital, thereby improving quality at the inferior hospital. Based on the information FTC staff has obtained to date, neither hospital appears to suffer from low quality levels, meaning the potential for overall quality improvements may be limited.[152]

Having said that, if Union Health and THRH want to engage in greater efforts to coordinate care with one another and improve health outcomes for patients, they have other options without having to merge. Although standardizing clinical policies and procedures may lead to quality improvements, the Parties can achieve these either on their own, through some collaboration short of a merger, or through mergers or affiliations with alternative partners that raise fewer competitive concerns. As the antitrust agencies have consistently made clear, the antitrust laws are not an impediment to legitimate, procompetitive collaboration that would benefit patients and employers without raising competitive concerns.[153] Generally, most of the

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[149] *See id.* at 24-25 ("Notwithstanding that the VA Healthcare System is completely administratively and financially integrated, and has a longstanding well-defined mission, there were significant challenges in merging facilities under common management primarily because of the often disparate local cultures prevalent at individual facilities – even when in some instances they were geographically separated by only a few miles and served much the same population.").

[150] COPA Application at 20.

[151] COPA Application at 20.

[152] *See* COPA Application at 36-37 and COPA Application Subsequent Submission at 59-64, RFI2 Attachment L(6) (listing Union Health's accreditations and certifications as evidence of its expertise and commitment to the provision of high-quality hospital services). The COPA Application and supplemental submissions do not list THRH's accreditations and certifications, so a direct comparison is not possible based on the information we have reviewed to date. The IN DOH may want to obtain this information from the Parties to understand whether Union Health offers significantly higher clinical quality levels than THRH. However, THRH's ordinary course documents indicate that it had quality ratings comparable to or higher than Union Health for certain service categories. *See, e.g.*, RFI1 Attachment P, HCA Healthcare/THRH Indiana Market 2023-2025 Strategic Plan (Oct. 4, 2022) at 6.

[153] *See, e.g.*, FTC Healthcare Advisory Opinions (explaining FTC staff's public analysis of specific healthcare provider collaborations), https://www.ftc.gov/system/files/ftc_gov/pdf/Overview-AdvisoryOpinions.pdf; FED. TRADE COMM'N & U.S. DEPT'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS

benefits from the merger may be achieved through alternatives that are less restrictive to competition and achieve comparable benefits or a more favorable balance of benefits over disadvantages.[154] Despite some statements to the contrary,[155] the Parties acknowledge that "[i]n addition to transfers and delivering care in the regular course," they have coordinated interventional radiology and laundry services.[156] There are likely numerous other services they could coordinate without having to merge.

Indeed, according to the COPA Application, Union Health has already undertaken several independent initiatives, as well as other joint ventures and partnerships, to improve clinical services absent the proposed merger. For example, Union Health commenced a Service Line Model of Care initiative in 2019 to optimize service delivery and outcomes for five service lines, including orthopedics, oncology, neurosciences, women's and children's health, and cardiovascular care.[157] Other examples include Union Health's establishment of the Mobile Healthy Transitions Team and the Collaborative Medical Clinic For Unsheltered Community Members, both of which are comprised of numerous physicians, nurses, and other healthcare providers in the Terre Haute community.[158] Union Health has also implemented a virtual nursing program, [redacted],[159] and is currently [redacted].[160] And Union Health is already a member of an accountable care organization ("ACO") in partnership with Caravan Health, which it claims is one of the largest Medicare Shared Savings Program ACOs, noting that "Caravan Health affiliated ACOs lead the nation in quality and savings."[161] Despite the claims in the COPA Application, there is no reason why THRH, owned by HCA, could not engage in some initiatives independently or through partnerships with other entities absent the proposed merger. As all of these initiatives by Union Health demonstrate, it is possible for a hospital to achieve improvements in clinical quality of care without having to merge with its closest competitor.

(2000), https://www.ftc.gov/sites/default/files/documents/public_events/joint-venture-hearings-antitrustguidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf.

[154] This assumes that benefits would be achieved as a result of the merger. FTC staff believes that any benefits resulting from the merger that are substantiated and merger-specific are likely to be modest.

[155] COPA Application at 4, 20 ("Currently, there is no opportunity for the Union Healthcare Providers and the Regional Healthcare Providers to coordinate service lines, or to otherwise thoughtfully utilize health care resources to address the health care needs of Vigo County and the other counties of the Wabash Valley Community.").

[156] COPA Application at 14. *See also* Testimony by Steve Holmen of Union Health at Indiana General Assembly 2021 Session, Health and Provider Services Committee Hearing on SB 416 (Feb. 10, 2021), https://iga.in.gov/session/2021/video/committee_health_and_provider_services_3900 (stating that Union Health and THRH have collaborated in various ways throughout the years).

[157] COPA Application at 32. *See also* COPA Application Subsequent Submission at 45-56, RFI2 Attachment L(4).

[158] *See* COPA Application at 20-21, footnote 10.

[159] *See* COPA Application at 30-31. *See also* COPA Application Subsequent Submission at 41-44, RFI2Attachment L(3).

[160] *See* COPA Application at 51.

[161] COPA Application at 29.

[redacted]. Furthermore, it is unclear how extensively HCA/THRH engaged in a search to identify other local, regional, and national providers with whom it may have partnered, and that may have raised fewer antitrust concerns. The IN DOH may wish to understand these dynamics better when considering if HCA/THRH had other options besides Union Health. Factors that FTC staff normally considers when evaluating this issue include: whether an outside firm was hired to conduct a formal shopping of the assets; what materials and information were presented to companies to gauge interest in the assets; what due diligence was performed with interested companies; how extensive were negotiations with interested companies, including whether HCA/THRH was willing to make concessions to enter into deals with other interested companies; and were all other options fully exhausted before HCA/THRH settled on Union Health. [redacted].[162] In our experience, merging hospitals sometimes claim there are no alternative purchasers for the acquired assets and therefore they should not face an antitrust challenge. However, as we have seen in other matters, they often are able to find viable alternative purchasers when their initially proposed anticompetitive mergers are not completed.[163]

3. Proposed Merger Is Unnecessary for Health Equity and Population Health Improvement Initiatives

The COPA Application describes several initiatives that Union Health has already implemented to achieve health equity and improve population health. The Parties suggest that as a result of the merger, Union Health will be able to expand these initiatives to THRH. However, Union Health was able to implement these initiatives absent the merger, and it is unclear why the merger is the only way for them to be achieved at THRH. Indeed, THRH is currently owned by HCA Healthcare – the largest health system in the United States with an estimated $49 billion in net patient revenue.[164] Presumably, THRH should already have access to extensive resources and expertise for any kind of program it chooses to implement.

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[162] [redacted]

[163] For example, a hospital system in North Carolina has found another buyer for one of its facilities despite claiming in a federal antitrust lawsuit that there were no plausible alternative buyers. *See* Global Competition Review USA Tipline, *The Deals: Community Health Systems* (Aug. 26, 2024), https://globalcompetitionreview.com/gcr-usa/article/realpage-turner-the-tipline-26-august-2024?utm_source=RealPage%2Bdemands%2Bprogressive%2Badvocate%2Bcease%2Band%2Bdesist&utm_medium=email&utm_campaign=GCR%2BUSA%2BBriefing.

[164] *See* Definitive Healthcare, *Top 10 largest health systems in the U.S.* (2023), https://www.definitivehc.com/blog/top-10-largest-health-systems#:~:text=What%20are%20the%20largest%20health,it%20was%20established%20in%201968.

Union Health has already implemented a Population Health Improvement Plan that consists of eleven initiatives with numerous components, and the merger was not necessary for this to happen. Some of these initiatives have already commenced, including those designed to address community health needs, employee wellbeing and retention, chronic diseases and other health drivers, the elderly's ability to age in place, access to insurance and affordable pharmaceuticals, access to obstetrics services, and reducing harms associated with substance abuse and addiction.[165] The remaining initiatives are in development, including those designed to address healthcare and resources for homeless and housing insecure individuals, healthcare workforce development, food insecurity and nutrition services, and healthcare education and support groups.[166] Union Health provided additional details about this plan in a supplemental submission to the IN DOH.[167]

The COPA Application claims that THRH has only limited population health programs and no current plans to implement initiatives similar to Union Health's population health plan. It also claims that without the merger, THRH resources will not be utilized as part of such a plan.[168] However, little evidence is offered to support these claims and it is unclear why THRH – a financially viable hospital offering similar services as Union Health, albeit it on a smaller scale – would not be able to implement population health initiatives on its own or through some alternative means to the merger that would not result in a loss of competition. [redacted]

In both its COPA Application and supplemental submission, Union Health cites reasons why health equity is important for improving patient health status and describes its adoption and implementation of its Health Equity Plan.[170] Notably, Union Health was able to implement this initiative absent the proposed merger. The Parties do not adequately explain why this merger is necessary for such an initiative to be implemented at THRH.

The Parties also suggest that Union Health's direct employment of physicians enables its primary care-oriented system, which achieves "better health outcomes, more health equity and lower costs."[171] They further suggest that THRH's model of not directly employing physicians has resulted in its patients not having access to primary care services.[172] [redacted]

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[165] *See* COPA Application at 25-27.
[166] *See* COPA Application at 27-28.
[167] *See* COPA Application Subsequent Submission at 31-40, RFI-2 Attachment L(2).
[168] COPA Application at 28.
[169] [redacted]
[170] *See* COPA Application at 23; COPA Application Subsequent Submission at 6-29, RFI-2 Attachment L(1).
[171] COPA Application at 34.
[172] COPA Application at 35.

[redacted],[173] so it is unclear why THRH could not implement a primary care-oriented model on its own. Furthermore, it is unclear that direct physician employment will achieve the benefits claimed by the Parties in the COPA Application. Indeed, recent empirical evidence suggests that vertical integration among hospitals and physician groups may lead to higher prices without improvements in quality of care.[174] The Petris Center report studied hospital-physician vertical integration trends in Indiana, and found modest price increases associated with vertical integration.[175] The report indicates that the share of primary care physicians vertically integrated with a hospital or health system increased significantly in the Terre Haute MSA from 2010 to 2018.[176] To the extent that the proposed merger results in even greater vertical integration between Union Health and primary care physicians, it could exacerbate any anticompetitive effects stemming from hospital-physician concentration.

To summarize, it is unclear why the proposed merger is necessary for any of these initiatives. The relevant question is whether Union Health and THRH would be more likely to participate in such initiatives, or participate more effectively, with this merger than they would without it. The Parties present no evidence that this is the case. It appears that the region can continue to benefit from these initiatives without incurring the disadvantages associated with the proposed merger. Antitrust laws do not prevent these hospitals from pursuing population health and other initiatives in the absence of the merger.

4. Implementation of Uniform EMR System Is Unnecessary to Improve Quality of Care

FTC staff has attempted to evaluate the Parties' claim that having a standardized electronic medical records ("EMR") system will enable them to share patients' clinical information and better coordinate care for patients.[177] Union Health claims that it will expand the use of its EMR system to include THRH, and that within one year of the closing date, it will spend $15 million on upgrades to its information technology in order for the Parties' systems to

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[173] [redacted]

[174] *See, e.g.*, Cory Capps, David Dranove & Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, 59 J. Health Econ. 139 (May 2018), https://www.sciencedirect.com/science/article/abs/pii/S016762961730485X?via%3Dihub; Thomas Koch, Brett Wendling & Nathan Wilson, *The Effects of Physician and Hospital Integration on Medicare Beneficiaries' Health Outcomes*, 103 REV. ECON. & STAT. 725 (2021), https://doi.org/10.1162/rest_a_00924.

[175] *See* Petris Center Report, *supra* note 33 at 47, 57 ("Physician billing practices, market power, and physician referral patterns are three key reasons why vertical integration can lead to higher prices.").

[176] *See* Petris Center Report, *supra* note 33 at 51 (Table 3.2 showing the share of primary care physicians vertically integrated with a hospital or health system increased significantly in the Terre Haute MSA from 2010 to 2018, from 16.4% to 36.2%, an increase of 19.8%).

[177] COPA Application at 33, 63-64 (describing potential benefits of standardized EMR and protocols for patient safety, coordinating care, efficiency and workflow, data analysis and research, cost savings, quality improvements, population health management, and patient engagement).

be fully integrated.[178] It is unclear exactly how much of this investment is dedicated for EMR standardization.

For many reasons, the Parties' claims regarding a uniform EMR system may be overstated. First, they have not demonstrated that the incremental benefit of a common IT platform would be of sufficient magnitude to significantly improve patient health outcomes – much less that it could obviate the other harms from eliminated competition between the Parties. For example, patients who will only use facilities in one of the current hospital systems are not likely to benefit from the combination of the EMR platforms. There are ways for hospitals to effectively share information with each other, even with separate EMR systems, further limiting the benefits of a common system. Moreover, federal legislation already regulates EMR interoperability which may reduce or obviate the need for a common EMR platform between the Parties.[179]

Second, any benefit of a common EMR system would have to be compared to its costs. Converting to a common EMR system can be extremely expensive and time consuming,[180] and the conversion process can delay access to critical patient information. All told, the time, difficulties, and expense of converting to a common EMR system may outweigh the potential benefit.

Third, a Health Information Exchange ("HIE") already exists in Indiana, which enables secure access to patient information for participating providers. The Indiana Health Information Exchange has been available since 2004, and allows for the intersection of digital health, payment reform, and patient care, thereby leading to less redundancy and faster and more efficient quality healthcare for patients throughout Indiana. The IHIE facilitates population health management and improves patient care.[181] Union Health already appears to be a participant in the IHIE,[182] and presumably THRH could also participate if it wanted to. The

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[178] COPA Application at 33. The technology upgrades will include network infrastructure, hardware, clinical and non-clinical systems, and network security.

[179] *See* Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), which requires widespread exchange of health information through interoperable certified EMR technology among healthcare providers. Absent the merger, the Parties are already required to achieve EMR interoperability. This undermines the Parties' argument that a merger is necessary to achieve a common EMR platform, so that the hospitals can exchange health information. *See also* CMS, *Promoting Interoperability Programs*, https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms?redirect=/ehrincentiveprograms (last accessed Oct. 3, 2022); CMS, *Certified EHR Technology*, https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification (last accessed Oct. 3, 2022); CMS, *2022 Medicare Promoting Interoperability Program: Certified Electronic Health Record Technology Fact Sheet*, https://www.cms.gov/files/document/2022-cehrt-fact-sheet.pdf (last accessed Oct. 3, 2022).

[180] *See* Akanksha Jayanthi & Ayla Ellison, *8 Hospitals' Finances Hurt by EHR Costs*, BECKER'S HOSPITAL CFO (May 23, 2016), http://www.beckershospitalreview.com/finance/8-hospitals-finances-hurt-by-ehr-costs.html; Akanksha Jayanthi, *8 Epic EHR Implementations with the Biggest Price Tags in 2015*, BECKER'S HEALTH IT & CIO REVIEW (Jul. 1, 2015), http://www.beckershospitalreview.com/healthcare-information-technology/8-epic-ehr-implementations-with-the-biggest-price-tags-in-2015.html.

[181] Indiana Health Information Exchange, *About Us*, https://www.ihie.org/about-us/.

[182] Indiana Health Information Exchange, *Participant List*, https://www.ihie.org/participant-list/.

Parties have not adequately explained the incremental benefit of the information accessible on a combined EMR system versus that available on the existing HIE.

In summary of Section VI.A, the proposed merger appears to eliminate direct head-to-head competition between Union Health and THRH, and will likely lead to significantly higher prices and reduced business incentives to maintain or improve quality and access to care. Importantly, the benefits of competition among healthcare providers are not confined to those patients covered by commercial insurance plans. Competition benefits *all* patients, including those who are covered by government insurance programs (*i.e.*, Medicare and Medicaid) or are uninsured. By far, the most important such benefit is improved quality of care. As noted above, competition-reducing mergers often reduce quality. Those quality reductions could affect all of the hospitals' patients, not just those with commercial insurance. Competition may also indirectly restrain the prices or premiums paid by patients covered by a government insurance program or who are uninsured.[183]

B. Proposed Merger Likely Would Reduce Public Access to Healthcare Services in the Terre Haute Area

Indiana COPA Act 16-21-15-4(b)(2): The preservation of sufficient health care services within the geographic area to ensure public access to acute care.[184]

ASSESSMENT: Hospital mergers often involve the consolidation of facilities and services to achieve cost savings and efficiencies, which can lead to a reduction in access to healthcare services. The Parties have identified some general service areas in which they expect to consolidate volume at one hospital or the other following the merger, including: high-level trauma care, wound care, outpatient mammography services, mother-baby/NICU/pediatric services, oncology/cancer center, ICU services, morgue/autopsy capabilities, cardiac catheterization labs, endoscopies, ophthalmology, dental procedures, pain services, and sterile processing services. As already noted, THRH recently made the decision to discontinue its

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[183] Many Medicare patients are covered by Medicare Advantage (MA) plans rather than by traditional Medicare. MA hospital prices are negotiated rather than fixed and, as such, vary from traditional Medicare hospital prices. *See* Robert A. Berenson, Jonathan H. Sunshine, David Helms & Emily Lawton, *Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices*, 34 HEALTH AFFAIRS 1289 (Aug. 2015), http://content.healthaffairs.org/content/34/8/1289.abstract; Laurence Baker, M. Kate Bundorf, Aileen Devlin & Daniel Kessler, *Medicare Advantage Plans Pay Hospitals Less Than Traditional Medicare Pays*, 35 HEALTH AFFAIRS 1444 (Aug. 2016), http://content.healthaffairs.org/content/35/8/1444.abstract. A competition-reducing merger may to some extent increase MA prices, and those increases will be passed through to Medicare beneficiaries in the form of higher MA premiums or reduced benefits. In addition, under the Patient Protection and Affordable Care Act, prices that non-profit hospitals charge to uninsured, self-pay patients eligible for financial assistance can be no more than "amounts generally billed to insured patients." *See* Sara Rosenblum, *Additional Requirements For Charitable Hospitals: Final Rules On Community Health Needs Assessments And Financial Assistance*, HEALTH AFFAIRS BLOG (Jan. 23, 2015), http://healthaffairs.org/blog/2015/01/23/additional-requirements-for-charitable-hospitals-final-rules-on-community-health-needs-assessments-and-financial-assistance/. The calculation of these "amounts generally billed" includes commercial insurance prices, which means that increases in commercial prices also increase the prices that hospitals are permitted to charge to uninsured patients.

[184] *See also* IN DOH COPA Checklist at 4, Factor B ("The preservation of sufficient health care services within the relevant services areas to ensure public access to healthcare services").

trauma services as of August 1, 2024, and [redacted], so in effect this consolidation appears to already be happening.[185] We encourage the IN DOH to carefully weigh the potential benefits of consolidating volume against the potential harms, including reduced capacity and increased patient drive times.

The Parties claim that "substantially reducing the operating costs of the Combined Enterprise is not a primary goal of the merger. The primary goal of the Merger is to significantly improve the health status of the residents," and so Union Health "has no plans to reduce the services currently provided" or "to close any facility or other location . . . currently in operation."[186] Likewise, the Parties claim to be "committed to protecting the employees of both [hospitals],"[187] suggesting that they do not plan to reduce staffing.

On the other hand, the Parties acknowledge that Union Health and THRH "provide substantially the same services," and that "[a] thorough understanding of these redundant services, and the cost savings that may be realized by virtue of the Combined Enterprises, cannot be obtained until after the Merger."[188] They claim that "the Merger will produce reductions in health care costs over time,"[189] without fully explaining how this would be achieved. The Post-Merger Initiatives listed in the COPA Application are essentially plans to consolidate services and facilities the Parties believe redundant. The Parties contend that these initiatives "will result in better health outcomes and less spending on costly emergency department visits and hospitalizations."[190] However, the practical effect of this consolidation may be reduced capacity and access for healthcare services in the Terre Haute area.

The Parties claim that the "current facilities of both Regional Hospital and Union Hospital will remain open."[191] However, they anticipate "there will be several space-related efficiencies that will be derived from the Merger. While a complete and precise understanding of these efficiencies will not be possible until the Combined Clinical Platform has been in operation for a number of months, Union Hospital has already identified, on a preliminary basis, some facility spaces that could be reasonably repurposed for cost and/or clinical reasons."[192] These plans appear to include consolidating the following services at Union Health or THRH facilities: high-level trauma care, wound care, outpatient mammography services, mother-baby/NICU/pediatric services, oncology/cancer center, ICU services, morgue/autopsy capabilities, cardiac catheterization labs, endoscopies, ophthalmology, dental procedures, pain services, and sterile processing services.[193] When these services are consolidated at one site, the other site that currently offers these services would need to be closed or repurposed. Thus, the current capacity and access for these services in the Terre Haute area would likely be reduced. In addition, the physician office building on Regional Hospital's campus will be used for patient

[185] *See supra* page 36-37 for discussion of THRH discontinuing these services.
[186] COPA Application at 19, 43.
[187] COPA Application at 18, 43.
[188] COPA Application at 43.
[189] COPA Application at 43.
[190] COPA Application at 43-44.
[191] COPA Application at 37.
[192] COPA Application at 38.
[193] *See* COPA Application at 38-40.

and employee education, which presumably could reduce access to physician services.[194] Notably, the Parties have made no firm commitments to keep open or maintain current service levels at hospitals and other facilities that are enforceable by the IN DOH, and THRH has already discontinued its trauma services ahead of the merger. As illustrated during the COVID pandemic, reduced capacity resulting from hospital consolidation could prove to be a risk rather than an efficiency benefit. Hospitals must be able to quickly ramp up the availability of beds, staff, and supplies during emergencies,[195] and this challenge may be exacerbated if capacity is already constrained due to consolidation.

C. Claims of Cost Savings, Efficiencies, and Improvements in Resource Utilization Are Unsubstantiated, Not Merger-Specific, and Insufficient to Overcome the Likely Competitive Harm

Indiana COPA Act 16-21-15-4(b)(3): The cost efficiency of services, resources, and equipment provided or used by the hospitals that are a party to the merger agreement, including avoidance of duplication of services to better meet the needs of the community.[196]

ASSESSMENT: As described above, the Parties' claims regarding cost savings and efficiencies are vague and inconsistent with claims regarding preservation of services and access. Nevertheless, the Parties have indicated that they intend to consolidate redundant services and facilities post-merger to achieve some degree of cost efficiencies and avoid duplication of services.

FTC staff often hears that hospital mergers have the potential to achieve cost savings and efficiencies, and we consider this as part of our analysis. Here, however, the Parties have not provided sufficient detail to evaluate the credibility and magnitude of their claims. For example, the Parties have not identified the specific steps necessary to achieve any savings, the expenditures involved, and a sufficient breakdown of the estimated annual cost savings for each category of claimed efficiencies in their COPA Application. Without this information, the likelihood and magnitude of cost savings claims cannot be verified, which is necessary for the IN DOH to determine whether any claimed efficiencies would offset the significant disadvantages of the proposed merger. Experience and evidence demonstrate that many hospital mergers do not

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[194] *See* COPA Application at 40.

[195] *See, e.g.*, Nadiyah Browning, *Chart of the Day: Hospital Capacity Strain Can Lead to Delayed Treatment*, Penn Leonard Davis Institute of Health Economics Population Health Blog (Jun. 14, 2022), https://ldi.upenn.edu/our-work/research-updates/chart-of-the-day-how-hospital-capacity-strain-can-lead-to-delayed-treatment/ ("To ensure consistent quality care delivery, hospital leaders and policymakers need to consider how to manage capacity strain when patient needs increase – not just during pandemics but in the course of ordinary variation in patient volume."); Joseph Cavallo, Daniel Donoho & Howard P. Forman, *Hospital Capacity and Operations in the Coronavirus Disease 2019 (COVID-19) Pandemic—Planning for the Nth Patient*, JAMA Health Forum Insights (Mar. 17, 2020), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2763353.

[196] *See also* IN DOH COPA Checklist at 4, Factor C ("The efficiency of services, resources, and equipment provided or used by the Applicant Groups, including avoidance of duplication of services to better meet the needs of the community"); *Id.* at 4, Factor D ("Utilization of healthcare, including preventable visits, re-admission, and impact on health outcomes").

result in significant efficiencies, despite company projections that they will.[197] Furthermore, even assuming the Parties could achieve some cost savings, it is unclear how much would be passed through to healthcare consumers in the form of lower prices.

In addition, many of the claimed savings are the type that likely are achievable without the proposed merger. The Parties have not shown that all of the claimed benefits are both merger-specific and incremental to the benefits the Parties would have achieved without the merger, or that the claimed benefits would actually accrue to the public. The Parties pledge to use cost savings derived from the merger to invest in quality and healthcare initiatives. However, it is unclear what portion of the savings is truly incremental compared to the current or future investments that the hospitals would have made independently, absent the merger. Union Health and THRH already make significant investments in quality and healthcare initiatives, and likely would continue to do so without the merger. When evaluating investment proposals from the Parties, the IN DOH should compare them to any investments that were likely to occur in response to competition between the Parties.

There do not appear to be any enforceable commitments to achieve cost savings or efficiencies, or to use these savings to fund quality and access improvements. Even if the Parties were able to reduce their costs by eliminating competing clinical services, that is not an unqualified benefit. Those cost savings may be derived from a reduction in staff or closure of facilities, thereby reducing patient access to healthcare services and forcing some patients to travel further to receive care or wait longer for appointments, which may reduce quality of care and patient satisfaction.

Although the Parties claim that they have no current plans to reduce services, eliminate jobs, and close facilities,[198] they also assert that they "will be alert for efficiencies and cost savings that may be realized post-Merger."[199] The Parties' integration plan "remains fluid and subject to revision due to the evolving nature of the information-gathering, planning,

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[197] *See* Hannah Neprash & J. Michael McWilliams, *Provider Consolidation and Potential Efficiency Gains: A Review of Theory and Evidence*, 82 ANTITRUST L.J. 551, 553 (2019) ("In total, the literature suggests that consolidation among health care providers – whether horizontal or vertical – does not, on average, result in welfare-enhancing efficiencies. While our findings do not preclude the existence of merger-specific efficiencies in specific transactions, they do suggest that antitrust enforcers and policymakers should apply considerable scrutiny to claims of such efficiencies."). *See also* BRUCE BLONIGEN & JUSTIN PIERCE, EVIDENCE FOR THE EFFECTS OF MERGERS ON MARKET POWER AND EFFICIENCY at 5 (Board of Governors of the Federal Reserve System, Finance and Economics Discussion Series 2016-082, 2016), https://www.federalreserve.gov/econresdata/feds/2016/files/2016082pap.pdf ("In summary, we find evidence that M&As increase markups on average across U.S. manufacturing industries, but find little evidence for channels often mentioned as potential sources of productivity and efficiency gains."); Scott A. Christofferson, Robert S. McNish, and Diane L. Sias, *Where mergers go wrong*, 10 McKinsey on Finance 1 (Winter 2004), http://www.mckinsey.com/client_service/corporate_finance/latest_thinking/mckinsey_on_finance/~/media/mckinsey/dotcom/client_service/corporate%20finance/mof/pdf%20issues/mof_issue_10_winter%2004.ashx ("Most companies routinely overestimate the value of synergies they can capture from acquisitions.").

[198] COPA Application at 18-19.

[199] COPA Application at 19. *See also* COPA Application at 43-44 ("A thorough understanding of these redundant services, and the cost savings that may be realized by virtue of the Combined Enterprises, cannot be obtained until after the Merger.").

collaboration, and execution processes"[200] relating to the proposed merger. Thus, the integration plan contains no specific details that would allow the IN DOH to assess claimed efficiencies, cost savings, and benefits for feasibility and veracity. Rather, the Parties contend that the formal process for integration will start upon closing of the merger and will "proceed organically over the course of 18-24 months."[201] The Parties' refusal to offer concrete integration plans until *after* the merger is consummated should be deeply concerning to the IN DOH. Once the Parties are merged, there will be no effective mechanism to evaluate the costs and benefits of any integration plans and then alter or improve those plans. The IN DOH should not credit the Parties' vague and aspirational statements when evaluating their COPA application.[202]

The Parties claim the proposed merger will enable them to utilize resources in a more efficient manner and reduce duplicative costs and administrative burden.[203] Yet, although they describe plans to avoid future capital expenditures, they have not identified any specific past expenditures that they believe to have been unnecessary or duplicative. To the contrary, the Parties intend to continue investing in capital expenditures that they claim will impact the volume and quality of patient care and services they are able to provide, including: $10.5 million for facility infrastructure improvements, the mechanical and electrical infrastructure of THRH; $15 million for information technology investments for the combined system, installing Union Health's EMR system at THRH; [redacted] and $60 million over five years in operating expenses and an initial capital investment of $2 million for the creation of LTAC units/beds in the next 1-2 years.[204]

Economic research indicates that hospital competition leads to lower costs, more effective resource utilization, and improved patient health outcomes, as compared to highly concentrated markets with less competition.[205] Competition between hospitals often leads to investments that improve patient care and access to healthcare services. Thus, to the extent that

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[200] COPA Application at 20.
[201] COPA Application at 20.
[202] *See* COPA Application at 18-20.
[203] COPA Application at 43-44 ("UHI's Post-Merger Initiatives will result in better health outcomes and less spending on costly emergency department visits and hospitalizations. Furthermore, unnecessary costs attributable to fragmented, uncoordinated care will be slashed."); 45 (describing how the proposed merger is "the most effective and cost-efficient way" to significantly improve the health status of area residents "through a single organized system of health care that will be able to maximize the appropriate application of limited health care resources."); 63 (describing how Union Health's Service Line Model of Care "is designed to improve the quality of care and, by coordinating care, reduce health care costs by eliminating duplicative, unnecessary, and untimely care."); 64 ("Cost Savings: By reducing duplicate tests, minimizing medication errors, and avoiding unnecessary procedures, healthcare organizations can decrease healthcare expenses. Additionally, streamlined workflows and improved efficiency contribute to cost savings by reducing administrative burdens and enhancing resource utilization.").
[204] COPA Application at 35-38, 51.
[205] *See* Dan P. Kessler & Mark B. McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q. J. ECON. 577 (2000), http://qje.oxfordjournals.org/content/115/2/577.full.pdf+html (finding that hospital competition unambiguously improves social welfare: competition leads to substantially lower costs and lower levels of resource use, as well as lower rates of adverse patient health outcomes); Martin Gaynor, Rodrigo Moreno-Serra & Carol Propper, *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service*, 5 AM. ECON. J.: ECON. POL'Y 134 (2013), https://www.aeaweb.org/atypon.php?doi=10.1257/pol.5.4.134 (finding that hospital competition leads to improved quality and resource utilization).

hospital competition results in facility expansions and new equipment purchases that improve access and quality, competition is good for consumers, not unnecessary or wasteful. Eliminating this competition could lead to a less productive allocation of resources and thereby deny consumers these benefits.[206] For example, although new equipment can be costly, the quality benefits associated with technology advances may justify these expenditures.[207] Investments in facilities, technology, and equipment can result in shorter wait times, more convenient service options for physicians and patients, and the continued availability of services when a piece of equipment fails, all of which are far from wasteful, but quite beneficial. In contrast, to the extent that the combined system's future plans include the consolidation of clinical services, including reduced facility and equipment investments, this could result in reduced patient choice and access to healthcare services.

D. The Proposed Merger Would Make It More Difficult for Health Care Payors to Negotiate Payment and Service Agreements with the Combined Hospital Entity, Likely Resulting in Higher Prices for Patients and Employers

Indiana COPA Act 16-21-15-4(b)(4): The ability of health care payors to negotiate payments and service agreements with hospitals proposed to be merged under the merger agreement.[208]

ASSESSMENT: The Indiana COPA Act requires the IN DOH to consider whether the proposed merger would have an adverse impact on the ability of health insurers to negotiate payment and service arrangements with healthcare providers. Ultimately, this is an important indicator of how the merger is likely to impact consumers because health insurers negotiate on

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[206] At the FTC COPA Workshop, participants discussed the impact of state regulatory approaches for reducing duplication of healthcare services. Robert Fromberg from Kaufman Hall, an organization that represents health systems, emphasized the importance of reducing duplicative or underused clinical services, and the role of COPAs as a mechanism for health systems to accomplish this goal. *See* FTC COPA Workshop Transcript: Session 2 (Afternoon) at 31-33 (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/session2_transcript_copa.pdf [hereinafter FTC COPA Workshop Transcript: Session 2]. *See also* Kaufman Hall Submission to the FTC (Jun. 4, 2019), https://www.regulations.gov/document?D=FTC-2019-0016-0010. Professor Thomas Stratmann then presented his economic research on the effects of CON laws. While CON laws are distinct from COPA laws, they both have the effect of restricting competition among healthcare providers in order to rationalize certain services. The policy goals of CON and COPA laws are also similar – to achieve cost savings by reducing duplicative or underused services, to improve quality of care, and to improve access for services. Thus, CON research may be relevant for considering the impact of COPA laws and regulations. Professor Stratmann's research indicates that states with CON laws have reduced access to care and reduced quality, as compared to states without CON laws. *See also* Vivian Ho Submission to the FTC (Jun. 5, 2019), https://www.regulations.gov/document?D=FTC-2019-0016-0012 (describing empirical research that demonstrates "[w]ell-intentioned state CON regulations have not improved patient outcomes or lowered costs for patients. Healthy market competition amongst hospitals is a better strategy for improving patient welfare.").

[207] *See* David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, 20 HEALTH AFFAIRS 11 (Sept. 2001), http://content.healthaffairs.org/content/20/5/11.full.pdf+html ("When costs and benefits are weighed together, technological advances have proved to be worth far more than their costs.").

[208] *See also* IN DOH COPA Checklist at 4, Factor E ("The ability of health care payors to negotiate payments and service agreements with the Applicant Groups and anticipated impact on reimbursement rates and service agreements, including any anticipated changes to any payor agreements and changes to the calculation of pricing").

behalf of their customers – area residents and employers. When hospitals obtain greater bargaining leverage, they are able to negotiate higher reimbursement rates (i.e., prices) with insurers. Insurers typically pass on these higher prices to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses. This affects fully insured employers who offer coverage to their employees, self-insured employers who pay their employees' healthcare claims, employees who pay some portion of their health insurance benefits, and individuals who purchase health insurance directly.[209] Furthermore, employers facing higher costs may reduce insurance coverage for their employees or eliminate insurance coverage altogether.[210] Higher healthcare costs can also be passed through to employees in the form of lower wages and total compensation.[211] Because the FTC is concerned about the impact that healthcare mergers will have on consumers, we take seriously the impact that a hospital merger will have on the ability of insurers to negotiate competitive prices and other contractual terms on consumers' behalf.

Currently, prices for inpatient, outpatient, and physician services provided by Union Health and THRH are set via negotiations between each hospital system and insurers. We focus our discussion below on inpatient hospital services, but the same analysis applies to outpatient

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[209] *See* Erin E. Trish & Bradley J. Herring, *How Do Health Insurer Market Concentration and Bargaining Power With Hospitals Affect Health Insurance Premiums?*, 42 J. HEALTH ECON. 104 (2015), http://www.sciencedirect.com/science/article/pii/S0167629615000375.

[210] *See* Amy Finkelstein, Casey McQuillan, Owen Zidar & Eric Zwick, *The Health Wedge and Labor Market Inequality*, NBER Working Paper 31091 at 31 (2023), http://www.nber.org/papers/w31091 ("In practice, health insurance financing reforms may change whether employers offer health insurance or the generosity of plan offerings."); Small Business Majority Response to Department of Justice, Department of Health and Human Services, and the Federal Trade Commission Request for Information on Consolidation in Health Care, Docket No. ATR 102 (May 3, 2024), https://smallbusinessmajority.org/sites/default/files/policy-docs/Small%20Business%20Majority%20DOJ-FTC-HHS%20Joint%20Healthcare%20Consolidation%20RFI.pdf ("Employers who have seen costs increase were most likely to respond by increasing employee contributions to health plans (51%), moving to an insurance plan offering more limited coverage (47%) and cutting other employee benefits (29%). Notably, nearly one-quarter (24%) of these small businesses dropped health coverage altogether. Some small businesses indicated that they had to increase prices on goods and services (21%) and even eliminate or reduce wage increases (4%) to make up for the increasing share of their budget going towards healthcare.").

[211] *See, e.g.*, Gaynor, Ho & Town, *supra* note 79, at 236 (stating that employers pass through higher health care costs dollar for dollar to workers, either by reducing wages or fringe benefits, or even dropping health insurance coverage entirely); GAYNOR & TOWN, *supra* note 79, at 1 ("Ultimately, increases in health care costs (which are generally paid directly by insurers or self-insured employers) are passed on to health care consumers in the form of higher premiums, lower benefits and lower wages[.]"); Daniel Arnold & Christopher Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages*, (2021 working paper), https://www.ehealthecon.org/pdfs/Whaley.pdf; Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LAB. ECON. 609 (2006), https://www.hks.harvard.edu/fs/achandr/JLE_LaborMktEffectsRisingHealthInsurancePremiums_2006.pdf (finding that increased health insurance costs lead to reduced wages and employment); Priyanka Anand, *Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey*, 26 Health Econ. 1601 (2017), https://onlinelibrary.wiley.com/doi/10.1002/hec.3452 (finding that as health insurance costs increase, employers that offer health insurance reduce total employee compensation); Jay Bhattacharya & M. Kate Bundorf, *The Incidence of the Healthcare Costs of Obesity*, 28 J. HEALTH ECON. 649 (2009), http://www.sciencedirect.com/science/article/pii/S0167629609000113 (finding that increased health insurance costs can be passed to employees in the form of lower wages); and Jonathan Gruber, *The Incidence of Mandated Maternity Benefits*, 84 AM. ECON. REV. 622 (1994), http://economics.mit.edu/files/6484 (finding that increased health insurance costs can be passed to employees in the form of lower wages).

and physician services. Each side in these negotiations has some bargaining power. The insurer's bargaining power stems from the fact that the hospital wants access to the insurer's patient members, and the hospital's bargaining power stems from the fact that its inclusion in the insurer's network will make that network more attractive to potential patient members. The prices that result from these negotiations are a function of the *relative* bargaining leverage of the two sides in the negotiations, which will depend on how each side would fare if no agreement were reached. Generally, the less one side has to lose from failure to reach an agreement, relative to the other side, the more favorable prices and other contractual terms it will be able to negotiate. Mergers of competing hospitals give hospitals more relative bargaining leverage because, after the merger, insurers now have more to lose from failing to reach agreement with the merged system.

Today, Union Health and THRH independently have bargaining leverage in negotiations with health insurers. An insurer network that lacks the hospitals of either system is less attractive to employers and consumers than a network that includes the hospitals of both systems, and this gives each system bargaining power today relative to insurers. However, the bargaining leverage of each hospital system is limited by the availability of the *other* system as an alternative. After the proposed merger, an insurer would have no other alternative in Terre Haute besides Union Health.

The Parties state that they anticipate the proposed merger will reduce reimbursement rates slightly as payors move from THRH contracts to Union Health contracts. [redacted][212] In addition, they offer several commitments to minimize any adverse impact on the ability of payors to negotiate payment and service arrangements, "and to ensure that post-Closing pricing is fair to both consumers and payors."[213]

Evidence obtained by the FTC, however, suggests that the proposed merger is likely to give the combined hospital system the ability to extract higher reimbursement rates, whether or not it occurs immediately. In general, a hospital's chargemaster may not reflect the actual rates it negotiates with individual payors and Union Health may not always offer lower contract rates than THRH. Although THRH is smaller and has less capacity than Union Health – so it may not be feasible for payors to terminate Union Health and move all of their business to THRH – there is market recognition of the value of having an independent THRH compete in this geographic area, as its presence provides balance when negotiating with Union Health. There is also some evidence to suggest that since the announcement of the proposed merger Union Health has been pursuing price increases more aggressively than in the past. Contrary to the Parties' claims, Union Health would have no incentive to reduce rates or charges following the merger, and

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[212] [redacted]

[213] COPA Application at 65-66.

payors would have little recourse if Union Health were to demand higher rates. Furthermore, it is unclear whether any of the commitments offered by the Parties to negotiate with payors in good faith (which presumably they should already be doing absent the proposed merger) are enforceable by the IN DOH.[214]

The Parties further claim that "[t]he Merger will not materially limit the ability of health care payors to negotiate payments or service agreements with Union Hospital" for several reasons.[215] FTC staff responds to each of these reasons as follows:

- The Parties claim that post-merger competition from hospitals located in the Wabash Valley Community and nearby counties will discipline Union Health if it attempts to increase prices. However, FTC staff's data analyses, as well as evidence obtained through other sources in staff's investigation, confirm that the Parties face minimal competition from the regional hospitals located in nearby counties. For this reason, the presence of those hospitals is unlikely to mitigate potential price increases resulting from the proposed merger.[216]

- The Parties also claim that statutory limitations on rate increases and the IN DOH's monitoring of the COPA, along with price transparency requirements in Indiana, will prevent them from raising prices. These claims will be addressed in Section VIII, however, it is highly unlikely that such mechanisms will effectively mitigate the potential for price increases resulting from the merger. It is also important to note that price transparency is unlikely to be effective in markets that lack competition and are highly concentrated; without a competitive incentive, hospitals are unlikely to respond to pricing information published by hospitals outside of their geographic area. In the absence of the proposed merger, the price transparency requirements recently enacted in Indiana may have benefitted patients and employers in Terre Haute because they could comparison shop between Union Health and THRH. If the merger is consummated, however, the price transparency requirements are unlikely to impact the behavior of Union Health because patients and employers would no longer have any other local options for general acute care services.

- The Parties also assert that "[b]y the sheer strength of [the payors'] respective market shares, these payors . . . will have the power to robustly negotiate provider contracts with UHI." As explained above, the prices resulting from negotiations between payors and hospitals is a function of their relative bargaining leverage. Following the merger, the

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[214] *See* COPA Application at 66. Union Health commits to negotiate in good faith with all payors offering health plans in the geographic services area, to attempt to include provisions for quality and other value-based incentives in payor contracts, to honor all current payor contract terms and not unilaterally terminate without cause any such contract prior to its slated expiration date, and to negotiate in good faith contract terms involving risk-sharing and capitation. These commitments do not include specific benchmarks that the Parties are required to meet, nor are there any penalties for failing to meet these commitments. Indeed, it is unclear how the IN DOH would adequately address the Parties' failure to meet these commitments. *See* Section VIII for further discussion.
[215] COPA Application at 59-60.
[216] *See* Section VI for discussion of FTC staff's data analyses.

> payors offering health plans in Terre Haute will have more to lose by failing to reach an agreement with Union Health, because Union Health will be the only general acute care hospital serving patients in Vigo County. Empirical evidence demonstrates that prices are likely to increase following this kind of hospital consolidation, even when payors have a high degree of market power themselves.[217]

Finally, despite the Parties' vague commitments to attempt to include value-based incentives and risk-sharing terms in payor contracts,[218] it is unclear exactly how the merger would affect the combined hospital system's business incentives to enter into value-based payment models. It is possible that the proposed merger, by increasing the combined hospital system's bargaining leverage, could diminish its willingness to cooperate with payers' attempts to lower costs through value-based and risk-based contracting models, if adopting such an approach would prove less profitable than traditional fee-for-service models. Thus, with its substantial post-merger market power, the combined hospital system may be able to resist certain efforts to negotiate beneficial value-based or risk-based contracts that make it worse off than fee-for-service contracts because insurers will have no viable alternatives than to contract with the combined hospital system. FTC staff confirmed that this outcome is possible during its investigation.

Supporting this conclusion, recent empirical research suggests that consolidation among healthcare providers has not facilitated the increased use of value-based payment models, and that providers in concentrated markets may be able to resist such initiatives.[219] On a related note, recent literature suggests that health systems with increased scale are not more likely to engage in or be more successful at value-based contracting.[220] Furthermore, the shift to value-based

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[217] *See* Erin E. Trish & Bradley J. Herring, *How Do Health Insurer Market Concentration and Bargaining Power With Hospitals Affect Health Insurance Premiums?*, 42 J. HEALTH ECON. 104 (2015), http://www.sciencedirect.com/science/article/pii/S0167629615000375.

[218] *See* COPA Application at 66.

[219] *See* Hannah Neprash, Michael Chernew & J. Michael McWilliams, *Little Evidence Exists to Support the Expectation that Providers Would Consolidate to Enter New Payment Models*, 36 HEALTH AFFAIRS 346, 353 (2017), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0840 ("These findings suggest that new payment models may have triggered some consolidation as a defensive reaction to the threat these models could pose, rather than as a way to achieve efficiencies in response to the new incentives. Hospitals and specialists in particular might consolidate both horizontally and vertically to achieve sufficient market share to resist payer pressure to enter risk contracts or weaken ACOs' ability to exploit competition in hospital and specialty markets, and compel reductions in prices and service volume. . . . Specifically, our study supports skepticism of claims by providers that they are consolidating primarily to engage in risk contracts and achieve efficiencies."); Cooper, Craig, Gaynor & Reenen, *supra* note 79, at 104 ("Finally, there is widespread agreement that payment reform (shifting to contracts where providers bear more risk) is crucial to increasing hospital productivity (McClellan et al. 2017). Our analysis suggests that providers who have fewer potential competitors will be more able to resist attempts at such payment reform.").

[220] *See, e.g.,* Anil Kaul, K.R. Prabha & Suman Katragadda, *Size Should Matter: Five Ways to Help Healthcare Systems Realize the Benefits of Scale*, PWC STRATEGY& (2016), http://www.strategyand.pwc.com/reports/size-should-matter (finding that greater size has not led to lower costs or better quality outcomes for consolidated health systems); David Muhlestein, Robert Saunders & Mark McClellan, *Medical Accountable Care Organization Results for 2015: The Journey to Better Quality and Lower Costs Continues*, HEALTH AFFAIRS BLOG (Sept. 9, 2016), http://healthaffairs.org/blog/2016/09/09/medicare-accountable-care-organization-results-for-2015-the-journey-to-better-quality-and-lower-costs-continues/ ("Also consistent with last year, large, consolidated ACOs did not

initiatives is already occurring among many hospital systems and insurers nationwide, and is mandated by CMS in some circumstances.[221] To the extent these hospitals have already transitioned to value-based initiatives and would have continued to expand value-based initiatives independently, this cannot be considered a merger-specific benefit.[222]

E. The Proposed Merger Likely Would Depress Wage Growth for Hospital Employees and Exacerbate Challenges with Recruiting and Retaining Healthcare Professionals

Indiana COPA Act 16-21-15-4(b)(5): Employment.[223]

ASSESSMENT: An important consideration when evaluating the impact of a merger on the overall economic health of a region is its effect on the local labor market. The proposed merger has the potential to cause significant harm to employee wages because it will eliminate competition between the two parties to hire employees. This compounds an issue already ongoing in the state of Indiana with highly consolidated healthcare markets and difficulty recruiting and retaining healthcare employees in rural areas like Terre Haute.

According to public sources, Union Health is currently the second largest employer in the Terre Haute/Vigo County region and THRH is the fourth largest.[224] In evaluating labor market dynamics, the IN DOH should consider the impact of the proposed merger on healthcare employee wages, and how that could exacerbate the current challenges with recruiting and retaining employees that the Parties have claimed.[225] The impact of hospital consolidation on

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necessarily achieve the best performance. In fact, we found that the opposite was often true, as smaller, physician-led ACOs were more likely to improve quality and lower cost enough to earn shared savings. **This result is a cautionary note given the trend toward mergers and consolidations among health systems; consolidation and larger size do not necessarily lead to the functional integration and efficiency needed to succeed under alternative payment models.**") (emphasis added).

[221] *See* CMS, *Value-Based Programs*, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs (last accessed Oct. 3, 2022); U.S. Dep't of Health & Human Servs., *Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements From Volume to Value* (Jan. 26, 2015).

[222] *See* Fed. Trade Comm'n v. Penn State Hershey Med. Ctr., 838 F.3d 327, 350-51 (3d Cir. 2016) (suggesting that the ability to engage in risk-based contracting cannot be considered a cognizable, merger-specific benefit when both of the merging hospitals are already capable of doing this independently).

[223] *See also* IN DOH COPA Checklist at 4, Factor F ("Employment, the healthcare workforce, recruiting and retention").

[224] *See* Terre Haute Economic Development Corp., *Major Employers - by Number of Employees*, https://terrehauteedc.com/top-employers-terre-haute-vigo-county-indiana (last accessed Dec. 12, 2023). *See also* COPA Application at 68. The Parties describe Union Health as the largest employer in the Wabash Valley region, employing over 3,000 people (including 2,480 FTE's) and contributing an estimated $745.9 million to the economy, which is believed to generate an additional 3,379 jobs. They describe THRH as employing approximately 700 people (including 500 FTE's), and contributing an estimated $145 million to the economy, which is believed to generate an additional 500 jobs.

[225] COPA Application at 50, 66-67 (describing physician shortages as a growing issue for the Wabash Valley Community). The Parties provide no evidence for their claims that the proposed merger will aid in the recruitment of physicians to the Terre Haute area by creating a larger medical staff that will allow for less frequent call coverage and greater depth in medical specialties.

competition in labor markets has garnered particular attention during recent FTC merger reviews and is relevant to the IN DOH's analysis, as this can affect employee pay and community access to healthcare services.[226] Recent empirical research also suggests that anticompetitive hospital mergers have had substantial negative effects on labor market outcomes, including outside the health sector, and on mortality.[227]

One recent academic study found that hospital mergers generating large increases in employer concentration have meaningful and statistically significant effects on employee wage growth.[228] FTC Staff's analysis, discussed in more detail below, found that the proposed merger would lead to a significant increase in employer concentration for registered nurses in an already highly concentrated market, suggesting that the merger likely would lead to slower wage growth for nurses. Depression of wage growth could dissuade qualified hospital employees (already in short supply in many parts of the country) from seeking employment and undermine the quality of patient care and access to services.[229] Lower income levels for hospital employees may also worsen population health in local communities where hospitals are leading employers.[230] Indeed,

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[226] *See e.g.,* FTC COPA Workshop Transcript: Session 2, *supra* note 206, Elena Prager remarks at 29 (describing how labor market effects are a relevant consideration for states who are evaluating COPAs, and may care about constituent pay and community access, among other policy goals; for states that have a broad public interest mandate and want to take these issues into account, there is sufficient evidence of "substantial and detectable effect on worker pay").

[227] *See* Zarek Brot-Goldberg, Zack Cooper, Stuart Craig, Lev Klarnet, Ithai Lurie & Corbin Miller, *Who Pays For Health Care Prices? Evidence From Hospital Mergers*, NBER Working Paper No. 32613 at 4 (2024), http://www.nber.org/papers/w32613 ("Based on our estimates, our results suggest that, on average, a single hospital merger in our sample would have led to 39 job losses, approximately $6 million in forgone wages, and a $1.3 million reduction in federal income tax revenue. Likewise, we estimate that the average merger that raised prices by 5% or more would have led to 203 job losses, about $32 million in forgone wages, a $6.8 million reduction in federal income tax revenue, and between 1 and 2 additional deaths from suicide and overdose. This implies that the aggregate economic harm from an individual merger that raises hospital prices by 5% or more is approximately $42 million.").

[228] *See* Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, American Economic Review (2021), https://www.aeaweb.org/articles?id=10.1257/aer.20190690 [hereinafter Prager & Schmitt Study]. *See also* David Arnold, *Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes*, Working Paper (2020), https://darnold199.github.io/jmp.pdf; Elena Prager Presentation at FTC COPA Workshop, *Effects of Hospital Mergers on Employee Pay* (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/slides-copa-jun_19.pdf at 109 (describing the study and methodology).

[229] *See, e.g.*, David Card, *Who Set **Your** Wage?*, Annual Meeting of the American Economic Association (Jan. 2022), https://davidcard.berkeley.edu/papers/Card-presidential-address.pdf; Vicky Lovell, SOLVING THE NURSING SHORTAGE THROUGH HIGHER WAGES, Institute for Women's Policy Research (2006), http://people.umass.edu/econ340/rn_shortage_iwpr.pdf.

[230] *See* FTC COPA Workshop Transcript: Session 2, *supra* note 206, Christopher Garmon remarks at 30-31 (discussing the impact of the Prager & Schmitt Study as applied to COPAs). *See also* Mikael Lindahl, *Estimating the Effect of Income on Health and Mortality Using Lottery Prizes as an Exogenous Source of Variation in Income*, 40 J. HUM. RESOUR. 144 (2005), http://jhr.uwpress.org/content/XL/1/144 (finding higher income generates better health); J. Paul Leigh & Juan Du, *Effects of Minimum Wages on Population Health*, HEALTH AFFAIRS HEALTH POLICY BRIEF (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180622.107025/ (suggesting higher income is correlated to improved population health).

some hospital employees have raised this concern in other states that have allowed anticompetitive hospital mergers to proceed subject to COPAs.[231]

In the COPA Application, the Parties claim that they do not intend to reduce the hospital workforce post-merger and are committed to protecting THRH employees.[232] [redacted], nor are there any enforceable conditions offered in the COPA Application that would protect employees from eventually losing their jobs or having their wages and benefits reduced post-merger. However, as discussed below, even if such conditions were put into place, conduct remedies are typically inadequate for addressing competitive harms that result from mergers of direct competitors.

The Parties also claim that in the event hospital employees "wish to seek other employment opportunities, there are a variety of alternative employment options."[234] They list critical access hospitals in Sullivan, Clay, Greene, and Crawford Counties; Horizon Health in Paris, Illinois; Harsha Behavioral Center, Hamilton Center, and Anabranch Recovery Center in

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[231] At a recent open Commission meeting, local nurse practitioner Leslie Taylor raised concerns about the negative impact of the Ballad Health COPA on the labor market and patient health outcomes in eastern Tennessee. *See* Leslie Taylor Public Comments at FTC Open Commission Meeting (May 23, 2024), https://www.ftc.gov/media/open-commission-meeting-may-23-2024 (beginning 17 minutes and 28 seconds into the video, 17:28).
In North Carolina, Mission Health, a state-sanctioned hospital monopoly formed pursuant to a COPA, was subsequently sold to HCA after the COPA was repealed. Since that time, Mission Health has faced multiple lawsuits for alleged abuse of its monopoly position and Mission Health nurses formed a union to negotiate better wages and working conditions. *See, e.g.*, Dave Muoio, *North Carolina towns, counties' antitrust lawsuit against HCA's Mission Health may continue, federal judge rules*, Fierce Healthcare (Feb. 23, 2024), https://www.fiercehealthcare.com/providers/nc-towns-counties-antitrust-lawsuit-against-hcas-mission-health-may-continue-federal; Jane Winik Sartwell, *Asheville nurses rally for change at Mission Hospital ahead of union contract renegotiation*, Carolina Public Press (Jun. 6, 2024), https://carolinapublicpress.org/64159/nurses-mission-health-hospital-union-rally-asheville-nc/. *See also* Samantha Liss, *Indiana weighs hospital monopoly as officials elsewhere scrutinize similar deals*, KFF Health News (Jun. 14, 2024), https://kffhealthnews.org/news/article/indiana-copa-hospital-monopoly-scrutiny/ (describing public concerns with Ballad Health and Mission Health).

[232] COPA Application at 18.

[233] [redacted]

[234] COPA Application at 8.

Terre Haute; various home health and hospice agencies; and private practices.[235] Based on the FTC's experience, we find that these alternative types of healthcare facilities generally are not viewed as close substitutes for healthcare workers, as compared to other GAC hospitals. However, because THRH has a large presence in the behavioral health services segment, we included behavioral health facilities in the labor market analysis below as a conservative measure.

There also may be another factor for the IN DOH to consider when assessing the ability of hospital employees to seek alternative employment. Based on evidence FTC staff gathered during its investigation, it appears that Union Health includes non-compete clauses in its employment agreements with nurses and physicians. Non-compete clauses restrict workers' fundamental freedom to seek a better job or to start their own business, and empirical research shows that the legal enforceability of non-compete clauses tends to raise healthcare costs, suppress wages, and reduce innovation.[236]

1. FTC Staff's Labor Analysis

FTC staff conducted an analysis of the likely competitive effects of the proposed merger in healthcare labor markets using 2019-2021 American Hospital Association ("AHA") data on employment of registered nurses.[237] While the AHA data report on several different categories of employees, we focus on registered nurses because of their high employment rates in hospitals, high share of employment among all hospital employees, specialized occupational knowledge that is difficult to substitute using other types of nurses, and low transition rate into other occupations.[238] Calculations are made starting in 2019, to check for impacts on the data from COVID-19 in 2020 and 2021. Although there are national patterns of decreasing employment for registered nurses in 2020 and 2021 that may not be representative of the labor market outside of

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[235] COPA Application at 9. The Parties also cite future job openings for non-clinical personnel, including the anticipated ENTEK manufacturing plant and Terre Haute Casino Resort. These employment options are not included in the FTC's hospital labor market analysis as they are not healthcare related and do not yet exist.
[236] *See* Federal Register, Federal Trade Commission Non-Compete Clause Rule (May 7, 2024), https://www.federalregister.gov/documents/2024/05/07/2024-09171/non-compete-clause-rule.
[237] *See* AHA Data Solutions, https://www.aha.org/data-insights/aha-data-products (representing information provided by nearly 6,300 hospitals and more than 400 health care systems).
[238] A majority of registered nurses are employed in hospitals. *See* U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook: Registered Nurses, Work Environment*, https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-3 (last accessed Feb. 26, 2024). Moreover, registered nurses make up more than 30% of hospital employment. *See* U.S. Bureau of Labor Statistics: The Economics Daily, *Registered nurses made up 30 percent of hospital employment in May 2019* (Apr. 27, 2020), https://www.bls.gov/opub/ted/2020/registered-nurses-made-up-30-percent-of-hospital-employment-in-may-2019.htm (last accessed Feb. 26, 2024). Registered nurses have higher education and licensing requirements than other types of staff nurses. *See* U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook: Registered Nurses, How to Become a Registered Nurse*, https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-4 (last accessed Feb. 26, 2024). Finally, research has shown that registered nurses are more likely to remain in the same position, even when changing employers. *See* Gregor Schubert, Anna Stansbury, & Bledi Taska, *Employer Concentration and Outside Options* (Dec. 16, 2022), https://ssrn.com/abstract=3599454.

the pandemic.[239] In the Terre Haute region, however, regardless of the years used, there are similar patterns and shares throughout this time period. The analysis in this comment will focus on the latest data from 2021, but similar results are found in 2019 and 2020.

FTC staff evaluated labor concentration in the commuting zone for nursing labor, as developed by the U.S. Department of Agriculture.[240] For the proposed merger, this commuting zone consists of the following seven counties: Clark, IL; Edgar, IL; Clay, IN; Parke, IN; Sullivan, IN; Vermilion, IN; and Vigo, IN. FTC staff used the AHA data to calculate the number and share of employees working at all hospital facilities in this commuting zone, as well as pre- and post-merger HHIs for the proposed merger. There are nine hospitals in the relevant commuting zone, six of which are general acute care hospitals. These hospitals are Union Hospital, Union Hospital Clinton, Terre Haute Regional Hospital, Paris Community Hospital, Sullivan County Community Hospital, Ascension St. Vincent Clay Hospital, Harsha Behavioral Center, Anabranch Recovery Center, and Hamilton Center.

FTC staff found that the labor market for registered nurses is highly concentrated. As the majority of registered nurses in this region are employed in the two merging hospital systems pre-transaction, the labor market will become even more highly concentrated post-transaction. Using the AHA data, Table 9 shows that Union Health and THRH have a combined share in the commuting zone of 75.1% for registered nurses in 2021 (78.5% in 2020 and 80.0% in 2019). The post-merger HHI is 5,846 and the increase in HHI is 2,652, strongly suggesting that the proposed merger would likely harm competition for registered nurses and that nurse wage growth would likely be suppressed post-merger.[241]

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[239] *See* McKinsey & Company Report, ASSESSING THE LINGERING IMPACT OF COVID-19 ON THE NURSING WORKFORCE, https://www.mckinsey.com/industries/healthcare/our-insights/assessing-the-lingering-impact-of-COVID-19-on-the-nursing-workforce.

[240] The U.S. Department of Agriculture developed commuting zones using 2000 census data on commuting patterns. FTC staff's definition of the labor market for registered nurses follows much of the recent literature, which shows that around 80% of job applications on career websites are submitted by residents living within the commuting zone. *See, e.g.*, Prager & Schmitt Study; José Azar, Ioana Marinescu & Marshall I. Steinbaum, *Labor Market Concentration*, NBER Working Paper No. 24147 (2019), https://www.nber.org/papers/w24147; Ioana Marinescu & Roland Rathelot, *Mismatch Unemployment and the Geography of Job Search*, 10 AM. ECON. J. MACROECON. 42 (2018), https://www.aeaweb.org/articles?id=10.1257/mac.20160312. While this commuting zone may not necessarily represent a relevant antitrust market for purposes of analysis under the antitrust laws, it is consistent with other empirical research on the effects of concentration in hospital labor markets.

[241] For context, this increase in HHI is likely to be above the 75th percentile among hospital mergers calculated in the Prager and Schmitt study, which found negative effects on hospital employee wage growth for mergers causing an increase in concentration above the 75th percentile. This study found mergers of similar magnitudes to the proposed Union Health/THRH merger lead to 6.8 percent lower wages for nurses over four years.

Table 9: Registered Nurse Shares in Union Health-THRH Commuting Zone (Based on 2021 AHA Data)[242]

Hospital	County	Registered Nurses	
		FTE	Share (%)
Union Hospital	**Vigo, IN**	**465**	**44.6%**
Union Hospital Clinton	**Vermillion, IN**	**23**	**2.2%**
Terre Haute Regional Hospital	**Vigo, IN**	**295**	**28.3%**
Paris Community Hospital	Edgar, IL	128	12.3%
Sullivan County Community Hospital	Sullivan, IN	63	6.0%
Harsha Behavioral Center	Vigo, IN	21	2.0%
Anabranch Recovery Center	Vigo, IN	21*	2.0%
Ascension St. Vincent Clay Hospital	Clay, IN	19	1.8%
Hamilton Center	Vigo, IN	7	0.7%
Combined Union-THRH Share		**75.1%**	
Pre-merger HHI		3,194	
Post-merger HHI		5,846	
Change in HHI		2,652	

2. Evaluation of the Parties' Labor Analysis

[redacted].

a) [redacted]

[redacted]

[242] *Anabranch Recovery Center does not appear in the 2021 AHA Data. Harsha Behavioral Center and Anabranch Recovery Center both have the same number of beds (81), so we assume the two facilities have the same number of FTE registered nurses as well. *See* Harsha Behavioral Center, https://www.harshacenter.com/about-us/ (showing 81 beds); Anabranch Recovery Center, https://anabranchrecovery.com/about/ (showing 81 beds).

[redacted]

b) [redacted]

[redacted]

[243] *See, e.g.*, Prager & Schmitt Study.
[244] In contrast, the Prager and Schmitt Study estimates the impact of changes in concentration and implicitly controls for factors that differ across areas but are constant over time.
[245] [redacted]

[redacted]

[redacted]

[redacted]

246 [redacted]

[redacted]

	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

[redacted]

[redacted]

247 [redacted]

248 [redacted]

249 [redacted]

250 [redacted]

251 [redacted]

252 [redacted]

253 [redacted]

[redacted]

[redacted] FTC staff first became aware of the proposed merger in early 2021, when Union Health lobbied the Indiana state legislature for a COPA statute with *this* merger in mind. This was publicly reported at the time, so employees in the area likely would have been aware of this.[254] More than three years of lingering uncertainty may have taken a toll on THRH's ability to recruit and maintain employees.

[redacted]

F. The Proposed Merger Likely Would Have a Negative Economic Impact

Indiana COPA Act 16-21-15-4(b)(6): Economic impact.[257]

ASSESSMENT: In the COPA Application, the Parties describe the significant impact health systems can have on local economies, both as large employers and as major purchasers of goods and services, and stating that "[a] strong health system is vital, similar to schools and

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[254] *See, e.g.*, Howard Greninger, *Talks Focus on Terre Haute Hospitals' Future: New State Law Opens Door to 'Merger' of Trauma Hospitals, Requires Certificate Approval*, TRIBUNE-STAR (Dec. 2, 2021), https://www.tribstar.com/news/indiana_news/talks-focus-onterre-haute-hospitals-future/article_685467e6-3bba-58c7-bf1b-4966091383b1.html.

[255] [redacted]

[256] [redacted]

[257] *See also* IN DOH COPA Checklist at 4, Factor G ("Economic impact").

housing markets, to economic development activities." They further claim that "[s]uccessful implementation of this acquisition will lead to significant growth in services to the nine-county service area increasing the overall economic impact."[258] FTC staff agrees that health systems can have a major impact on local economies, but for all of the reasons we have discussed, strenuously disagree that the proposed merger would have a positive economic impact on the patients and employers in and around Vigo county.

As we have already discussed in prior Sections, the proposed merger is likely to reduce hospital employee wage growth, as well as increase costs for patients and employers who purchase health plans for their employees. Employers across the country are struggling to contain healthcare costs for their workers.[259] In a recent poll, only four percent of business leaders disagreed with the statement "employer costs for health benefits are excessive" and almost 9 in 10 respondents said they believed the cost of providing health benefits would be unsustainable in the next five to ten years.[260] As employers and workers devote more of their funds to compensating healthcare providers, they have less money to accomplish other important goals in their local communities. Furthermore, public entities that use tax dollars to fund employee health plans would have less money to invest in their respective missions. Recent research also shows that hospital consolidation leads to fewer Medicaid admissions in an average hospital, an effect which was particularly pronounced for births.[261] This result, combined with existing research on other merger effects, indicates that hospital concentration may have negative effects on care for low-income patients.[262]

Furthermore, as noted earlier, recent empirical research suggests that anticompetitive hospital mergers have had substantial negative effects on labor market outcomes, including outside the health sector, and mortality. This research estimates "the average [hospital] merger that raised prices by 5% or more would have led to 203 job losses, about $32 million in forgone wages, a $6.8 million reduction in federal income tax revenue, and between 1 and 2 additional deaths from suicide and overdose. This implies that the aggregate economic harm from an individual merger that raises hospital prices by 5% or more is approximately $42 million."[263]

In a recent local news article, Vigo County Auditor Jim Bramble described another unusual implication of the proposed merger – the loss of county tax revenues. He explains that

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[258] COPA Application at 68.
[259] *See, e.g.*, Center for American Progress, *Health Insurance Costs are Squeezing Workers and Employers* (Nov. 29, 2022), https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers/.
[260] Gary Claxton and others, *How Corporate Executives View Rising Health Care Cost and the Role of Government* (San Francisco: Kaiser Family Foundation, 2021), https://www.kff.org/report-section/how-corporate-executives-view-rising-health-care-cost-and-the-role-of-government-findings/.
[261] Sunita Desai et al., *Hospital Concentration and Low-Income Populations: Evidence from New York State Medicaid*, 90 J. Health. Econ. 102770 (Jul. 2023).
[262] *See* Sunita Desai and Kyle Smith, *The Impacts of Increasing U.S. Hospital Consolidation on Medicaid Recipients*, Washington Center for Equitable Growth (Jan. 25, 2024), https://equitablegrowth.org/the-impacts-of-increasing-u-s-hospital-consolidation-on-medicaid-recipients/.
[263] Zarek Brot-Goldberg, Zack Cooper, Stuart Craig, Lev Klarnet, Ithai Lurie & Corbin Miller, *Who Pays For Health Care Prices? Evidence From Hospital Mergers*, NBER Working Paper No. 32613 at 4 (2024), http://www.nber.org/papers/w32613.

THRH paid roughly $508,000 in county taxes for 2023 and is one of the county's larger tax-paying businesses. This revenue could be lost if THRH is acquired by Union Health, a non-profit hospital that is exempt from paying taxes.[264] Although this is not a traditional antitrust concern, the IN DOH may want to consider this when evaluating the potential economic impact of the proposed merger.

Although the Parties claim that several business and community leaders "enthusiastically supports the Merger,"[265] FTC staff is aware of some stakeholders who have expressed concerns about the economic impact of the proposed merger. For example, Dr. Gloria Sachdev, President and CEO of Employers' Forum of Indiana, has publicly opposed the merger.[266] This organization engages in efforts to better understand how rising healthcare costs are unsustainable for employers who sponsor healthcare plans for their employees, and how to address this problem. The proposed merger would create a near-monopoly that is likely to lead to higher healthcare costs and negatively impact the economy. As we noted earlier, we have also learned that the IN DOH has received over 200 public comments, and that the vast majority expressed concerns about or are opposed to the proposed merger.

Furthermore, the Parties cite to a BlueCross BlueShield Association report which concluded there is a relationship between a healthy population and a strong local economy.[267] The report emphasizes that a healthy workforce is more likely to be productive and employed. We disagree, however, with the Parties' claim that the report "reinforces the need for, and the appropriateness of, the Merger" because according to them the merger would result in improved quality and access for healthcare services in the Wabash Valley region.[268] For all of the reasons we have discussed, FTC staff believes the proposed merger is *unlikely* to result in improved quality and access and that it is likely to *reduce* wages, and therefore would *not* lead to a healthier workforce or a stronger local economy. And to be clear, the report does not discuss the impact of hospital mergers on local economies.

In summary of Section VII, it appears that the proposed merger is likely to result in serious disadvantages resulting from the loss of competition, while any benefits are likely to be modest and may be largely achievable by other means that are less restrictive to competition. In

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[264] *See* Samantha Liss, *Indiana weighs hospital monopoly as officials elsewhere scrutinize similar deals*, KFF Health News (Jun. 14, 2024), https://kffhealthnews.org/news/article/indiana-copa-hospital-monopoly-scrutiny/.
[265] COPA Application at 68.
[266] *See, e.g.,* Nicole Krasean, *'It's not a done deal'; where the Union Health acquisition of Regional Hospital stands,* WIBQ (Dec. 19, 2023), https://wibqam.com/2023/12/19/its-not-a-done-deal-where-the-union-health-acquisition-of-regional-hospital-stands/ (quoting Dr. Sachdev). *See also* Samantha Liss, *Indiana weighs hospital monopoly as officials elsewhere scrutinize similar deals*, KFF Health News (Jun. 14, 2024), https://kffhealthnews.org/news/article/indiana-copa-hospital-monopoly-scrutiny/ (describing other citizens' concerns with the proposed merger, including an emergency first responder and a former THRH physician and county coroner).
[267] *See* COPA Application at 67-68. *See also* BlueCross BlueShield Association, THE HEALTH OF AMERICA REPORT: HEALTHY PEOPLE, HEALTHY ECONOMIES (2016), https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/BCBS.HealthOfAmericaReport.Moodys_0.pdf; Institute of Medicine, The Future of the Public's Health in the 21st Century (2003), https://www.ncbi.nlm.nih.gov/books/NBK221239/pdf/Bookshelf_NBK221239.pdf.
[268] COPA Application at 67.

the following section, we assess whether regulatory terms and conditions could mitigate the likely disadvantages of the COPA.

VIII. Possible Terms and Conditions Imposed Under the COPA Are Unlikely to Mitigate the Disadvantages Resulting from Loss of Competition

The Indiana COPA Act contains provisions intended to mitigate the disadvantages resulting from the loss of competition. Beyond this, the Parties have offered commitments regarding payor contract negotiations that they claim will minimize adverse effects and ensure fair pricing for both consumers and payors – most of which merely appear to be promises to negotiate in "good faith." For the reasons described below, the statutory provisions and the Parties' commitments are unlikely to mitigate the potential anticompetitive harms resulting from the merger.

A. General Concerns with Conduct Remedies

The Indiana COPA Act requires recipients of COPAs to comply with statutory limitations on rate increases and a commitment to return cost savings derived from the merger to the community, as well as annual reporting requirements to the IN DOH. The IN DOH also has independent discretion to impose additional terms and conditions on recipients of COPAs in an attempt to mitigate the disadvantages resulting from loss of competition.[269] Other states have imposed various types of terms and conditions on recipients of COPAs, including rate regulation, mechanisms for sharing cost savings and efficiencies with local residents, public reporting of quality metrics, and commitments regarding certain contractual provisions between the hospitals and commercial health insurers. Such terms and conditions are often referred to as "conduct remedies" because they attempt to ameliorate the harm to competition and consumers resulting from a merger by regulating the merged entity's conduct.[270]

It is doubtful that conduct remedies can drive meaningful cost savings and quality improvements with as much force as maintaining a competitive environment. Conduct remedies require continuous monitoring and oversight, creating administrative costs and challenges. Even with oversight, conduct remedies that purport to restrain price increases are unlikely to replicate the pricing dynamics that would have prevailed absent the merger because such a remedy cannot replace the competitive conditions that otherwise would have existed. Rate review cannot simulate the nuanced, iterative responses that competitors make in response to each other during the negotiation process.[271]

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[269] Indiana COPA Act § 16-21-15-4(e).

[270] In contrast to conduct remedies, "structural remedies," which include divestitures and injunctions preventing mergers, restore or maintain competition at the pre-merger level, thereby remedying the source of the anticompetitive harm – the elimination of competition between the merging hospitals. Under a conduct remedy, competition at the pre-merger level is not maintained. Designing a conduct remedy that would counteract the effects of an anticompetitive merger is nearly impossible because the source of the harm is not prevented.

[271] *See* Commonwealth v. Partners Healthcare Sys., No. SUCV2014–02033–BLS2, Memorandum of Decision and Order on Joint Motion for Entry of Amended Final Judgment by Consent at *22 (Sup. Ct. of Mass. Jan. 30, 2015, not reported in N.E.3d) (*2015 WL 500995) ("A conduct remedy, which typically involves regulation of specific

Conduct remedies designed to prevent price increases have several serious deficiencies. First, they are typically temporary. After the conduct remedy expires, the less competitive market structure remains, but any constraint imposed by the remedy will be eliminated, and prices are likely to increase as a result.[272] Second, designing and enforcing price restrictions is a complicated and highly resource-intensive endeavor, in part because such restrictions would need to constrain prices for all current and future services provided by the merged entity during the relevant timeframe, and account for different (or changes in) reimbursement methodologies.[273] The oversight required to enforce conduct remedies can also be costly and create administrative burden. In the healthcare industry, in particular, where prices, quality, and costs are difficult to measure, these kinds of regulatory mechanisms often do not achieve their intended purpose, no matter how well-intentioned.[274]

Even assuming that price restrictions could somehow effectively replicate pricing that would prevail were the Parties to continue to compete, the proposed merger would still likely cause a reduction in business incentives to improve or maintain quality. Economic theory and empirical evidence indicate that adverse quality effects of mergers are particularly likely in markets where prices are regulated.[275] For example, studies of the United Kingdom healthcare market, where rate regulation has long been the norm, demonstrate that highly concentrated provider markets have worse patient health outcomes than competitive provider markets.[276]

Designing a conduct remedy to mitigate the harms of lost quality competition between hospitals would be extremely difficult and resource intensive. Any meaningful remedy would need to both establish an explicit quantitative measure of the level of quality that competition would have produced and require the merged entity to produce at least that level of quality. This is nearly impossible, for several reasons. While objective quality measures exist for specific inpatient hospital services (and may be incorporated into commercial insurance contracts), these measures are not comprehensive and are difficult to establish; moreover, it would be even more

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conduct over a limited period of time, is more difficult to craft and easier to circumvent. It also does not directly address the problem, which is a loss of competition: indeed, it permits consolidation and then attempts to limit the consequences that flow from that by imposing certain restrictions on the defendant's behavior. . . . [C]onduct remedies 'seek to thwart the natural incentives of the merged entity to behave as a single firm' and thus require constant and costly monitoring.").

[272] *See id.* at *2 (stating that the temporary conduct remedies would be "like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is taken off.").

[273] The purpose of imposing a conduct remedy is to constrain the exercise of market power following the merger. The constraint would not be effective if market power could be exercised by increasing the price of bundles of services containing a mix of constrained and unconstrained services.

[274] *See* Gregory S. Vistnes, *An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health* 11 (Feb. 10, 2011), http://www.mountainx.com/files/copareport.pdf ("Economists have long recognized the difficulties of regulating monopolists and how regulation, no matter how carefully crafted and implemented, can inadvertently create undesirable incentive problems."); Cory S. Capps, *Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health System* 32 (May 2, 2011) ("Economists generally agree that, with rare exceptions, competition produces better outcomes than regulation.").

[275] *See, e.g.*, Gaynor, Ho & Town, *supra* note 79.

[276] *See, e.g.*, Gaynor, Moreno-Serra & Propper, *supra* note 205.

difficult to establish those measures for non-inpatient services (*e.g.*, outpatient services) because those quality measures are generally much less developed.

It would be equally challenging to design a compliance mechanism to ensure that the combined hospital system achieved defined quality targets. Due to the complexities of assessing quality, no mechanism exists to impose a conduct remedy sufficient to offset a loss of quality competition. It is difficult to envision how a supervisor of the COPA would be able to effectively force the combined hospital system to achieve a particular quality metric. Even if it were possible to establish a meaningful penalty for failure to perform, the combined health system still would be less likely to reach the quality levels that the hospitals would have achieved independently in a competitive environment.

Indeed, there is some indication that this has occurred in other states with hospitals that have received COPAs, despite commitments intended to mitigate this result. Several news articles have described concerns about quality of care and patient experiences with Ballad Health.[277] In particular, Tennessee's former COPA monitor stated that Ballad Health has not made adequate capital investments to maintain its facilities and equipment, and that if this trend continues, Ballad would struggle to meet the COPA's objectives.[278]

The federal antitrust agencies have long contended that conduct remedies are inadequate for addressing competitive harms that result from mergers of direct competitors. Instead, to the extent that a remedy was appropriate, the agencies strongly prefer "structural remedies," which seek to restore pre-merger competitive conditions through an injunction preventing consummation of a merger or a divestiture of assets.[279] Courts generally agree with this

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[277] *See, e.g.*, Adam Friedman, *With Ballad Health under new scrutiny, Tennessee to hold yearly hearing on monopoly agreement*, Tennessee Lookout (Jul. 1, 2024), https://tennesseelookout.com/2024/07/01/with-ballad-health-under-new-scrutiny-tennessee-to-hold-yearly-hearing-on-monopoly-agreement/ (summarizing public's concerns with the Ballad Health COPA); Brett Kelman and Samantha Liss, *These Appalachia hospitals made big promises to gain a monopoly. They're failing to deliver.*, USA Today (Sept. 29, 2023), https://www.usatoday.com/story/news/nation/2023/09/29/ballad-health-hospitals-fall-short-quality-and-charity-care/70975091007/.

[278] *See* Jeff Keeling, *COPA monitor: Ballad underspending on capital upkeep*, WJHL News Channel 11 (May 10, 2024), https://www.wjhl.com/news/local/copa-monitor-ballad-underspending-on-capital-upkeep/ (quoting the state's COPA monitor: "'Since Ballad does not have inpatient competition, it is not subject to the normal market pressures to maintain quality and updated property, plant, and equipment (PPE),'. . . Fitzgerald, who just retired from the COPA Monitor position he'd held since Ballad's inception, said if that trend continued, Ballad would 'struggle to meet the objectives of the TOC.' He specifically listed consistent high-quality patient care, appropriate physician, employee and patient satisfaction, improved population health, expanded access to care, particularly in rural areas, and maintaining modern diagnostic and therapeutic equipment.").

[279] *See* FED. TRADE COMM'N, THE FTC'S MERGER REMEDIES 2006-2012: A REPORT OF THE BUREAUS OF COMPETITION AND ECONOMICS (2017), https://www.ftc.gov/system/files/documents/reports/ftcs-merger-remedies-2006-2012-report-bureaus-competition-economics/p143100_ftc_merger_remedies_2006-2012.pdf [hereinafter FTC Merger Remedies Study]; Deborah L. Feinstein, Former Director, Bureau of Competition, FTC, Remarks at the Fifth National Accountable Care Organization Summit: Antitrust Enforcement in Health Care: *Proscription, not Prescription* (Jun. 19, 2014), https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf. *See also* Fed. Trade Comm'n, Analysis of Proposed Agreement Containing Consent Order to Aid Public Comment: In the Matter of

position.[280] In 2015, for example, a Massachusetts court rejected a consent agreement that would have allowed multiple hospital systems to merge, provided they agreed to certain conduct remedies. The court found that the proposed conduct remedies – which included price caps, component contracting, a prohibition on joint contracting, and physician and network growth restrictions – would have done little to restore the lost competition or to address the anticompetitive harms.[281] Furthermore, the court expressed serious concerns about its ability to enforce the conduct remedies, which would have required substantial technical expertise and resources to resolve complicated issues relating to healthcare pricing during a time in which healthcare contracting practices were changing enormously.[282] While every geographic area has unique aspects, these challenges would almost certainly arise in the Terre Haute area.

B. Specific Conduct Remedies Described in the Indiana COPA Act Likely Would Not Mitigate the Anticompetitive Effects of the Proposed Merger

The Indiana COPA Act states that hospitals "may not increase the charge for each individual service the hospital offers by more than the increase in the preceding year's annual average of the Consumer Price Index for Medical Care as published by the federal Bureau of Labor Statistics."[283] However, using the medical care CPI as a benchmark for future price increases would be insufficient to contain costs and is a poor substitute for pricing pressure from competition. The use of the medical care CPI as a benchmark is presumably intended to allow prices to increase commensurate with costs, where the benchmark serves as a proxy for costs. However, the CPI benchmark does not take into account differences in cost structures, case mix, or service offerings between the merging hospitals and the other hospitals that make up the benchmark. Thus, the CPI benchmark could overstate cost changes in Indiana if, for example, costs in Indiana were to grow slower than the national or regional average.

In addition, the medical care CPI is calculated based on a basket of goods and services that includes expenditures for medical devices and drugs as well as provider services.[284] Thus, using the medical care CPI could overstate price (and cost) growth of provider services if the rate

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Phoebe Putney Health System, Inc., et al., Docket No. 9348, at 1 (Aug. 22, 2013), https://www.ftc.gov/sites/default/files/documents/cases/2013/08/130822phoebeputneyanal.pdf ("The Commission has declined to seek price cap or other nonstructural relief, as such remedies are typically insufficient to replicate pre-merger competition, often involve monitoring costs, are unlikely to address significant harms from lost quality competition, and may even dampen incentives to maintain and improve healthcare quality.").

[280] *See, e.g.*, United States v. E.I. du Pont de Nemours & Co., 366 U.S. 316, 330-31 (1961) (Supreme Court held that structural remedies to preserve competition are the preferred form of relief for mergers that violate Section 7 of the Clayton Act because they are "simple, relatively easy to administer, and sure.").

[281] *See Partners Healthcare Sys.*, *supra* note 271, at 2.

[282] *See Partners Healthcare Sys.*, *supra* note 271, at *10 (stating that the methodology for regulating prices "remains a mystery" to the court, and expressing concerns that any monitor would be able to handle the complex task of administering the price caps) ("Even with some expertise in the field, the monitor will have to take into account complex contractual arrangements between Partners and the major payers, each of which have their own unique features and tradeoffs. The prices at issue are not for a homogenous good or a single product but for a complex set of services which can be bundled and redefined from one year to the next.").

[283] Indiana COPA Act § 16-21-15-7(c).

[284] U.S. BUREAU OF LABOR STATISTICS, Consumer Price Index, *Measuring Price Change in the CPI: Medical Care* https://www.bls.gov/cpi/factsheets/medical-care.htm (last updated Nov. 14, 2023).

of growth in drug prices, for example, exceeds that of provider prices. If either of these scenarios were to occur, relying on the medical care CPI as a benchmark may allow the combined hospital's prices to rise by more than its costs. Also, the medical care CPI is a measure of the *price* of medical goods and services rather than their cost of production. Prices generally reflect the cost of producing a good or service plus a markup. To the extent that consolidation among producers of medical goods and services (such as hospitals, physician groups, and insurers) drives increases in markups, prices will tend to increase faster than costs and therefore the medical care CPI will tend to overstate a hospital's cost growth.

During FTC staff discussions with payors and other stakeholders, concern was expressed about using the CPI as a benchmark, with some stakeholders explaining it would be an ineffective mechanism for controlling rates. They explained that the CPI is variable and may be higher than a hospital's actual charges. Instead, they suggested that using a fixed percentage of Medicare would be a more effective and predictable benchmark than the CPI. Some also suggested that tying hospital payments to improvements in quality of patient care would be more effective than attempting to use the CPI as a rate benchmark.

Furthermore, the Parties state in the COPA Application that only Union Health hospitals and facilities in Vigo County would be subject to COPA oversight, which would not include Union Hospital Clinton in Vermillion County.[285] The IN DOH may want to evaluate whether Union Health could raise rates at its hospital facility in Clinton to make up for any rate increase limitations imposed on its main hospital facility in Terre Haute, thus undermining the goals of the COPA. The IN DOH may also want to pay particular attention to any rate increases that occur immediately prior to merger consummation. This is a strategy that hospitals generally could use to raise the initial charge benchmark in anticipation of statutory rate regulation.

Finally, the proposed rate limitations may not apply to evolving delivery and payment models. The proposed rate review attempts to limit Union Health's ability to raise prices under existing fixed-rate contracts. But this may not prevent price increases if Union Health's future contracts with payers are structured as value-based contracts or risk-based contracts. As delivery and payment models for healthcare services continue to evolve, we question how the proposed rate review would be applicable to new value-based contracting models, which do not rely on fee-for-service reimbursement rates.[286] The terms of these value-based contracts are negotiated, however, so Union Health could exercise its enhanced bargaining leverage to demand significantly higher prices. Competitive environments naturally allow for healthcare providers to adjust their output and quality in response to changes in reimbursement structures. Regulatory environments, such as what is being proposed by this COPA, do not allow for such adjustments.

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[285] COPA Application at 13, footnote 6.

[286] Rates based on different types of reimbursement models are not directly comparable because they depend on different definitions of a "unit of service." For example, risk-based contracts rates that involve per-member-per-month payments are not comparable to contract rates that involve fixed payments for particular diagnoses. In such an environment, where there is no uniform definition of what constitutes a reimbursable unit of service, prices are particularly challenging and resource-intensive to measure.

In addition to rate limitations, the Indiana COPA Act states that for the first five years of the COPA, the hospital must invest the realized cost savings from efficiencies and improvements identified in the COPA Application for the benefit of the community served by the hospital.[287] While this requirement may provide some funding for community initiatives, it is unlikely to prevent any price increases or reductions in quality and access that are likely to result from the merger. Also, the Parties have not provided enough information about projected cost savings and efficiencies expected from the merger, so it is not possible for the IN DOH to properly evaluate this factor – including whether the benefits of the COPA outweigh the disadvantages resulting from a loss of competition. It should be noted that in the case of such a merger to near-monopoly, it would be extremely difficult for efficiencies to offset the likely anticompetitive harms. Finally, there are no specific parameters to this requirement that would make it effective or enforceable, such as a target dollar amount and penalties for failure to meet the target. Indeed, we have observed this in other states that have approved COPAs. Public reporting shows that Ballad Health has failed to meet its community investment targets since that COPA was implemented, and it is unclear whether the state has an effective mechanism for addressing this situation.[288]

The Indiana COPA Act requires the IN DOH to review annual reports submitted by the hospitals. The annual reports must include information about benefits attributed to the COPA, information about the hospital's compliance with its commitments or terms imposed by the IN DOH, and information relating to the price, cost, health improvements, quality, and access for healthcare services in the community served by the hospital.[289] However, the COPA Act does not specify which data and metrics must be used to objectively verify the hospital's claims regarding benefits, as well as price, cost, health improvements, quality and access. If the annual reporting requirement is merely a written narrative by the Parties, with no process for verifying the information they provide, then it is doubtful this will be an effective monitoring mechanism.

In particular, measuring healthcare quality can be challenging and the Indiana COPA Act does not specify objective, quantitative quality of care benchmarks by which claimed benefits can be evaluated, much less weighed against the disadvantages likely to result from the COPA. It is unclear how the IN DOH could objectively determine whether the hospital attestations regarding quality benefits are accurate, and thus whether the combined hospital entity is complying with the requirements of the COPA.[290] Critically, there appear to be no meaningful enforcement mechanisms if the hospital fails to achieve its promises regarding quality improvements, other than revoking the COPA. And it should be noted that revoking the COPA does not really punish the Parties for failing to achieve quality improvements. Indeed, the Parties

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[287] Indiana COPA Act § 16-21-15-7(d).
[288] *See, e.g.*, Adam Friedman, *With Ballad Health under new scrutiny, Tennessee to hold yearly hearing on monopoly agreement*, Tennessee Lookout (Jul. 1, 2024), https://tennesseelookout.com/2024/07/01/with-ballad-health-under-new-scrutiny-tennessee-to-hold-yearly-hearing-on-monopoly-agreement/ (summarizing Ballad Health's failure to meet its community investment commitment).
[289] Indiana COPA Act § 16-21-15-8.
[290] *See* Indiana COPA Act § 16-21-15-8 (describing several factors that COPA recipients must address in their annual performance reports, but not specifying any objective data or metrics).

may consider this outcome desirable because it would leave them unconstrained in their ability to exercise market power to the detriment of Terre Haute area patients.

Short of revoking the COPA, the IN DOH can issue a deficiency notice if the hospital is in violation of the COPA terms and conditions, and require the hospital to adopt a plan of correction.[291] However, no further details are specified as to what would be required in a correction plan and it is unclear what happens if a correction plan proves inadequate for resolving a problem with the COPA.

C. Possibility of Voluntary Termination Poses Serious Concerns and Revocation of COPA Is Unlikely to be an Effective Remedy

Under the Indiana COPA Act, the hospital can voluntarily terminate its COPA by giving 30 days' notice after the COPA has been in effect for a minimum of five years.[292] This means that once all of the hospital assets are combined, the hospital could terminate the COPA and therefore no longer be constrained by any meaningful competition or state regulation of potentially anticompetitive conduct. At this point, antitrust enforcement would not be a likely remedy. The FTC's COPA Policy Paper describes COPA situations in other states where this has been a problem.[293] Indeed, as we discuss below, we have significant concerns about the difficulty and feasibility of separating a hospital system after assets have been integrated.

The Indiana COPA Act further allows the IN DOH to revoke the COPA if it investigates the hospital's activities and determines that the hospital is not complying with the terms of the COPA or the benefits of the merger no longer outweigh the disadvantages attributable to a reduction in competition.[294] Unfortunately, revoking the COPA would not restore competition; it would merely remove state oversight and regulation from a dominant healthcare provider. Once the hospital assets are consolidated, antitrust enforcement to restore the lost competition would be extremely difficult and highly unlikely.[295]

Hospital mergers often involve a significant degree of integration. For example, the combined entity could consolidate or close hospitals; consolidate and transfer service lines; reorganize physician and other staffing at hospitals (with some physicians potentially leaving the area); negotiate new, consolidated contracts with health insurers; integrate EHR and other IT systems; integrate accounting and other financial systems; eliminate management and other staff; consolidate administrative services and vendors; and change many aspects of daily operations at these hospitals. These changes likely would alter patient travel patterns and facility preferences,

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[291] Indiana COPA Act § 16-21-15-9(b).
[292] Indiana COPA Act § 16-21-15-5.
[293] *See* FTC COPA Policy Paper (Attachment A) at 7-10, for discussion of the challenges following the termination of the Mission Health COPA in North Carolina, the Benefis COPA in Montana, and the MaineHealth COPA in Maine.
[294] Indiana COPA Act § 16-21-15-9.
[295] *See* FTC Merger Remedies Study, *supra* note 279, at 12, 18-19 (2017) (describing the significant challenges in crafting a remedy for a consummated merger when assets have been combined).

as well. Reversing all of this integration through revocation of the COPA would be highly disruptive.

For that reason, antitrust agencies typically seek to prevent or remedy problematic mergers *before* they are consummated because it is more challenging to "unscramble the eggs" and unwind the assets of companies after they have been integrated than it is to stop the merger in the first instance.[296] Historically, the FTC has faced difficulties in obtaining effective remedial relief after assets have been combined through a merger, including hospital and other healthcare provider mergers. Indeed, even in certain cases where the FTC has proven that such a merger was anticompetitive and resulted in higher prices without offsetting quality improvements or enhanced patient experience, the FTC has been unable to obtain a viable divestiture remedy for these harms.[297] Similarly, if the COPA is approved, and Union Health is allowed to merge its operations with THRH, the remedies available if the merger does not yield its promised benefits could be severely limited.

The revocation provision does not guarantee a restoration of pre-consolidation market competition, nor does it guarantee an adequate timeline for restoring pre-consolidation market competition. Based on FTC experience, it can take a year or more to finalize divestitures, even when there has not been significant facility, clinical, and other integration between the Parties.[298]

D. The Parties' Proposed Commitments Are Insufficient

The Parties have offered the following commitments regarding payor contract negotiations that they claim will minimize adverse effects and ensure fair pricing for both consumers and payors – most of which merely appear to be promises to negotiate in good faith (which presumably they should already be doing).

- Negotiate in good faith with all payors to be included in health plans offered in the geographic services area
- Not unreasonably refuse to negotiate with potential new payor entrants or payors that have small market shares

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[296] *See, e.g.,* Feinstein, *supra* note 279.

[297] *See, e.g.*, Opinion of the Commission on Remedy in the Matter of Evanston Northwestern Healthcare Corp. 89-91, Docket No. 9315 (Apr. 28, 2008), https://www.ftc.gov/sites/default/files/documents/cases/2008/04/080428commopinionon remedy.pdf; Statement of the Federal Trade Commission in the Matter of Phoebe Putney Health Sys., Inc., Docket No. 9348 (Mar. 31, 2015), https://www.ftc.gov/system/files/documents/public_statements/634181/150331phoebeputneycommstmt.pdf (Commission unable to unwind merger of two hospitals merging to a monopoly because of state certificate of need laws and regulations).

[298] *See, e.g.*, Press Release, Fed. Trade Comm'n, FTC Approves ProMedica Health System's Divestiture of former Rival St. Luke's Hospital (Jun. 24, 2016), https://www.ftc.gov/news-events/press-releases/2016/06/ftc-approves-promedica-health-systems-divestiture-former-rival-st (Divestiture of hospital approved in June 2016, four years after Commission ruled that the proposed transaction violated the Clayton Act); Order to Maintain Assets at 1-2, Saint Alphonsus Med. Center-Nampa, Inc. v. St. Luke's Health System, Ltd., No. 1:12-cv-00560-BLW (D. Idaho Dec. 10, 2015) (Order appointing trustee to oversee divestiture of hospital 22 months after district court enjoined the transaction and over two and a half years after Commission filed complaint for permanent injunction).

- Attempt to include reasonable provisions for improved quality and other value-based incentives in payor contracts
- Honor all payor contract terms and not unilaterally terminate without cause any such contract prior to its slated expiration date
- Attempt in good faith to contract with all payors that offer terms on a capitated bases, percentage of premium revenue, or other terms that require UHI to assume risk[299]

These commitments do not appear to be enforceable by the IN DOH or likely to mitigate the potential anticompetitive harms resulting from the merger. To the contrary, the proposed commitments fail to define exactly what would be required of the Parties, provide no objective assurance that any of these commitments will actually be achieved, and lack any mechanism for holding the combined hospital system accountable if it does not fulfill the commitments.

In the COPA Application, the Parties list quality measures that they claim "will be used to measure the quality of hospital and healthcare services provided to Indiana residents resulting from the proposed merger agreement."[300] The list is comprised of recognized quality measures that are currently used to assess acute care hospitals participating in federal programs, such as hospital acquired infections, patient safety indicators, hospital acquired injuries, length of stay, and readmission rates.[301] Both Union Health and THRH already strive to maintain acceptable standards for these measures, and they do not explain how the proposed merger will result in improvements for any of these measures. Absent the merger, the Parties would have to continue meeting these standards to participate in federal hospital programs – so it is unclear how the merger changes anything. Furthermore, the IN DOH does not appear to have any recourse if the hospitals fail to maintain acceptable quality standards, other than to revoke the COPA.

The Parties provide a list of factors they would include in the annual reports to the IN DOH that includes narrative descriptions of post-merger benefits and performance, limited data (most of which is controlled solely by the hospital), and financial statements. Beyond this, the Parties offer to provide quarterly reports containing narrative descriptions of integration efforts, quarterly financial statements, and quality metrics reported to CMS. Finally, the Parties pledge to notify the IN DOH of any facts or circumstances that would materially impact the hospital's operations and financial condition.[302] However, none of this reporting ensures that any objective standards or goals will be met, or that it will be possible to hold the hospital accountable for failure to achieve the claimed benefits of the COPA. Again, short of the revoking the COPA, the IN DOH lacks any enforcement mechanisms to hold the hospital accountable for failure to achieve the claimed benefits of the COPA. As explained above, revoking the COPA will not mitigate any disadvantages resulting from the merger.

The Parties also suggest that the price transparency requirements enacted in Indiana in 2021 "will serve as a further check on Union Hospital's ability to increase rates."[303] Despite the

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[299] *See* COPA Application at 65-66.
[300] COPA Application at 44.
[301] *See* COPA Application at 44-45.
[302] *See* COPA Application at 69-71.
[303] COPA Application at 60. *See* 45 CFR § 180.10 et seq.

potential benefits that may be realized throughout the state as a result of this legislation, price transparency is unlikely to be effective in markets that lack competition and are highly concentrated. Unless hospitals face competitive pressure when negotiating with payors, they will not have incentives to lower their rates. Likewise, they are unlikely to respond to pricing information published by hospitals in other geographic areas. In the absence of the proposed merger, the price transparency requirements may have benefitted patients and employers in Terre Haute because Union Health and THRH would continue to compete against each other, and patients would have options they could choose between for healthcare services. If the merger is consummated, however, the price transparency requirements are unlikely to impact the behavior of Union Health because patients would no longer have any other options for care in Terre Haute.

In summary of Section VIII, rate regulation and other conduct remedies do not replicate lost competition resulting from mergers, they are challenging and costly to implement, and they require constant supervision to ensure compliance. Adding to this complexity, hospitals subject to rate regulation and other conduct remedies often have strong financial incentives to circumvent the required regulatory commitments.[304] Furthermore, unenforceable commitments to negotiate with payers in good faith and comply with price transparency law requirements will do nothing to prevent anticompetitive price increases that are likely to occur as a result of the proposed merger. All of these factors would strain the state's ability to determine whether the public policy goals of the COPA are being met and to hold the combined hospital system accountable.

IX. Conclusion

Competition between Union Health and THRH benefits patients, employers, and hospital employees in the Terre Haute area by constraining prices for inpatient, outpatient, and physician services, which ultimately helps control out-of-pocket healthcare expenses. Competition also incentivizes hospitals to maintain and improve quality of care.

The proposed merger would eliminate this beneficial competition and give Union Health the ability to exercise significant market power. This would likely result in higher prices and reduced quality for healthcare services in the Terre Haute area. Union Health has not provided sufficient information regarding its plans for cost savings, efficiencies, and quality improvements to allow the IN DOH to fully assess these factors. Any cost savings or quality benefits of the merger would need to be extraordinary in order to outweigh the significant competitive harm that is likely to result from the merger, and there is no indication that this is the case. Moreover, many of the claimed benefits likely could be achieved through an alternative arrangement – either independently, through another form of collaboration with each other, or through a merger or affiliation with a different partner – that would be less harmful to competition. It is doubtful that terms and conditions imposed under the state's attempt at active supervision could mitigate the likely price effects of this merger, and they could exacerbate reductions in the quality of care

[304] *See Partners Healthcare Sys., supra* note 271, at *22, *17 ("Particularly where the product or transaction is complex and enforcement of the remedies is over a long period of time, there are many opportunities for the entity, in pursuit of its own self-interest, to 'crowd' the border of stated rules and create ways to evade them.").

or access to care for patients in the Terre Haute area. Furthermore, there do not appear to be any enforceable commitments to maintain or improve quality and access, and any such commitments would in any event likely be unworkable and are no substitute for preserving competition.

FTC staff respectfully encourages the IN DOH to consider the following factors and questions when reviewing the COPA Application submitted by Union Health and THRH:

1. Will the proposed merger substantially reduce competition, allowing the combined hospital to negotiate higher prices for healthcare services, and reducing its business incentives to maintain or improve quality of care?

2. Are the claimed benefits (a) credible and verifiable, (b) likely to be achieved and passed through to consumers, (c) achievable only through *this* merger, and (d) of sufficient magnitude to outweigh the proposed merger's significant disadvantages?

3. Have the hospitals substantiated their plans sufficiently to ascertain the steps, timeframe, and costs necessary to (a) consolidate clinical services, (b) surpass volume thresholds that the hospitals are not already capable of achieving independently to improve patient health outcomes, and (c) achieve projected synergies and cost reductions?

4. How will consolidation of services and facilities impact patient access to healthcare services?

5. Will the proposed merger eliminate competition in the labor market, resulting in reduced wages and benefits for hospital and other employees?

6. Will terms and conditions imposed by the IN DOH under active supervision effectively mitigate the competitive harms of the merger, and are they capable of being successfully implemented and objectively monitored, to determine whether the COPA is meeting the stated public policy goals?

7. Is there any meaningful mechanism for the IN DOH to discipline the combined hospital if it fails to meet the COPA requirements?

8. How long does the IN DOH intend to provide regulatory oversight of the COPA, and what will happen in the event that the combined hospital voluntarily terminates the COPA or the underlying legislation is repealed or revised to allow the COPA to expire?

In our assessment, there is insufficient evidence that the potential benefits of the COPA outweigh the potential disadvantages of the elimination of competition between Union Health and THRH.

We thank you for the opportunity to present our views and hope they will be helpful as you evaluate the COPA Application. We would be happy to provide any additional expertise and information that we are authorized to share in connection with your review.

Please direct all questions regarding this submission to Guia Dixon, Attorney, Mergers IV Division, Bureau of Competition, 202-326-2792, gdixon@ftc.gov; and Stephanie Wilkinson, Attorney Advisor, Office of Policy Planning, 202-326-2084, swilkinson@ftc.gov.

FTC Public Comment
Attachment A

FTC Policy Perspectives on Certificates of Public Advantage

Staff Policy Paper

August 15, 2022

FEDERAL TRADE COMMISSION

Lina M. Khan, Chair
Noah Joshua Phillips, Commissioner
Rebecca Kelly Slaughter, Commissioner
Christine S. Wilson, Commissioner
Alvaro M. Bedoya, Commissioner

Contents

Questions may be directed to FTC staff at CopaAssessment@ftc.gov.

Introduction

This paper by Federal Trade Commission staff presents information for state lawmakers considering proposed legislation regarding Certificate of Public Advantage ("COPA") laws.[1] The FTC routinely challenges hospital mergers that would substantially lessen competition, and therefore would raise healthcare prices for patients, reduce quality of care, limit access to healthcare services, and depress wage growth for hospital employees. COPA laws attempt to immunize such hospital mergers from the antitrust laws by replacing competition with state oversight and limiting the FTC's ability to challenge them. COPAs thus allow for hospital consolidation that is likely to harm patients and employees. The existing research shows that COPAs' purported benefits are simply unproven, so there are many reasons to be skeptical of their use. Experience and research demonstrate that COPA oversight is an inadequate substitute for competition among hospitals, and a burden on the states that must conduct it. Hospital competition, on the other hand, has proven to result in lower prices and improvements in quality of care, expanded access to healthcare services, and even higher wages for some hospital employees. For these reasons, the FTC advocates against the use of COPAs to shield otherwise illegal hospital mergers.[2] Indeed, both Democratic and Republican administrations and several leading academics have raised concerns about COPAs, cautioning states not to rely on them in the absence of evidence that COPAs produce better results than market-based competition.[3]

FTC staff invites state lawmakers to work collaboratively with competition policy experts to minimize the negative effects of further anticompetitive hospital consolidation and avoid using COPAs. We also urge states that have existing COPA laws to consider repealing those laws if they do not have an active COPA in place. We welcome the opportunity to speak with any state lawmakers who wish to better understand the FTC's hospital merger review process or the COPA studies described in this paper.

What is a COPA and why do hospitals seek them?

COPA laws are enacted to replace competition among healthcare providers with regulatory oversight by state agencies. In states with COPA laws, officials allow hospitals to merge if they determine the likely benefits from a particular merger outweigh any disadvantages from reduced competition and increased consolidation. States often impose various terms and conditions on COPA recipients intended to mitigate harms from a loss of competition, including price controls and rate regulations, mechanisms for sharing cost savings and efficiencies, and commitments about certain contractual provisions between hospitals and commercial health insurers. Once granted, COPAs purport to shield provider mergers and other types of collaborations from federal antitrust enforcement under the state action doctrine.[4] State departments of health – often in consultation with state attorneys general offices – are responsible for implementing COPA regulations, evaluating COPA applications submitted by hospitals, and actively supervising any approved COPAs in perpetuity.

Hospitals that wish to merge seek COPAs when a specific merger would otherwise violate antitrust laws. Indeed, most COPAs that have been approved so far resulted in a single hospital monopoly.[5]

Mergers that lead to lower prices or better health outcomes for patients are unlikely to violate antitrust laws and thus would not require COPAs to mitigate anticompetitive harms.[6]

Why should state lawmakers be concerned about hospital consolidation?

Healthcare experts consistently find that highly concentrated healthcare markets are more likely to have higher prices for consumers (e.g., patients and employers who fund employee health plans), reduced quality of care and patient health outcomes, and reduced access to healthcare services. Most studies show that competition among health systems – not consolidation – results in the lowest prices and optimal quality benefits for patients,[7] as well as optimal wages and benefits for employees.[8]

Hospitals compete for inclusion in insurance plans, and insurers rely on that competition to negotiate better prices and higher quality of care commitments for plan members. When hospitals have substantial market power, their negotiating leverage with health insurers increases and they often are able to demand higher rates (i.e., prices), which are then passed on to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses.[9] Notably, this finding holds true with *both* for-profit and not-for-profit merging hospitals.[10] By eliminating competition among hospitals, a merger can create or exacerbate this market power. When considering a request for a COPA to permit a merger that will eliminate competition, we urge state lawmakers to consult local health insurers regarding the impact that COPA legislation could have on their ability to negotiate competitive rates or implement value-based delivery and payment models, as this could have a big impact on patients and employers. Also, employers facing higher costs may limit insurance coverage for their employees or eliminate insurance coverage altogether. Studies show that rising healthcare costs caused by hospital consolidation are often passed through to employees in the form of lower wages and less generous benefits.[11]

In addition to raising consumer prices, eliminating competition may reduce hospital incentives to maintain or improve quality and patient access to care.[12] Studies demonstrate the net effect of mergers of competing hospitals on quality is often negative, and increased competition is associated with better quality.[13] Based on the available evidence, we cannot presume that any given hospital merger is likely to improve quality or reduce costs by enough to offset a price increase.

Finally, a recent study found that mergers that significantly increase hospital concentration in local labor markets, reducing the number of hospital employers, result in slowed wage growth for workers whose employment prospects are closely linked to hospitals. This study showed that four years after such high-impact mergers occurred, nominal wages were 6.8% lower for nurses and pharmacy workers and 4.0% lower for non-medical skilled workers than they would have been without the merger.[14] State lawmakers and health departments must evaluate whether COPAs are in the best interest of the public and the impact on labor markets is highly relevant to this analysis. This type of wage depression could dissuade qualified hospital employees (already in short supply in many parts of the country) from seeking employment, which could undermine the quality of patient care and access to services.[15]

Lower income levels for hospital employees may also worsen population health in local communities where hospitals are leading employers.[16] FTC staff are not aware of any COPA that has attempted to address a merger's impact on hospital employee wages.

Competition results in better outcomes than consolidation subject to COPAs

Competition has proven to be more reliable and effective than COPAs for controlling healthcare costs while preserving quality of care, including in rural areas facing economic challenges. Competition between hospitals benefits area employers and residents. It enables health insurers to negotiate lower hospital reimbursement rates (i.e., prices) on behalf of customers, which reduces the prices that area employers and residents must pay in premiums, copayments, deductibles, and other out-of-pocket expenses. That competition also incentivizes hospitals to improve healthcare quality and the availability of services and new healthcare technologies, as the hospitals compete to attract patients to their respective systems. As a result, area employers and residents – commercially insured, those covered by Medicare and Medicaid, and the uninsured – have benefited from this competition.

Research demonstrates that COPAs have resulted in significant price increases and contributed to declines in quality of care. Sometimes these adverse effects may occur after the COPAs have expired (often at the hospitals' urging), but they may also manifest while the COPAs are in effect, due to the difficulties inherent in implementation and monitoring. In 2017, the FTC announced a policy project to assess the impact of COPAs on prices, quality, access, and innovation for health care services.[17] This project has included research of past COPAs, a public workshop highlighting practical experiences with COPAs and related policy considerations, and an ongoing study of recently approved COPAs.[18] As discussed in more detail beginning on page 7 below, key findings from specific COPA case studies are:

- **Mission Health COPA Studies:** The first study found substantial increases in commercial inpatient prices during early COPA years (at least 20%). The second study found substantial price increases during later COPA years (an average of 25%) and even greater price increases after the COPA was repealed (at least 38%). Both studies demonstrate that price regulations during the COPA were ineffective, and the second study demonstrates the risk of eventually having an unregulated monopolist.

- **Benefis Health COPA Study:** Substantial increases in commercial inpatient prices after the COPA was repealed (at least 20%), demonstrating the risk of eventually having an unregulated monopolist.

- **MaineHealth COPA Study:** Substantial increases in commercial inpatient prices at an unregulated hospital during the COPA (at least 38%), as well as after the COPA expired at both hospitals – for a total price increase of at least 50% during the COPA and post-COPA period. The study demonstrates the risk of selectively regulating hospitals within a larger system –

MaineHealth exercised its market power by raising prices at the unregulated hospital. It also demonstrates the risk of eventually having an unregulated monopolist. Perhaps more importantly, there was a measurable decline in quality at the acquired hospital after the COPA expired.

The next section describes some of the purported benefits that hospitals often claim as justification for COPAs. We are not aware of any studies showing that these purported benefits are ever actually achieved.

In addition, COPAs can be extremely difficult to implement and monitor, requiring significant state resources over many years, sometimes decades. Regulatory fatigue, staff turnover, and changes in funding priorities at state agencies can lead to less vigorous supervision over time. Also, the hospitals subject to COPAs often lobby for repeal of COPA oversight or fewer COPA conditions, citing costs and difficulties of compliance. When this happens, the practical effect is that the merged healthcare system that was previously subject to state COPA oversight is then able to exercise increased market power (in most cases, monopoly power) unconstrained by either state regulation or antitrust enforcement against merger-related harms.

> *"My bottom line is that COPA regulation is fraught with difficulties. Regulations can become obsolete and less effective over time. State regulators became referees to resolve competitive battles, and the political pressure is considerable. And most significantly, the end game or exit strategy can be a problem and might leave you with a concentrated, but unregulated market power."*
>
> *Mark Callister, Monitor for Benefis Health COPA*

Hospital arguments in favor of consolidation subject to COPAs are flawed

Hospitals offer a variety of justifications when lobbying state lawmakers to enact COPA laws, but there are many reasons for lawmakers to be skeptical. Hospitals seeking COPAs commonly claim their proposed mergers would result in cost savings and efficiencies that would allow for improvements in clinical quality outcomes. Experience and evidence demonstrate, however, that many hospital mergers do not result in significant efficiencies, despite hospital projections that they will.[19]

Hospitals seeking COPAs have also cited concerns about low reimbursement rates or future reductions in reimbursement that may occur as a result of declining admissions and healthcare reform efforts. They argue their proposed mergers would improve their financial condition and enable them to meet such challenges. In each of the last four hospital mergers the FTC investigated that received a COPA, and in our experience more broadly, hospitals seeking COPAs have had adequate financial resources to continue operating independently and to maintain quality and access to healthcare services without requiring a merger – contrary to the claims often made by the hospitals. Indeed, if a hospital is truly failing financially and the proposed merger is the only way for it to remain viable, the FTC is unlikely to challenge such a merger and the hospital does not need COPA protection against antitrust enforcement.

Hospitals often claim their proposed mergers would create jobs and ensure local access to healthcare facilities and services. In the FTC's experience, though, hospitals frequently project cost savings premised on facility consolidation, the elimination of services, and job reductions. Therefore, lawmakers should examine these claims carefully and consider how they align with post-merger plans for integration and operations, as cost savings projections may indicate that a merger would reduce employment and patient access to healthcare services in local communities.[20]

Hospitals frequently argue that proposed mergers should proceed subject to COPAs because they would create a larger combined patient base, allowing them to improve population health efforts. Merging hospitals also claim that increasing their patient base would facilitate cost-saving, value-based payment models with health insurers. However, population health initiatives can be (and usually are) pursued by the hospitals independently, so mergers are generally not necessary to gain these benefits. And recent empirical research suggests that consolidation among healthcare providers has *not* facilitated the increased use of value-based payment models. Instead, providers in concentrated markets may be better positioned to resist such initiatives.[21] Related research suggests that health systems with increased scale are not more likely to engage in or be more successful at value-based contracting.[22] Indeed, the shift to value-based initiatives is already occurring among many hospital systems and insurers nationwide, and is mandated by Centers for Medicare & Medicaid Services in some circumstances.[23]

Hospitals also claim their proposed mergers would eliminate unnecessary and duplicative costs associated with competition, sometimes referred to as "wasteful duplication," allowing them to save money by avoiding capital expenditures. But again, it is unclear whether hospitals are really interested in avoiding unnecessary or duplicative expenditures or simply want to avoid the pressures of competition. Many hospital mergers do not result in significant cost savings,[24] and some studies have found that hospital competition leads to improved patient health outcomes with more effective resource utilization, as compared to highly concentrated markets with less competition.[25] Competition can incentivize hospitals to invest in facilities, technology, and equipment that improve access and quality.[26] For example, these types of investments can result in shorter wait times, more convenient service options for physicians and patients, and the continued availability of services when a piece of equipment fails. In this regard, competition is good for patients, not unnecessary or wasteful.

Finally, hospitals argue lawmakers should not be concerned about the negative effects of their proposed merger, because the states can impose various types of regulatory conditions on COPA recipients that would mitigate the harms resulting from consolidation. Common examples include price controls and rate regulation, mechanisms for sharing cost savings and efficiencies with local residents, public reporting of quality metrics, and commitments regarding certain contractual provisions between the hospitals and commercial health insurers. But such conditions do not replicate the benefits of competition; rather, they distort competition. They are also challenging and costly to implement, requiring considerable supervision, as hospitals subject to COPAs often have strong financial incentives to evade the regulatory conditions, thus undermining their efficacy.[27]

FTC efforts to prevent harmful hospital consolidation are undermined by COPAs

The FTC is an independent, bipartisan agency with a dual mission of promoting competition and protecting consumers. Under its statutory mandate, the FTC challenges mergers and acquisitions that are likely to substantially lessen competition and harm consumers.[28] Anticompetitive mergers and conduct in healthcare markets have long been a focus of FTC law enforcement, research, and advocacy.[29] The FTC has considerable experience in evaluating mergers involving hospitals, outpatient facilities, and physician groups to determine whether they are, on balance, likely to benefit or harm consumers.[30]

At the heart of FTC investigations is how healthcare mergers impact patients, employers, and employees in local communities. FTC staff considers a wide range of factors, including the impact on prices charged to patients, wages paid to hospital employees following greater employer concentration, patient health outcomes and quality of care, patient access to healthcare services, and the potential for the merger to result in innovative healthcare delivery and payment models. We often consult physician experts with experience in both clinical and academic research settings, to help us evaluate the hospitals' quality of care and health improvement claims. Staff also speaks to local business and community members, including other healthcare providers, public and private employers, and health insurers, to understand how mergers will impact them. We examine a significant amount of public and non-public information, including business documents and data from the merging hospitals and other market participants. Staff also performs an economic analysis of hospital discharge data, as well as a financial analysis of the merging hospitals. Notably, these factors are similar to those that state health departments are required to consider when evaluating COPAs. However, the FTC has spent several decades and substantial resources to develop expertise evaluating mergers, and state health departments often have different areas of expertise.

There are certainly circumstances where a bona fide regulatory approach that has the side effect of limiting competition may be an appropriate way to implement important public policy goals. Yet, the available evidence shows COPAs do not achieve the purported policy goals of reducing healthcare costs and improving quality. Instead, COPAs shield specific hospital transactions from vigorous antitrust enforcement, to the detriment of those very goals. Antitrust authorities are better positioned to

challenge anticompetitive mergers that are likely to result in higher prices and reduced quality of care for patients when we do not face the litigation obstacles presented by COPAs. We invite state lawmakers to engage with us in addressing the problems associated with anticompetitive hospital consolidation and avoid the use of COPAs.

Case studies: COPAs do not prevent hospitals from exploiting market power

Many states have enacted COPA legislation since the 1990s. FTC staff are aware of nine states that have approved hospital mergers pursuant to such legislation: North Carolina, South Carolina, Montana, Maine, Minnesota, and most recently, West Virginia, Tennessee, Virginia, and Texas.[31] But some of these states have decided to do away with COPAs. North Carolina, Montana, and Minnesota have repealed the underlying legislation so that hospitals in these states are no longer allowed to obtain COPAs. Unfortunately, these legislative changes also eliminated state regulatory oversight of the hospital systems that were allowed to merge under COPAs. Furthermore, antitrust enforcement was no longer practical since the mergers had long been consummated. As a result, these systems can now exercise their substantial market power unconstrained by state oversight or antitrust enforcement against merger-related harms.

FTC staff has evaluated several of these COPAs, and the findings illustrate the significant challenges of trying to regulate a hospital with substantial market power in perpetuity. COPAs can be difficult to implement and monitor over time, and are often unsuccessful in mitigating merger-related price and quality harms. Furthermore, when COPA oversight is removed, which happens frequently, the risk of price and quality harms increases significantly because of the absence either of the preexisting competition or regulation. For these reasons, FTC staff recommends that state lawmakers not enact COPA laws. In states where COPA laws already exist, FTC staff recommends repealing these laws provided there is not an active COPA currently in place. If there is already an active COPA in place, states should not approve any new COPA applications.

> *"Almost all of the COPAs established prior to 2015 have expired or were repealed, leaving the affected communities with unregulated hospital monopolists, higher prices, and likely reduced quality. States considering the use of a COPA to grant antitrust immunity to merging hospitals should carefully weigh this risk of harm against the possibly short-run and limited benefits of the merger."*
>
> *Christopher Garmon & Kishan Bhatt*

Mission Health System (North Carolina)

In December 1995, Memorial Mission Hospital and St. Joseph's Hospital, the only two general acute care hospitals in Asheville, North Carolina, entered into an agreement under the state's COPA law for certain collaborative activities. In 1998, the two hospitals merged and amended their agreement with the state to approve the merger subject to certain terms and conditions – including margin, cost, and physician employment caps, as well as quality and contracting commitments. The merged hospital, renamed Mission Health System, operated under these terms for nearly 20 years. In 2015, the North Carolina legislature repealed the state's COPA law after lobbying by Mission Health, and the Mission Health COPA ended in September 2016 – leaving no competitive or regulatory constraint on Mission Health's monopoly power in Asheville. In February 2019, Mission Health was acquired by the for-profit healthcare system HCA Healthcare – despite the fact that the COPA was originally approved, in part, to prevent out-of-state for-profit healthcare systems from acquiring the local hospitals.

Empirical research on the price effects of the Mission Health COPA for inpatient hospital services from 1996 to 2008 shows that Mission Health increased its prices by at least 20% more than peer hospitals during the COPA period, suggesting that despite the margin and cost regulations, state COPA oversight did not prevent Mission Health from raising prices more than similar hospitals.[32] A second study found an average price increase of 25% through 2015, driven by large increases several years into the COPA period. It also found prices increased by another 38% after the COPA was repealed in 2015 and before Mission Health was acquired by HCA Healthcare – indicating the post-COPA price increase likely reflects the removal of the COPA oversight rather than the conversion to a for-profit hospital system.[33] In addition, an attorney from the North Carolina Attorney General's office, responsible for overseeing the Mission Health COPA for nearly 20 years, stated that he does not recommend using COPAs due to the potential for regulatory evasion during the COPA period, and the ability of hospitals to eventually be freed of COPA oversight, which leaves the community with an unregulated monopoly.[34] And a healthcare economist hired to evaluate the Mission Health COPA in 2011 discussed the difficulty of designing a regulatory scheme that prevents evasion *and* is flexible enough to allow for industry changes over the full COPA duration.[35]

Benefis Health System (Montana)

In July 1996, the Montana Department of Justice allowed Columbus Hospital and Montana Deaconess Medical Center – the only two general acute care hospitals in Great Falls, Montana – to merge pursuant to a COPA and form Benefis Health System. COPA conditions included revenue caps, quality commitments, and other cost-saving commitments. In 2007, at Benefis Health's urging, the Montana state legislature passed a bill that effectively terminated the COPA agreement, despite the Montana Attorney General's objections. As a result, Benefis Health has been able to freely exercise its market power in Great Falls with no regulatory or antitrust oversight for merger-related harms since 2009, when the legislation took effect.

Empirical research on the price effects of the Benefis Health COPA for inpatient hospital services from 1992 to 2013 shows that Benefis's prices closely tracked the prices of peer hospitals in duopoly markets during the COPA period, but then increased by at least 20% following the repeal of the COPA.

This suggests that the COPA was effective in constraining prices to the level of peer hospitals, but that the COPA removal led to higher prices consistent with the exercise of market power by an unconstrained hospital monopoly.[36] The CEO of Benefis has stated that, although he did not observe the post-COPA price increases found in this study, he does not believe COPAs adequately address the rising costs of healthcare.[37]

An attorney hired by the Montana Department of Justice to oversee the Benefis Health COPA stated:

> My bottom line is that COPA regulation is fraught with difficulties. Regulations can become obsolete and less effective over time. State regulators become referees to resolve competitive battles, and the political pressure is considerable. And most significantly, the end game or exit strategy can be a problem and might leave you with a concentrated, but unregulated market power.[38]

Also, a policy advisor for the Montana Insurance Commissioner explained that his office proposed legislation in 2019 to repeal Montana's COPA law to enhance competition in provider and insurance markets. His office viewed COPAs as a "regulatory incentive for consolidation" at a time when the research has clearly shown "that hospital consolidation leads to poor outcomes for both quality and costs." [39] He claimed that since the Benefis Health COPA expired, "their market power has played out in several different high-profile circumstances," including dramatic cost increases and most recently, "Benefis was able to be the last holdout of the Montana employee state health plans reference pricing initiative to lower health costs."[40]

Palmetto Health System (South Carolina)

In May 1997, Baptist Healthcare System and Richland Memorial Hospital, two general acute care hospitals in Columbia, South Carolina, merged to form Palmetto Health System. The South Carolina Department of Health and Environmental Control ("DHEC") approved the transaction, subject to terms and conditions of a COPA. During the initial five-year period of the COPA, Palmetto Health was subject to rate and revenue controls, as well as commitments to achieve cost savings and to provide a portion of its revenues to fund public health initiatives and community outreach programs. Several conditions were changed or eliminated in November 2003, although Palmetto Health continued to report annually to DHEC. In November 2017, Palmetto Health merged with Greenville Health System to create the largest health system in South Carolina, now known as Prisma Health System.[41]

Empirical research on the price effects of the Palmetto Health COPA for inpatient hospital services from 1992 to 2008 shows that prices at Palmetto Health did not increase more than prices at other comparable hospitals. This may be due to COPA oversight, but it may also be the result of hospital competition that remained in the area after the merger.[42] Unlike the other COPAs studied that involved mergers to monopolies, Palmetto Health continued to face competition from other hospitals serving the Columbia area, including most notably Providence Health (later acquired by LifePoint Health) and Lexington Medical Center.[43] Indeed, in its COPA application submitted to DHEC, Palmetto Health highlighted this competition as a constraint on its ability to exercise post-merger market power.

In 2020, Prisma Health persuaded DHEC to expand the original COPA to include LifePoint's hospital and emergency room assets in the greater Columbia area. This maneuver potentially would have allowed Prisma Health to acquire these facilities without facing an antitrust challenge.[44] The FTC had significant concerns about this proposed acquisition, as it would have eliminated much of the remaining hospital competition in the area. After a legal challenge from rival hospital Lexington Medical Center, a South Carolina Administrative Court held that DHEC's incorporation of the LifePoint facilities into the original COPA was "outside the scope of the COPA law's purposes."[45] Prisma and LifePoint then announced that they would no longer pursue the proposed acquisition.[46] Since then, the LifePoint assets were acquired by another health system that did not raise anticompetitive concerns. The court's decision is the first known holding that a COPA modification did not pass muster under the state action doctrine, and underscores that there are important and meaningful limitations to using COPAs to shield hospital mergers from antitrust scrutiny.

MaineHealth (Maine)

In March 2009, MaineHealth acquired Southern Maine Medical Center ("SMMC") under a COPA issued by the Maine Department of Health and Human Services. SMMC is located about 20 miles from MaineHealth's flagship general acute care hospital in Portland, Maine Medical Center ("MMC"), and the combined organization has a dominant share of patient discharges in the SMMC service area. The COPA terms required MaineHealth to limit SMMC's operating profit margin and reduce expenses, as well as expand access and maintain quality. But the COPA did not impose any conditions on the other hospitals operated by MaineHealth, including MMC. In accordance with the state COPA law, the MaineHealth COPA expired after six years in May 2015.

Empirical research on the price and quality effects of the MaineHealth COPA for inpatient hospital services from 2003 to 2018 showed varying results for the regulated SMMC hospital and the unregulated MMC hospital. During the COPA period, SMMC's prices increased by about 8% to 13% compared to peer hospitals, but this increase was not statistically significant and the conclusion is that the COPA was largely effective at constraining SMMC's prices during the COPA period. However, SMMC's prices increased by almost 50% following the expiration of the COPA in 2015. At MMC, prices increased by 38% during the COPA period, and by 62% following the expiration of the COPA (for an average of 50% during the entire post-merger period). Furthermore, SMMC's quality declined across most measures following the expiration of the COPA.[47] The study summarizes as follows:

> These results highlight the deficiencies of the MaineHealth COPA, which only placed restrictions on SMMC's price, not that of MMC or any other MaineHealth hospital. The evidence suggests that MaineHealth was able to exercise the market power gained in the SMMC acquisition (and possibly other acquisitions) through a price increase at the unregulated MMC.[48]

Recent COPAs and Developments

Ballad Health System (Tennessee/Virginia) and Cabell Huntington Hospital (West Virginia)

In January 2018, Mountain States Health Alliance and Wellmont Health System – competitors in the geographic region that straddles the border of southwestern Virginia and northeastern Tennessee – merged to form Ballad Health System under COPA approvals from the Tennessee and Virginia Departments of Health.[49] Both states imposed terms and conditions, including a price increase cap, quality of care commitments, a prohibition of certain contractual provisions, and a commitment to return cost savings to the local community. The Tennessee Department of Health has already agreed to amend these conditions on three separate occasions, on July 31, 2019, April 27, 2021, and July 1, 2022.[50] On March 31, 2020, the Tennessee Department of Health and Tennessee Attorney General's Office temporarily suspended several COPA conditions due to the COVID-19 pandemic.[51] Approximately two years later, some of these conditions were resumed on January 1, 2022, and the remaining conditions were set to resume on July 1, 2022.[52] Some concerns have been raised about recent modifications to these conditions, however, most notably Ballad Health resuming the ability to oppose certificate of need applications filed by providers seeking to enter the market.[53]

In May 2018, Cabell Huntington Hospital and St. Mary's Medical Center – both located in Huntington, West Virginia – merged after receiving a COPA approval in 2016 from the West Virginia Health Care Authority ("Authority").[54] COPA conditions include annual reporting, regulatory rate review, the prohibition of certain contracting practices, quality of care and population health commitments, and the maintenance of St. Mary's Medical Center as a free-standing general acute care hospital for a minimum of seven years. The COPA is set to terminate in 2024. Soon after the COPA was approved, the West Virginia legislature made significant changes to the Authority, including eliminating the salaried board of directors (including those who approved the COPA), a 50% reduction in funding, and large staffing reductions (including those who evaluated the COPA). In addition, the Authority's autonomy was eliminated, and it was placed under the direction of the West Virginia Department of Health and Human Resources.[55] The Authority is still responsible for continued oversight of the Cabell COPA, although with substantially fewer resources and a lack of independent authority.

In October 2019, the FTC announced that it would study the Ballad Health and Cabell Huntington COPA effects on prices, quality, access, and innovation of healthcare services, as well as the impact of hospital consolidation on employee wages. The FTC intends to collect information over several years that will help FTC staff to conduct retrospective analyses of the Ballad Health and Cabell COPAs, and we will report these findings publicly when the study is complete.[56]

During a panel discussion on early observations of the Ballad Health COPA, staff from the Tennessee Attorney General's office and the Virginia Department of Health described the lengthy process by the states to approve and monitor the COPAs.[57] A representative for Ballad Health described the COPA implementation as successful.[58] However, representatives from an independent physician group and health insurer raised concerns about the early COPA performance, including reduced access and

pricing issues relating to the rapid closure of outpatient surgical facilities, trauma centers, and NICUs, as well as difficult payer negotiations that they claim have hindered the transition to value-based contracting.[59] And a former member of the Tennessee COPA Local Advisory Council described the significant public concerns with the COPA, primarily relating to facility closures and staffing shortages.[60]

Hendrick Health System and Shannon Health System (Texas)

In October 2020, Hendrick Health System and Shannon Health System – both located in Texas – received COPA approvals from the Texas Health and Human Services Commission for their respective mergers.[61] FTC staff conducted preliminary investigations of these mergers and determined that they were likely to lessen competition substantially and lead to price increases and quality reductions for patients, as well as depressed wages for nurses.[62] In an attempt to mitigate any merger-related harms, the state imposed limited terms and conditions as part of the COPA approvals, primarily consisting of regulatory rate review and reporting requirements. Although it is too early to assess the price and quality effects of these COPAs, we will continue to monitor developments.

Conclusion

To summarize, the weight of the empirical evidence indicates that "[i]n the long run, hospital mergers shielded with COPAs often lead to higher prices and reduced quality from unconstrained provider market power."[63] Despite hospital claims that COPAs will result in lower costs and improved population health outcomes, we are not aware of any proven benefits of COPAs. For these reasons, FTC staff urges state lawmakers to avoid using COPAs to shield otherwise anticompetitive hospital mergers.

Questions may be directed to FTC staff at CopaAssessment@ftc.gov.

Endnote References

[1] This policy paper represents the views of the staff of the Federal Trade Commission. It does not necessarily represent the views of the Commission or of any individual Commissioner. The Commission, however, has voted to authorize staff to issue this policy paper.

[2] *See, e.g.*, FTC Staff Submissions Regarding the Proposed Merger and COPA Applications of Mountain States Health Alliance and Wellmont Health System, https://www.ftc.gov/enforcement/cases-proceedings/151-0115/wellmont-healthmountain-states-health; FTC Staff Comment to Texas Health and Human Services Commission Regarding Certificate of Public Advantage Applications (Sept. 11, 2020), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhsccopacomment.pdf.

[3] *See. e.g.,* U.S. DEP'T OF THE TREASURY, THE STATE OF LABOR MARKET COMPETITION 48 (Mar. 7, 2022), https://home.treasury.gov/system/files/136/State-of-Labor-Market-Competition-2022.pdf; U.S. DEP'T OF HEALTH & HUMAN SERVICES, U.S. DEP'T OF THE TREASURY, & U.S. DEP'T OF LABOR, REFORMING AMERICA'S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION 57-59 (Dec. 2018), https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf; Martin Gaynor, WHAT TO DO ABOUT HEALTH-CARE MARKETS? POLICIES TO MAKE HEALTH-CARE MARKETS WORK 22 (Brookings Institution, The Hamilton Project Policy Proposal 2020-10, Mar. 2020), https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf; Liam Bendicksen & Christopher Koller, *The Risk of Repeal: Examining the Use of State-Action Immunity for Hospital Mergers*, HEALTH AFFAIRS FOREFRONT (Aug. 10, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210806.481073/full/. *See also* Executive Order on Promoting Competition in the American Economy (Jul. 9, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/ (discussing the importance of hospital competition).

[4] To obtain antitrust immunity for conduct by private actors that might otherwise violate the federal antitrust laws, the state action doctrine requires both a clear articulation of the state's intent to displace competition in favor of regulation and that the state provide active supervision over the regulatory scheme or body. *See* N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1114 (2015); FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003, 1013 (2013).

[5] Of the ten COPAs that have been approved, seven of them involved mergers between the only two general acute care hospitals serving a local region. Only three COPAs involved situations where any significant competition remained in the local region post-merger, but even these mergers created hospitals with dominant market shares. *See* Case Studies section, *infra* page 7, for further discussion of previously approved COPAs.

[6] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 10 (2010). Antitrust laws are not an impediment to legitimate, procompetitive collaboration that would benefit consumers. Antitrust agencies have provided extensive guidance to healthcare providers seeking ways to collaborate without running afoul of the antitrust laws. *See, e.g.*, U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf; Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Fed. Trade Comm'n & U.S. Dep't of Justice Oct. 28, 2011), http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf.

[7] *See, e.g.*, Zack Cooper, Stuart Craig, Martin Gaynor & John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q.J. ECON. 51 (2019), https://healthcarepricingproject.org/sites/default/files/Updated_the_price_aint_right_qje.pdf; Nancy Beaulieu, Leemore Dafny, Bruce Landon, Jesse Dalton, Ifedayo Kuye & J. Michael McWilliams, *Changes in Quality of Care after Hospital Mergers*

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[8] *See, e.g.,* Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, 111 AM. ECON. REV. 397 (2021), https://www.aeaweb.org/articles?id=10.1257/aer.20190690 [hereinafter Prager & Schmitt Study]; Daniel Arnold & Christopher Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages*, (2021 working paper), https://www.ehealthecon.org/pdfs/Whaley.pdf.

[9] *See* Erin E. Trish & Bradley J. Herring, *How Do Health Insurer Market Concentration and Bargaining Power With Hospitals Affect Health Insurance Premiums?*, 42 J. HEALTH ECON. 104 (2015), http://www.sciencedirect.com/science/article/pii/S0167629615000375.

[10] *See, e.g.*, Robert Town, *The Economists' Supreme Court Amicus Brief in the Phoebe Putney Hospital Acquisition Case*, 1 HEALTH MGMT. POL'Y & INNOVATION 60 (2012), http://www.hmpi.org/pdf/HMPI-%20Town,%20Phoebe%20Putney.pdf; Gaynor, Ho & Town, *supra* note 7.

[11] *See, e.g.*, Arnold & Whaley, *supra* note 8; Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LAB. ECON. 609 (2006), https://www.hks.harvard.edu/fs/achandr/JLE_LaborMktEffectsRisingHealthInsurancePremiums_2006.pdf; Priyanka Anand, *Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey*, 26 HEALTH ECON. 1601 (2017), https://onlinelibrary.wiley.com/doi/10.1002/hec.3452; Gaynor, Ho & Town, *supra* note 7, at 236; Gaynor & Town, *supra* note 7, at 1.

[12] *See* Gaynor, Ho & Town, *supra* note 7; Gaynor & Town, *supra* note 7; Beaulieu, Dafny, Landon, Dalton, Kuye & McWilliams, *supra* note 7, at 56; Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, MED. CARE RES. REV. 1-18, at 14 (2019), https://journals.sagepub.com/doi/pdf/10.1177/1077558719828938; Patrick Romano & David Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Hospital*, 18 INT'L J. ECON. BUS. 45 (2011), http://www.tandfonline.com/doi/abs/10.1080/13571516.2011.542955.

[13] *See* Gaynor, Ho & Town, *supra* note 7, at 249; Gaynor & Town, *supra* note 7, at 4.

[14] *See* Prager & Schmitt, *supra* note 8.

[15] *See, e.g.*, David Card, *Who Set **Your** Wage?*, Annual Meeting of the American Economic Association (Jan. 2022), https://davidcard.berkeley.edu/papers/Card-presidential-address.pdf; Vicky Lovell, SOLVING THE NURSING SHORTAGE THROUGH HIGHER WAGES, Institute for Women's Policy Research (2006), http://people.umass.edu/econ340/rn_shortage_iwpr.pdf.

[16] *See* FTC COPA Workshop Transcript: Session 2 (Afternoon) at 30-31 (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/session2_transcript_copa.pdf [hereinafter FTC COPA Workshop Transcript: Session 2] (statement by Christopher Garmon on the impact of the Prager & Schmitt Study as applied to COPAs). *See also* Mikael Lindahl, *Estimating the Effect of Income on Health and Mortality Using Lottery Prizes as an Exogenous Source of Variation in Income*, 40 J. HUM. RESOUR. 144 (2005), http://jhr.uwpress.org/content/XL/1/144 (finding higher income generates better health); J. Paul Leigh & Juan Du, *Effects of Minimum Wages on Population Health*, HEALTH

AFFAIRS HEALTH POLICY BRIEF (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180622.107025/ (suggesting higher income is correlated to improved population health).

[17] *See* FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments (Nov. 1, 2017), https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa_assessment_public_notice_11-1-17_revised_3-27-19.pdf.

[18] *See* FTC Public Workshop, *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets* (Jun. 18, 2019), https://www.ftc.gov/news-events/events/2019/06/health-check-copas-assessing-impact-certificates-public-advantage-healthcare-markets [hereinafter FTC COPA Workshop]; FTC Press Release, *FTC to Study the Impact of COPAs* (Oct. 21, 2019), https://www.ftc.gov/news-events/press-releases/2019/10/ftc-study-impact-copas [hereinafter FTC COPA Study].

[19] *See, e.g.*, Hannah Neprash & J. Michael McWilliams, *Provider Consolidation and Potential Efficiency Gains: A Review of Theory and Evidence*, 82 ANTITRUST L.J. 551, 553 (2019), https://www.americanbar.org/digital-asset-abstract.html/content/dam/aba/publishing/antitrust_law_journal/alj-82-2/neprash-mcwilliams-alj-82-2.pdf; Anil Kaul, K.R. Prabha & Suman Katragadda, *Size Should Matter: Five Ways to Help Healthcare Systems Realize the Benefits of Scale*, PwC Strategy& (2016), http://www.strategyand.pwc.com/reports/size-should-matter. Furthermore, in some hospital merger cases courts have found that efficiency claims do not rebut a presumption of anticompetitive effects. *See e.g.*, Fed. Trade Comm'n v. ProMedica, No. 3:11 CV 47, 2011 WL 1219281, at *57 (N.D. Ohio Mar. 29, 2011).

[20] *See* David Arnold, *Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes* (2021 working paper), https://darnold199.github.io/jmp.pdf.

[21] *See, e.g.*, Hannah Neprash, Michael Chernew & J. Michael McWilliams, *Little Evidence Exists to Support the Expectation that Providers Would Consolidate to Enter New Payment Models*, 36 HEALTH AFFAIRS 346, 353 (2017), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0840; Cooper, Craig, Gaynor & Reenen, *supra* note 7, at 104.

[22] *See, e.g.*, David Muhlestein, Robert Saunders & Mark McClellan, *Medical Accountable Care Organization Results for 2015: The Journey to Better Quality and Lower Costs Continues*, HEALTH AFFAIRS BLOG (Sept. 9, 2016), http://healthaffairs.org/blog/2016/09/09/medicare-accountable-care-organization-results-for-2015-the-journey-to-better-quality-and-lower-costs-continues/.

[23] *See* Centers for Medicare & Medicaid Services, *Value-Based Programs*, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs (last accessed Aug. 4, 2022).

[24] *See, e.g.*, Neprash & McWilliams, *supra* note 19; Kaul, Prabha & Katragadda, *supra* note 19.

[25] *See* Dan P. Kessler & Mark B. McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q. J. ECON. 577 (2000), http://qje.oxfordjournals.org/content/115/2/577.full.pdf+html; Martin Gaynor, Rodrigo Moreno-Serra & Carol Propper, *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service*, 5 AM. ECON. J.: ECON. POL'Y 134 (2013), https://www.aeaweb.org/atypon.php?doi=10.1257/pol.5.4.134.

[26] *See* David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, 20 HEALTH AFFAIRS 11 (Sept. 2001), http://content.healthaffairs.org/content/20/5/11.full.pdf+html.

[27] *See, e.g.,* Gregory S. Vistnes, *An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health* 11 (Feb. 10, 2011), http://www.mountainx.com/files/copareport.pdf; Cory S. Capps, *Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health*

System 32 (May 2, 2011). *See also* FTC COPA Workshop Transcript: Session 2, *supra* note 16, Erin Fuse Brown remarks at 18-20; Erin C. Fuse Brown, *Hospital Mergers and Public Accountability: Tennessee and Virginia Employ a Certificate of Public Advantage* (Milbank Memorial Fund 2018), https://www.milbank.org/publications/hospital-mergers-and-public-accountability-tennessee-and-virginia-employ-a-certificate-of-public-advantage/; Erin C. Fuse Brown, *To Oversee or Not to Oversee? Lessons from the Repeal of North Carolina's Certificate of Public Advantage Law* (Milbank Memorial Fund 2019), https://www.milbank.org/publications/to-oversee-or-not-to-oversee-lessons-from-the-repeal-of-north-carolinas-certificate-of-public-advantage-law/.

[28] *See* Clayton Act, 15 U.S.C. § 18; Federal Trade Commission Act, 15 U.S.C. § 45.

[29] *See, e.g.*, *Competition in the Health Care Marketplace*, FED. TRADE COMM'N, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care; FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2022), https://www.ftc.gov/system/files/ftc_gov/pdf/2022.04.08%20Overview%20Healthcare%20%28final%29.pdf.

[30] *See* FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, *supra* note 29, at Section III.

[31] Hospital systems that have been awarded COPAs include: HealthSpan Hospital System (Minnesota, 1994); Mission Health System (North Carolina, 1995); Benefis Health System (Montana, 1996); Palmetto Health System (South Carolina, 1998); MaineHealth (Maine, 2009); Cabell Huntington Hospital (West Virginia, 2016); Ballad Health System (Tennessee and Virginia, 2018); Hendrick Health System (Texas, 2020); Shannon Health System (Texas, 2020). In April 2021, a COPA law was enacted in Indiana to allow for a possible merger between Union Health and Terre Haute Regional Hospital. *See* Howard Greninger, *Talks Focus on Terre Haute Hospitals' Future: New State Law Opens Door to 'Merger' of Trauma Hospitals, Requires Certificate Approval*, TRIBUNE-STAR (Dec. 2, 2021), https://www.tribstar.com/news/indiana_news/talks-focus-on-terre-haute-hospitals-future/article_685467e6-3bba-58c7-bf1b-4966091383b1.html. And in July 2022, State University of New York Upstate Medical University and Crouse Health System announced they would seek a COPA for their proposed merger. *See* Anna Langlois, *Syracuse Hospitals Seek Antitrust Immunity*, GLOBAL COMPETITION REVIEW (Jul. 28, 2022), https://globalcompetitionreview.com/gcr-usa/article/syracuse-hospitals-seek-antitrust-immunity.

[32] Lien Tran & Rena Schwarz Presentation at FTC COPA Workshop, *The Mission Health COPA: Evidence on Price Effects from CMS HCRIS Data* (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/slides-copa-jun_19.pdf at 37.

[33] Christopher Garmon & Kishan Bhatt, *Certificates of Public Advantage and Hospital Mergers* at 19 (Feb. 2022, paper forthcoming in J. Law Econ.).

[34] FTC COPA Workshop Transcript: Session 1 (Morning), Kip Sturgis remarks at 43 (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/session1_transcript_copa.pdf [hereinafter FTC COPA Workshop Transcript: Session 1].

[35] FTC COPA Workshop Transcript: Session 1, *supra* note 34 Cory Capps remarks at 34-35. *See also* Randall R. Bovbjerg & Robert A. Berenson, URBAN INSTITUTE, CERTIFICATES OF PUBLIC ADVANTAGE: CAN THEY ADDRESS PROVIDER MARKET POWER? (2015), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf; Vistnes COPA Study, *supra* note 27; Capps COPA Study, *supra* note 27. In this prior research, health policy experts and economists evaluated certain aspects of the Mission Health COPA, but they were unable to reach conclusions about whether the COPA successfully constrained prices, reduced healthcare costs, or improved quality.

[36] Garmon & Bhatt, *supra* note 33, at 20.

[37] FTC COPA Workshop Transcript: Session 1, *supra* note 34, John Goodnow remarks at 40, 43-44.

[38] FTC COPA Workshop Transcript: Session 1, *supra* note 34, Mark Callister remarks at 38. Mark Callister informed us that the Benefis Health COPA was opposed by medical professionals and citizens of Great Falls, and was supported by the payers. *Id.* at 37.

[39] FTC COPA Workshop Transcript: Session 1, *supra* note 34, Kendall Cotton remarks at 40.

[40] *Id.* at 41.

[41] The Palmetto Health hospitals still operate under the COPA that was originally approved in 1997, although the degree of current active supervision by DHEC is questionable. In 2013, South Carolina cut funding for its Certificate of Need program, which encompasses the COPA program, thereby reducing the level of state monitoring.

[42] *See* Garmon & Bhatt, *supra* note 33, at 20, 42.

[43] At that time, four general acute care hospitals served the Columbia Core-Based Statistical Area in addition to Baptist Healthcare and Richland Memorial: Providence Health in Columbia (later acquired by LifePoint), Lexington Medical Center in West Columbia, Kershaw Health in Camden (later acquired by LifePoint), and Fairfield Memorial Hospital in Winnsboro (closed in 2018). *See* Garmon & Bhatt, *supra* note 33, at 42 ("Baptist and Richland together represented 55 percent of the bed capacity in the Columbia CBSA and treated 66 percent of the commercially insured inpatients.").

[44] *See* South Carolina Department of Health and Environmental Control, Final Staff Decision In Re Prisma Health Midlands COPA (Feb. 28, 2020), https://www.scdhec.gov/sites/default/files/media/document/FINAL-STAFF-DECISION-IN-RE-PRISMA-HEALTH-MIDLANDS-COPA_2-28-2020.pdf; Palmetto Health-USC Medical Group, *Prisma Health to Acquire KershawHealth and Providence Health* (Mar. 5, 2020), https://phuscmg.org/news/prisma-health-to-acquire-kershawhealth-and-provide.

[45] In the Matter of Lexington County Health Services District Inc. v. South Carolina Department of Health and Environmental Control, Prisma Health-Midlands, Providence Hospital, LLC, Order Denying Cross-Motions for Summary Judgment, Docket No. 20-ALJ-07-0108-CC (SC Admin. Law Court, Nov. 2, 2020).

[46] *See* Dave Muoio, *Prisma Health, LifePoint Health Call Off Sale of 3 South Carolina Hospitals*, FIERCE HEALTHCARE (Apr. 13, 2021), https://www.fiercehealthcare.com/hospitals/prisma-health-lifepoint-health-call-off-sale-three-south-carolina-hospitals.

[47] Garmon & Bhatt, *supra* note 33, at 21-22, 34.

[48] *Id.* at 21.

[49] FTC staff investigated the proposed merger of Mountain States and Wellmont for more than two years. FTC staff submitted public comments and testimony to the Virginia and Tennessee state departments of health and offices of Attorneys General recommending denial of the COPA. *See* FTC Staff Submissions Regarding the Proposed Merger and COPA Applications of Mountain States Health Alliance and Wellmont Health System, https://www.ftc.gov/enforcement/cases-proceedings/151-0115/wellmont-healthmountain-states-health.

[50] *See* Tennessee Dep't of Health, *Certificate of Public Advantage (COPA)*, https://www.tn.gov/health/health-program-areas/health-planning/certificate-of-public-advantage.html (last accessed Aug. 4, 2022).

[51] *See* Letter from Tennessee Office of the Attorney General to Ballad Health CEO (Mar. 31, 2020), 2020-03-31 Temporary Suspension-Letter -executed.pdf (tn.gov) (last accessed Aug. 4, 2022); Tennessee Dep't. of Health, List of Suspended

Provisions, https://www.tn.gov/content/dam/tn/health/documents/copa/copa-emergency-declaration-memo.pdf (last accessed Aug. 4, 2022).

[52] *See* Letter from Tennessee Office of the Attorney General to Ballad Health CEO (Dec. 3, 2021), 2021-12-03-AG-and-TDH-Reasonable-Recovery-Letter-to-Ballad.pdf (tn.gov) (last accessed Aug. 4, 2022).

[53] *See* Jeff Keeling & Ashley Sharp, *Changed Ballad COPA Restrictions Draw Docs' Criticism*, WJHL-TV (Jul. 13, 2022), https://www.wjhl.com/news/investigations/changed-ballad-copa-restrictions-draw-docs-criticism/.

[54] In November 2015, the FTC issued an administrative complaint alleging that the proposed merger of Cabell Huntington Hospital and St. Mary's Medical Center violated antitrust laws. In March 2016, while litigation was pending, West Virginia enacted COPA legislation purporting to extend antitrust immunity to certain hospital mergers under the state action doctrine. Subsequently, the West Virginia Health Care Authority approved a COPA application submitted by the hospitals. The FTC opposed the legislation and COPA application. In July 2016, the FTC dismissed its administrative complaint against the proposed merger in light of the COPA approval. *See* Statement of the Federal Trade Commission in the Matter of Cabell Huntington Hospital, Inc., Docket No. 9366 (Jul. 6, 2016), https://www.ftc.gov/system/files/documents/public_statements/969783/160706cabellcommstmt.pdf.

[55] *See* West Virginia Health Care Authority, *About HCA*, https://hca.wv.gov/About/Pages/default.aspx (last accessed Aug. 4, 2022).

[56] *See* FTC COPA Study, *supra* note 18.

[57] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Janet Kleinfelter and Joseph Hilbert remarks at 3-6.

[58] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Richard Cowart remarks at 8-10. *See also* Richard Cowart Submission on behalf of Ballad Health to the FTC (Aug. 2, 2019), https://www.regulations.gov/document?D=FTC-2019-0016-0174; Ballad Health Submission to the FTC (Aug. 2, 2019), https://www.regulations.gov/document?D=FTC-2019-0016-0173.

[59] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Scott Fowler and John Syer remarks at 11-16.

[60] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Daniel Pohlgeers remarks at 16-17. *See also* numerous submissions to the FTC from concerned citizens, https://www.regulations.gov/docketBrowser?rpp=25&so=DESC&sb=commentDueDate&po=0&dct=PS&D=FTC-2019-0016.

[61] *See* Texas Health and Human Services, *Certificate of Public Advantage*, https://www.hhs.texas.gov/providers/health-care-facilities-regulation/certificate-public-advantage (last accessed Aug. 4, 2022).

[62] FTC staff submitted a comment to the Texas Health and Human Services Commission recommending denial of both COPAs. *See* FTC Staff Comment to Texas Health and Human Services Commission Regarding Certificate of Public Advantage Applications (Sept. 11, 2020), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhsccopacomment.pdf.

[63] Garmon & Bhatt, *supra* note 33, at 1. "Overall, COPA regulation, if properly designed, may result in hospital prices that are consistent with the pre-merger market. However, COPA-regulated hospitals have a strong incentive to evade regulation and pursue the removal of the COPA. Almost all of the COPAs established prior to 2015 have expired or were repealed, leaving the affected communities with unregulated hospital monopolists, higher prices, and likely reduced quality. States considering the use of a COPA to grant antitrust immunity to merging hospitals should carefully weigh this risk of harm against the possibly short-run and limited benefits of the merger." *Id.* at 26.

Federal Trade Commission

Key COPA Facts

FTC.gov/COPA

Certificate of Public Advantage ("COPA") laws attempt to immunize hospital mergers from antitrust laws by replacing competition with state oversight. COPAs facilitate hospital consolidation, which is a key driver of higher healthcare costs without improvements in quality of care. Indeed, hospitals only seek COPAs for specific mergers that would otherwise violate antitrust laws and often result in monopolies.

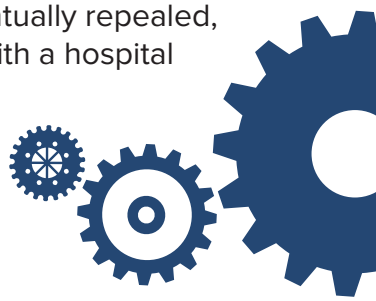
FTC staff urges states to avoid using COPAs and invites state lawmakers to work collaboratively with competition policy experts to minimize the harmful effects of further hospital consolidation on local patients, employers, and hospital employees.

- **Mission Health COPA (NC):** Substantial increases in commercial inpatient prices during early COPA years (at least 20%), during later COPA years (average 25%), and after COPA was repealed (at least 38%). Demonstrates price regulations during COPA were ineffective, as well as the risk of eventually having an unregulated monopolist.
- **Benefis Health COPA (MT):** Substantial increases in commercial inpatient prices after COPA was repealed (at least 20%). Demonstrates the risk of eventually having an unregulated monopolist.
- **MaineHealth COPA (ME):** Substantial increases in commercial inpatient prices at unregulated hospital during COPA (at least 38%), as well as after COPA expired at both hospitals – for a total price increase of at least 50% during the COPA and post-COPA period. Demonstrates the risk of selectively regulating hospitals within a larger system, as well as the risk of eventually having an unregulated monopolist. Measurable decline in quality at the acquired hospital after the COPA expired.

COPAs rarely work as promised. Here are the reasons to be skeptical:

- **COPAs exacerbate the widespread problem of hospital consolidation.** Studies show various harms can arise from hospital consolidation, including higher prices for patients without improvements in quality of care, reduced patient access to healthcare services, hospital resistance to value-based delivery and payment models intended to help reduce costs, and lower wages for hospital employees as a result of fewer employment options. Antitrust enforcers have successfully challenged anticompetitive hospital mergers likely to cause such harms, and COPAs undermine these efforts.
- **COPAs can reduce hospital employee wage growth.** Hospitals are major employers in most communities. When mergers result in high levels of hospital concentration, local labor markets suffer because fewer hospitals compete for workers. A recent study shows that such mergers can lead to lower wages for workers whose employment prospects are closely linked to hospitals, such as nurses and pharmacy workers. COPAs are sought for hospital mergers involving the highest levels of concentration and therefore can reduce employee wages.

- **COPA monitoring and compliance are difficult.** Effective COPA oversight requires significant state expertise and resources. Over time, regulatory fatigue, staff turnover, and changes in funding priorities at state agencies can lead to less vigorous supervision. Hospitals also must devote significant resources to compliance with COPA conditions, which leads them to eventually lobby for repeal of COPA oversight or fewer COPA conditions – defeating the original purpose of the COPA.
- **COPAs are susceptible to regulatory evasion.** COPA regulation is rarely, if ever, comprehensive enough to address all of the ways hospitals can exercise market power. Competition allows for greater flexibility when responding to market dynamics and has been proven to produce better results for consumers.
- **COPAs are only temporary.** Most COPAs do not last in perpetuity. They are eventually repealed, revoked, or terminated. Once state oversight ends, the community is often left with a hospital monopoly that can exercise its market power without constraint.



Hospitals make several unproven claims when seeking COPAs to form monopolies:

Claim	Fact
This merger will eliminate "wasteful duplication" associated with competition.	**Competition benefits patients, employers, and hospital employees – it is not unnecessary or wasteful. Competition can incentivize hospitals to invest in facilities, technology, and equipment that improve patient access to healthcare services and quality of care.**
This merger will reduce healthcare costs and generate efficiencies.	**Many hospital mergers do not achieve projected cost savings and efficiencies.**
Vulnerable rural hospitals will close without this merger.	**Facilities often close even with a merger. Antitrust enforcers already consider hospital financial conditions when evaluating mergers. If a rural hospital is truly failing financially and the proposed merger is the only way for it to remain viable, then the FTC is unlikely to challenge the merger and antitrust immunity is not necessary.**
This merger will improve quality of patient care and overall population health.	**Studies show that hospital mergers in highly concentrated markets are unlikely to improve quality and instead are associated with quality declines. There are many ways hospitals can achieve these laudable goals without a merger, and the antitrust laws do not prevent hospitals from engaging in initiatives to improve the quality of patient care and population health.**
This merger will enhance access to healthcare facilities and create jobs.	**Many of the cost savings projected by merging hospitals are the direct result of planned facility consolidation, elimination of services, and job reductions.**

FTC Public Comment
Attachment B

Table B1: Market Shares and HHIs in Prior Healthcare Merger Cases[305]

Case	Combined Share	HHI Increase	Post-Merger HHI	Outcome
Rockford Memorial (7th Cir. 1990)	68%	2,322	5,111	Enjoined
University Health (11th Cir. 1991)	43%	630	3,200	Enjoined
OSF Healthcare (N.D. Ill. 2012)	59%	1,767	5,179	Enjoined
ProMedica Health System (6th Cir. 2014)	58%	1,078	4,391	Enjoined
Advocate Health Care Network (7th Cir. 2016)	60%	1,782	3,943	Enjoined
Penn State Hershey Medical Center (3rd Cir. 2016)	76%	2,582	5,984	Enjoined
Hackensack Meridian Health (3d. Cir. 2022)	47%	841	2,835	Enjoined
Union Health/THRH (Vigo County Discharges)	**79.6%**	**2,640**	**6,398**	**TBD**

[305] For figures provided in Table B1, *see* United States v. Rockford Mem'l Corp., 717 F. Supp. 1251, 1280 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1211 n. 12 (11th Cir. 1991); Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1078-79 (N.D. Ill. 2012); ProMedica Health Sys., Inc. v. Fed. Trade Comm'n, 749 F.3d 559, 568, 570 (6th Cir. 2014); Fed. Trade Comm'n v. Advocate Health Care Network, et al., 841 F.3d 460 (7th Cir. 2016), *on remand*, No. 15-C-11473, 17 (N.D. Ill. 2017); Fed. Trade Comm'n v. Penn State Hershey Medical Center, 838 F.3d 327, 347 (3rd Cir. 2016); Fed. Trade Comm'n v. Hackensack Meridian Health, Inc., 30 F.4th 160, 172 (3d. Cir. 2022).

FTC Public Comment
Attachment C

Union Health and THRH Individual and Combined Primary Service Areas