No. 14-762

IN THE

Supreme Court of the United States

PROMEDICA HEALTH SYSTEM, INC.,

Petitioner,

v.

FEDERAL TRADE COMMISSION,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF OF *AMICUS CURIAE* AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONER

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TABLE OF AUTHORITIES

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CASES

Brown Shoe v. Unites States,
370 U.S. 294 (1962) 4

FTC v. Arch Coal, Inc.,
329 F. Supp. 2d 109 (D.D.C. 2004) 5

FTC v. Nat'l Tea Co.,
603 F.2d 694 (8th Cir. 1979) 7

FTC v. Univ. Health Inc.,
938 F.2d 1206 (11th Cir. 1991) 7, 8

FTC v. Warner Commc'ns, Inc.,
742 F.2d 1156 (9th Cir. 1984) 6, 8

Kaiser Aluminum & Chem. Corp. v. FTC, 652 F.2d 1324 (7th Cir. 1981) 3, 6

Lektro-Vend Corp. v. Vendo Co.,
660 F.2d 255 (7th Cir. 1992) 7

Nat'l Fed'n of Indep. Bus. v. Sebelius,
132 S. Ct. 2566 (2012) 14

United States v. Citizens & S. Nat'l Bank, 422 U.S. 86 (1975) 5

United States v. General Dynamics Corporation, 415 U.S. 486 (1974) .... *passim*

TABLE OF AUTHORITIES
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Page(s)

United States v. Int'l Harvester Co.,
564 F.2d 769 (7th Cir. 1977)....................................7

STATUTES AND REGULATIONS

15 U.S.C. § 18 ....2, 4

42 U.S.C. § 1395ww(n) 16

42 U.S.C. § 1395ww(q) 13

42 U.S.C. § 1396r-4(F)(7)(A)(ii)..............................13

42 C.F.R. § 495.6(f)(2) 16

OTHER SOURCES

Abelson, Reed, *Nonprofit Hospitals' 2013 Revenue Lowest Since Recession, Report Says*, New York Times (Aug. 27, 2014) 11, 12

Arrick, Martin D., et al., *U.S. Not-For-Profit Health Care Outlook Remains Negative Despite a Glimmer of Relief* (S&P RatingsDirect, Dec. 17, 2014) ....*passim*

Davis, Kenneth L., *Hospital Mergers Can Lower Costs and Improve Medical Care* (Wall Street Journal, Sept. 15, 2014)... 21, 23

TABLE OF AUTHORITIES
(continued)

Page(s)

DesRoches, Catherine M., et al., *Small, Nonteaching, and Rural Hospitals Continue to be Slow in Adopting Electronic Health Record Sys. Health Affairs* (May 2012)....16

Fitch Ratings, *Capital Expenditure Trends Among Nonprofit Hospitals* (May 16, 2012)....18

Fitch Ratings, *US Hospital M&A Generally Positive for Bondholders* (July 6, 2012)....21

Grauman, Daniel M., et al., *Access to Capital: Implications for Hospital* Consolidation, *HFM Magazine* (Apr. 2010)....22

Healthcare Fin. Mgmt. Ass'n, *Financing the Future II, Report 6; The Outlook for Capital Access and Spending* (Aug. 2006)....20

Healthcare Fin. Mgmt. Ass'n, *How are Hospitals Financing the Future?: Capital Spending in Health Care Today* (Jan. 2004)....19

TABLE OF AUTHORITIES
(continued)

Page(s)

Healthcare Fin. Mgmt. Ass'n, *Value in Health Care: Current State and Future Directions* (June 2011) 14, 15

Hessler, Frederick A., *The Capital Challenge in Managing the Transition H&HN Magazine* (2012) 15, 21

Holloran, J. Kevin K., et al., *The Outlook for U.S. Not-For-Profit Health Care Providers Is Negative From Increasing Pressures* (S&P Capital IQ, Dec. 10, 2013) 13, 14

Kutscher, Beth, *S&P: Expect More Not-for-profit Hospital Mergers and Acquisitions*, Modern Healthcare (Oct. 21, 2014) 18

Lasalandra, Michael, *Impact of Electronic Medical Records Discussed Harvard Public Health NOW* (Oct. 30, 2009) 16

Loo, Jeffrey, *Industry Surveys, Healthcare: Facilities* (S&P Capital IQ, August 2014) 24

TABLE OF AUTHORITIES
(continued)

Page(s)

McNamara, Margaret E., et al., *U.S. Not-for-Profit Health Care Stand-Alone Ratios: Operating Margin Pressure Signals More Stress Ahead* (S&P RatingsDirect, Aug. 13, 2014)......... 17, 20, 21

Miller, Andy, *Economic Changes Hurt the Bottom Line for Rural Ga Hospitals* (Kaiser Health News, Mar. 27, 2013) 14

Moody's Investors Serv., *Hospital Revenues in Critical Condition; Downgrades May Follow* (Aug. 10, 2011) 11, 12

Moody's Investors Serv., *New Forces Driving Rise for Not-for-Profit Hospital Consolidation* (Mar. 8, 2012) 11, 17, 21, 22

Moody's Investors Serv., *Two-Midnight Rule Will Reduce Revenue for Most Hospitals* (Mar. 12, 2014) 12

TABLE OF AUTHORITIES
(continued)

Page(s)

Moody's Investors Serv., *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook* (Aug. 30, 2011) 20, 22

Moody's Investors Serv., *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012* (Jan. 25, 2012) 10, 11, 15, 18

Moody's Investors Service, *2015-Outlook – US Not-for-Profit Healthcare: Cash Flow Settling into Low Level of Growth Amid Negative Outlook* (Dec. 2, 2014) 10, 12, 20

Perry, Jeffrey H. & Richard H. Cunningham, *Effective Defenses of Hospital Mergers in Concentrated Markets*, *27-SPG Antitrust* (Spring, 2013) 9, 11

Rau, Jordan, *Medicare Fines 2,610 Hospitals in Third Round of Readmission Penalties* (Kaiser Health News, Oct. 2, 2014) 13

TABLE OF AUTHORITIES
(continued)

Page(s)

U.S. Dep't of Justice and Fed. Trade Comm'n, Horizontal Merger Guidelines § 1.0 (Aug. 19, 2010) 4

INTEREST OF THE *AMICUS CURIAE*[1]

The American Hospital Association ("AHA") respectfully submits this brief in support of granting Petitioner ProMedica Health System Inc.'s petition for certiorari. The AHA represents nearly 5,000 hospitals, healthcare systems, and networks, as well as 40,000 individual members. AHA members are committed to a robust and competitive hospital provider market, and they are deeply affected by current market trends and changes in law and technology. The AHA has a substantial interest in the application of antitrust law to hospital mergers. Hospital mergers often foster—rather than diminish—competition, and in many cases are necessary for hospitals to deliver care effectively in a rapidly changing field.

Amicus curiae files this brief specifically to urge the Court to grant certiorari over the third question presented—regarding how lower courts should weigh evidence that a merging company in the future will likely have less competitive significance. Because of its work with hospitals nationwide, the AHA can illustrate the significant confusion in the courts surrounding this so-called "weakened competitor" doctrine. This confusion has left struggling hospitals unsure when merging remains a legal option. The

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[1] Counsel of record received timely notice of the intention to file this brief, and all parties have consented to the filing of this brief. As required by Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part, and no person other than *amicus*, its members, and its counsel made any monetary contribution intended to fund the preparation or submission of this brief.

AHA can also detail how the erosion of the "weakened competitor" doctrine—as reflected in the Sixth Circuit's decision here—leaves the viability of many small and stand-alone hospitals in jeopardy.

SUMMARY OF THE ARGUMENT

Fundamental changes in the health care sector, accelerated by the Affordable Care Act ("ACA"), have transformed the competitive landscape of the field. Due to these changes, many hospitals that are viable today—particularly small and stand-alone hospitals—may not be competitive in the future. To continue serving their communities, they look to merge with other hospitals.

The key Supreme Court precedent governing mergers by "weakened" companies in transforming industries is *United States v. General Dynamics Corporation* ("*General Dynamics*"), 415 U.S. 486 (1974). But *General Dynamics* has not been addressed by this Court for forty years, and in that time lower courts have misapplied or even ignored it.

In *General Dynamics*, this Court held that market share statistics—the exact type of evidence relied upon by the Sixth Circuit here—are not determinative of whether a merger will have anticompetitive effects. 415 U.S. at 498. Rather, lower courts must examine the particular sector, including developing and ongoing transformations in the industry, to evaluate the probable effects of a merger. *Id*. Even if a company manages to remain solvent today, its weakened future prospects may justify a merger under the Clayton Act. *See id.*; 15 U.S.C. § 18.

Now, after forty years, the Court's review is warranted for three fundamental reasons:

First, "[t]he Supreme Court has not explained or amplified its holding in *General Dynamics* to any significant degree," and consequently "[l]ower courts have read *General Dynamics* in a variety of ways." *See Kaiser Aluminum & Chem. Corp. v. FTC*, 652 F.2d 1324, 1336-37 (7th Cir. 1981). These conflicting interpretations leave both lower courts and companies guessing as to the legal regime governing potential mergers.

Second, this conflict is significant in the context of a transforming healthcare sector, making this case an ideal vehicle for certiorari. Dramatic changes in healthcare, catalyzed by the ACA and other market reforms, place significant pressure on many hospitals (especially small and stand-alone hospitals) to merge in order to remain competitive.

Lastly, the Sixth Circuit's decision erodes the *General Dynamics* doctrine, setting a precedent that must be reversed. Relegating the "weakened competitor" doctrine to a "Hail-Mary pass," as the Sixth Circuit did here (Pet. App. 28a), eliminates a critical tool for many hospitals struggling to serve their communities. Contrary to the lower court's decision, hospitals should not have to wait until they are on the edge of bankruptcy to merge. Such a rule not only does a disservice to Supreme Court precedent, but also to patients and the general public.

ARGUMENT

I. COURTS ARE IN CONFLICT AS TO THE SCOPE AND MEANING OF THE *GENERAL DYNAMICS* "WEAKENED COMPETITOR" DOCTRINE.

In the past forty years, courts have adopted varying approaches to *General Dynamics*' "weakened

competitor" analysis, including ignoring it altogether. Such conflicting approaches demonstrate the need for this Court's review.

A. Under *General Dynamics*, Courts Are Required to Consider Whether Market Changes Will Weaken a Firm's Ability to Compete in the Future.

Merger analysis under the Clayton Act is forward-looking and "necessarily predictive." U.S. Dep't of Justice and Fed. Trade Comm'n, Horizontal Merger Guidelines § 1.0 (Aug. 19, 2010). Section 7 of the Clayton Act restricts acquisitions when "the effect . . . may be to substantially lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18. Thus, the Clayton Act "requires a prognosis of the *probable future effect* of the merger," *Brown Shoe Co. v. Unites States*, 370 U.S. 294, 332 (1962) (emphasis added), and courts look to compare the future competitive significance of a company if a merger proceeds "to what will likely happen if it does not." Horizontal Merger Guidelines, *supra* § 1.0.

In *General Dynamics*, the Supreme Court reemphasized the forward-looking nature of antitrust analysis when it focused on the future prospects of a company in the rapidly changing coal industry. 415 U.S. at 501. "[F]undamental changes in the structure of the market for coal" due to industry trends and governmental regulations placed "pressures on the coal industry in all parts of the country." *Id*. at 501-506. Thus, in evaluating the merger of two coal companies, the Court discounted current market share statistics. *Id*. "Such evidence" of fundamental change, the Court concluded, "went directly to the question of whether future lessening

of competition was probable." *Id.* at 506. Even though evidence of "past production" suggested that the acquired company was healthy and strong, evidence of industry transformation led the Court to conclude that there was no antitrust violation. *Id.*

Accordingly, under *General Dynamics*' "weakened competitor" doctrine, courts must recognize that "[s]tatistics concerning market share and concentration" based on past performance do not always paint a "proper picture of a company's future ability to compete," and "[are] not conclusive indicators of anticompetitive effects." *Id.* at 498, 501. "[O]nly a further examination of the particular market—its structure, history and probable future—can provide the appropriate setting for judging the probable anticompetitive effect of the merger." *Id.* at 498; *see also United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120 (1975) (holding that "market-share statistics gave an inaccurate account of the acquisitions' probable effects on competition").

Crucially, *General Dynamics* distinguished between its analysis of likely future "weakened" competitors and the wholly separate "failing company" defense, applicable to companies on the brink of collapse. 415 U.S. at 506-07. This Court recognized that even if a company is not teetering on the verge of bankruptcy, "it still may not have a future ability to compete" because of recent or ongoing changes in the structure of a given market. The "failing company defense" is thus "inapposite" to whether a merger can be justified based on a company's likely future "weak competitive status." *Id.* at 508; *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004).

B. Lower Court Decisions Reflect Confusion As to How to Apply *General Dynamics*.

Since *General Dynamics*, lower courts have struggled to integrate its holding into their antitrust analyses. One court summarized just a few of the questions arising after *General Dynamics*:

> how wide-ranging an examination should a court or commission conduct or permit in such a showing [of a company's future weakened competitiveness] and how much weight should a court or commission give to those factors revealed by such an examination when it decides if the statistics are an inaccurate indicator of future competitive conditions.

Kaiser, 652 F.2d at 1336. Lower courts also must grapple with how "weakened" a company must be (or will be) to fall within the *General Dynamics* analysis, and how certain it is that a company will fall to such weakened status in the future. Courts must determine which evidence is suitable to make such showings, and they must then discern how to weigh such evidence against current market share statistics.

After forty years without this Court's clarification, it is perhaps unsurprising that "[l]ower courts have read *General Dynamics* in a variety of ways." *Id.* at 1337; *see also* *FTC v. Warner Commc'ns, Inc.*, 742 F.2d 1156, 1164-65 (9th Cir. 1984) (per curiam) (recognizing that courts have given differing "weight to a defense of financial

plight as a ground for justifying a merger"). Lower courts interpret and apply *General Dynamics* in one of two conflicting ways.

On one hand, in light of *General Dynamics*, some courts have incorporated analysis of "the particular market" and the "weakened financial condition" of a merging company into their examination of whether a proposed acquisition threatens a "substantial lessening of competition." *United States v. Int'l Harvester Co.*, 564 F.2d 769, 773-74 (7th Cir. 1977). These courts essentially ask whether, given the financial condition of the firm and transformations in the industry, a company could "compete effectively" if it remained in the market. *Id*. at 774-75; *see also Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255, 276-77 (7th Cir. 1981) (holding no antitrust violation where firm's "deteriorating market position prior to the acquisition" showed that the firm "was not about to collapse," but was "anything but healthy"); *FTC v. Nat'l Tea Co.*, 603 F.2d 694, 699-701 (8th Cir. 1979) (noting changes in industry made it probable that grocery chain would leave relevant region). If not, a merger survives antitrust scrutiny even when current market statistics might indicate otherwise.

By contrast, other courts will not even consider the *General Dynamics* doctrine except in the most extreme cases. These courts consider the *General Dynamics* doctrine the "weakest ground of all for justifying a merger." *FTC v. Univ. Health Inc.*, 938 F.2d 1206, 1221 (11th Cir. 1991). They "credit such a defense only in rare cases when the defendant makes a substantial showing that the acquired firm's weakness" (1) cannot be resolved by any competitive means (such as merger with a different company);

and (2) would cause the firm's market share to reduce to a level that would undermine the government's prima facie case that the merger would be anticompetitive based on past and current conditions. *Id.*; *see also Warner*, 742 F.2d at 1164-65 (finding reasons for "rejecting or attaching little weight" to "weakened competitor" doctrine, and holding that a company's "financial weakness does not in itself justify a merger."). By requiring such a strong showing that a company is *currently* uncompetitive, these courts have eviscerated a core principle articulated in *General Dynamics*—that antitrust law must evaluate the likely future (not current) competitiveness of a merging company.

In the instant case, for example, the Sixth Circuit deemed the "weakened competitor" doctrine the "Hail-Mary pass of presumptively doomed mergers." (Pet. App. 28a.) It stated that it would "'credit such a defense only in rare cases'" when the acquired firm's weakness, "'which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level that would undermine the government's *prima facie case*.'" (*Id.* (quoting *Univ. Health*, 938 F.2d at 1221).)

Based on its poor financial condition and changing market pressures, St. Luke's argued below that it was not (and would not be) a meaningful constraint on its competitors. The Sixth Circuit held that this argument had "no basis," but it evaluated St. Luke's difficulties only "*before* the merger" without looking at St. Luke's future prospects. (*Id.* (emphasis added).) The Sixth Circuit emphasized that St. Luke's had "sufficient cash reserves to pay all of its [current] obligations," but dismissed

significant evidence of St. Luke's likely future decline. (*Id.*) Absent from its decision is any discussion of the changing nature of the healthcare sector, and whether St. Luke's would have the capital to make the necessary changes to remain competitive.

Given this line of cases, some commentators have deemed the "weakened competitor" doctrine all but moribund. Tellingly, a recent article published by the Assistant Director of the Bureau of Competition at the FTC and a former Senior Trial Counsel in the same division described the *General Dynamics* doctrine as so "highly disfavored by courts and rarely successful" that it is essentially a nonissue in judicial proceedings. Jeffrey H. Perry & Richard H. Cunningham, *Effective Defenses of Hospital Mergers in Concentrated Markets*, 27-SPG Antitrust 42 (Spring, 2013). By their reading, the "weakened competitor" doctrine "only saves a transaction in the rare scenario in which the acquired firm is so weak that its market share would soon decline and bring the merger below the Merger Guidelines and case law concentration thresholds." *Id.* This is a "high bar for defendants," requiring them to show that they are (if not actually failing) only a breath away from failing. *Id.* In essence, *General Dynamics* is—to many courts—only a "lite" version of the failing competitor affirmative defense. *See id.*

By granting certiorari, the Court can bring clarity to the *General Dynamics* doctrine, which, though recognized by some courts, teeters on the edge of irrelevancy in others.

II. THE "WEAKENED COMPETITOR" DOCTRINE IS ESPECIALLY CRUCIAL FOR HOSPITALS GIVEN THE CURRENT HEALTHCARE TRANSFORMATION.

This case provides an ideal vehicle for clarifying *General Dynamics* because the doctrine is critical in rapidly changing sectors. It is undisputed that "[t]he healthcare industry is undergoing a period of fundamental transformation in which the very model of healthcare delivery is being questioned and changed." Moody's Investors Serv., *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, 7 (Jan. 25, 2012) (hereinafter *Moody's 2012 Outlook*). The ACA, along with other statutes, regulations, and sector reforms, is placing new pressures on hospitals, especially smaller and stand-alone hospitals.

Specifically, the combined pressures of (1) changing hospital reimbursement rates and methods that *reduce revenue*; (2) the need for extremely expensive electronic medical records that *increase costs*; and (3) the limited availability of capital for needed improvements to *finance change* together mean that hospitals must find new ways to increase quality while cutting costs, lest they follow a well-recognized "downward spiral" to collapse. *See* Moody's Investors Service, *2015-Outlook – US Not-for-Profit Healthcare: Cash Flow Settling into Low Level of Growth Amid Negative Outlook*, 1 (Dec. 2, 2014) (hereinafter *Moody's Outlook 2015*).

Simply cutting costs one year will not keep struggling hospitals competitive in the face of these mounting pressures. Hospitals must create economies of scale and gain access to capital. To do so, many have looked to mergers as the only means

to remain competitive. As a result, there is a major realignment occurring in the healthcare field that has generated an unprecedented number of merger challenges and "more litigated antitrust merger cases than any other segment of our economy." Moody's Investors Serv., *New Forces Driving Rise for Not-for-Profit Hospital Consolidation*, 1 (Mar. 8, 2012) (hereinafter *Moody's Consolidation Report*); Perry & Cunningham, *supra* at 42. Given the continued transformation of the health care sector, "hospital merger activity appears likely to continue unabated in the foreseeable future." Perry & Cunningham, *supra* at 42.

Accordingly, granting certiorari here would have widespread impact on struggling healthcare providers seeking to stay viable and serve local communities in a drastically changing landscape.

A. The Healthcare Sector Is Undergoing a Fundamental Transformation that Threatens the Future Viability of Many Hospitals.

1. Hospitals Face Changing Reimbursement Methods that Constrain Revenue.

Declining reimbursements have resulted in an "unprecedented threat to revenues," challenging many hospitals' financial health more dramatically than at any other time in decades. *Moody's 2012 Outlook*, at 2; *see also* Moody's Investors Serv., *Hospital Revenues in Critical Condition; Downgrades May Follow*, 2 (Aug. 10, 2011) (hereinafter *Moody's Downgrades*) ("median hospital revenue growth rate is the lowest in two decades"); Reed Abelson, *Nonprofit Hospitals' 2013 Revenue Lowest Since*

Recession, Report Says, N.Y. Times, Aug. 27, 2014, at B9 ("Nonprofit hospitals last year had their worst financial performance since the Great Recession."). The causes of reduced reimbursements are multifold.

First, hospital reimbursement rates under Medicare and Medicaid—which make up over half of hospital revenues—have been constrained and are likely to suffer even deeper cuts in coming years. *Moody's Downgrades*, at 3-4; *see also* Abelson, *supra* ("Hospitals also saw lower Medicare payments as a result of the across–the–board federal budget cuts enacted last year and other moves to cut costs.").

Beyond general rate reductions, several recent regulations that change how Medicare and Medicaid reimbursements are calculated (or penalize hospitals in certain circumstances) mean that many hospitals have recently seen, or will soon see, their revenues drop. These adjustments are not one-time cuts, but *are designed to force* structural changes that will have long-term future impact. Among these changes, just three are:

- "Two Midnight" Rule—Medicare's "two midnight" rule (effective October 2013) means that many hospital visits that do not last "two midnights" are deemed "outpatient" when they used to be reimbursed at higher "inpatient" rates. *Moody's Outlook 2015*, at 4. As a result, expected "revenue growth is lower, even though actual patient volume is unchanged." *Id.* "Smaller community hospitals" are disproportionately impacted by this rule, because they have "low average lengths of stay" that are now reimbursed at lower rates under the new rule. Moody's

Investors Serv., *Two-Midnight Rule Will Reduce Revenue for Most Hospitals*, 1 (Mar. 12, 2014) (estimating that rule will reduce revenue averaging $3000 to $4000 per case).

- Readmission Penalties—For Medicare reimbursement, hospitals now face financial penalties for having disproportionately high readmission rates. These penalties can cost a hospital up to three percent of its total Medicare reimbursements. *See* 42 U.S.C. § 1395ww(q); Jordan Rau, *Medicare Fines 2,610 Hospitals in Third Round of Readmission Penalties* (Kaiser Health News, Oct. 2, 2014). These penalties will particularly hurt those struggling hospitals without the capital to implement changes to reduce readmissions. (*See* Part 3 *infra*.)
- Reductions in Medicaid Disproportionate Share Hospital ("DSH") Payments—Starting October 2016, and extending through 2023, hospitals will face deep cuts in Medicaid DSH payments. DSH payments provide assistance to hospitals caring for a high number of Medicaid and uninsured patients. Martin D. Arrick, et al., *U.S. Not-For-Profit Health Care Outlook Remains Negative Despite a Glimmer of Relief,* 7 (S&P RatingsDirect, Dec. 17, 2014) (hereinafter *S&P 2015 Outlook*); J. Kevin K. Holloran, et al., *The Outlook for U.S. Not-For-Profit Health Care Providers Is Negative From Increasing Pressures*, 6 (S&P Capital IQ, Dec. 10, 2013) (hereinafter *S&P Increasing Pressures*); 42 U.S.C. § 1396r-4(f)(7)(A)(ii). Congress cut billions of dollars in DSH payments as part of the ACA, assuming that

> more people would be insured through the Medicaid expansion, and hence DSH payments would be less necessary. Andy Miller, *Economic Changes Hurt the Bottom Line for Rural Ga. Hospitals* (Kaiser Health News, Mar. 27, 2013). Many States, however, decided not to expand Medicaid. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2604-05 (2012). Especially in states that elected not to expand Medicaid coverage, and for hospitals that have a high percentage of uninsured patients, DSH cuts leave a "significant gap to bridge." *S&P 2015 Outlook*, at 7.

Second, the shift from "volume"-based to "value"-based reimbursement methods threatens to reduce revenues significantly for hospitals unable to make fundamental structural and clinical accommodations necessary to reduce costs and improve quality. Both government and private insurers are moving to reimbursement models that compensate providers based on patient *outcomes* (i.e., value), not for the volume of services provided. As is oft-noted, "[o]f the many forces transforming our nation's healthcare system, none is more significant than the turn from payment based on volume to payment based on value." Healthcare Fin. Mgmt. Ass'n, *Value in Health Care: Current State and Future Directions* 1 (June 2011) (hereinafter *Value in Health Care*).

Because under this model hospitals are not compensated based on each service provided, they must improve patient outcomes or face drastic reductions in revenue. *S&P Increasing Pressures*, at 8 (volume-to-value "paradigm shift" requires

hospitals to "accept and manage greater risk"). Moreover, to comply with new performance standards, providers must have information technology ("IT") (described *infra*) that permits them to "[a]ccurately and consistently report data on appropriate metrics," share information throughout the organization, implement clinical protocols to promote consistent practices, and measure quality results against benchmarks to monitor progress. *Value in Healthcare*, at 16. Unsurprisingly, then, this "[s]hift away from fee for service" is regularly cited as a key transformation that is squeezing many hospitals. *See, e.g.*, *S&P 2015 Outlook*, at 5.

2. Hospitals Must Spend Significant Capital on Costly Electronic Health Records Systems to Remain Competitive.

A second transformation in the healthcare field is the movement toward electronic health records, which represents a significant (and often prohibitively expensive) cost to hospitals. Electronic health records can make health care delivery more efficient, cost-effective, and safe. *See* Frederick A. Hessler, *The Capital Challenge in Managing the Transition*, H&HN Magazine, 11 (2012). And they are essential to succeed in the value-based reimbursement model, as described above. Consequently, hospitals' ability to make these investments in electronic records is an important measure of their future ability to compete. *See Moody's 2012 Outlook*, at 12 ("[i]ncreased need for capital relating to plant modernization and IT systems" is one of top reasons for negative outlook for hospitals).

Additionally, a portion of Medicare and Medicaid reimbursements is now conditioned on hospitals' adoption of electronic health records. Under new regulations, every hospital is expected to meet new standards for having and using electronic medical records for its patients. *See S&P 2015 Outlook*, at 12. Initially, these federal requirements encourage hospitals to utilize electronic records in a way that promotes efficiency and quality by awarding "incentive payments" to hospitals that meet standards of "meaningful use." *Id.*; 42 U.S.C. § 1395ww(n). For example, one "meaningful use" standard requires hospitals to implement certified technology that, *inter alia*, can conduct drug-drug and drug-allergy interaction checks. 42 C.F.R. § 495.6(f)(2). However, hospitals that do not meet this and other "meaningful use" requirements will face penalties starting in 2015. *See S&P 2015 Outlook*, at 12.

Despite this imperative, hospitals' overall rate of electronic health record adoption remains low because of the large upfront costs of implementing electronic records. Michael Lasalandra, *Impact of Electronic Medical Records Discussed*, Harvard Public Health NOW (Oct. 30, 2009) (estimating that implementing electronic health records will cost between $20 and $200 million, depending on the size of the hospital). "Many hospitals have struggled with implementation and the high cost of keeping information technology systems current including capital and training costs." *S&P 2015 Outlook*, at 12.

As a result, many smaller and stand-alone hospitals struggle to keep up. *See* Catherine M. DesRoches, et al., *Small, Nonteaching, and Rural*

Hospitals Continue to be Slow in Adopting Electronic Health Record Sys., Health Affairs 4 (May 2012). If they cannot adopt electronic records, the consequences snowball over time. *S&P 2015 Outlook*, at 12. Large, system-based hospitals that are more able to afford electronic records will reap the eventual cost-saving benefits. But cash-strapped, smaller, independent hospitals will miss these benefits and instead be saddled with "meaningful use" penalties, leaving them further and further behind. *See id.*

3. Many Hospitals Face a Capital Crisis.

Although hospitals' need for capital is greater now than ever, many hospitals face structural difficulties in accessing the capital they need to adopt sophisticated IT (including electronic health records) and compete in the healthcare field. As the Administrative Law Judge ("ALJ") recognized in this case, hospitals are very "capital intensive" and to "avoid decline" they "must maintain their equipment" and "provide new systems." (Pet. App. 380a-81a.)

Yet, hospitals face great difficulty in accessing capital in today's market. Given the negative financial outlook, hospitals have faced credit downgrades, and the Standard & Poor's Ratings Services expects downgrades will continue to "outpace upgrades." Margaret E. McNamara, et al., *U.S. Not-for-Profit Health Care Stand-Alone Ratios: Operating Margin Pressure Signals More Stress Ahead,* 2 (S&P RatingsDirect, Aug. 13, 2014) (hereinafter *S&P More Stress Ahead*). Smaller, stand-alone hospitals have an even more difficult time accessing credit. *See Moody's Consolidation*

Report, at 2 ("Access to the capital markets has become more difficult for smaller and lower-rated hospitals, driving the need for many to seek a partner."); Beth Kutscher, *S&P: Expect More Not-for-profit Hospital Mergers and Acquisitions*, Modern Healthcare (Oct. 21, 2014) ("Credit-rating agencies . . . set[] a higher bar for stand-alone hospitals to achieve the same rating as multihospital systems.").

With the capital crisis, hospitals have been forced to scale back their projects. For instance, "[i]n order to preserve liquidity, some healthcare systems delayed major projects that were not already started, halted projects already begun, postponed new equipment purchases and/or re-prioritized projects." *Moody's 2012 Outlook*, at 14. Delaying or eliminating improvement projects, however, only contributes to future decline. Without new investment, hospitals cannot improve quality (necessary for value-based reimbursement), and also may face governmental penalties. "Given the pace of change in the industry," then, "hospitals may not be able to rein in capital expenditures and remain competitive." Fitch Ratings, *Capital Expenditure Trends Among Nonprofit Hospitals*, 5-6 (May 16, 2012). Hence, hospitals facing a capital crisis, though afloat today, may not be able to compete in the future absent a partner "to help them invest in these areas." *Id*. at 6.

4. Because of the New Pressures in Healthcare, Struggling Hospitals Face a "Downward Spiral," Threatening Their Ability to Continue to Serve Community Needs.

Together, the transformations in the healthcare field create a "downward spiral" for many hospitals. Healthcare Fin. Mgmt. Ass'n, *How are Hospitals Financing the Future?: Capital Spending in Health Care Today*, 2 (Jan. 2004). The spiral follows this sequence:

1. "Hospitals increasingly struggle with their financial health." *Id.* Due to changes in reimbursement rates and methods (to which they are unable to adapt because of insufficient capital to adopt electronic records and make other improvements to increase cost-efficiency) hospital revenues decline.
2. "[D]eteriorating financial health makes [hospitals] less creditworthy. . . [and] their ability to access capital becomes limited." *Id.*
3. Thus, hospitals "must devote a larger portion of their capital to keeping up with current demands" and "are decreasingly able to invest in the future." *Id.*
4. The result is that their "financial health drops significantly." *Id.*

As the Standard and Poor's Rating Services summarizes: "many providers will not be able to adapt" to new pressures, so they will see "ongoing

operating margin and cash flow erosion lead to [credit] rating deterioration" and an inability to stop the decline. *S&P 2015 Outlook*, at 2.

As "[s]truggling hospitals" experience this "very slow and downward spiral," they become "unable to meet consumer and competitive needs." Healthcare Fin. Mgmt. Ass'n, *Financing the Future II, Report 6; The Outlook for Capital Access and Spending*, 14 (Aug. 2006). The outlook can be especially bleak for smaller hospitals that enter the spiral with lower credit ratings and less access to capital. "[E]ventually, if they are not acquired, they wind down and close." *Id.* The results are devastating for both patients and the community.

B. Mergers Are Critical to the Future Ability of Many Hospitals to Compete as the Healthcare Field Changes.

Because hospitals "are facing mounting challenges" due to "increased industry pressures," some have sought to merge in order to maintain long-term competitive viability. *S&P More Stress Ahead*, at 2. For some, it is their only option.

Short of merging, hospitals have implemented "aggressive cost reduction strategies across the board" by, for example, cutting salaries and benefits. Moody's Investors Serv., *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, 6 (Aug. 30, 2011) (hereinafter *Moody's Medians*). But hospitals have "exhausted many of the 'low-hanging fruit' strategies to preserve margins over the last several years." *Moody's Outlook 2015*, at 3. The sustained duration of these funding challenges makes short-term cuts a mere band-aid

on a large wound. For not-for-profit and stand alone hospitals, "the sector is at a tipping point where negative forces have started to outweigh many providers' ability to implement sufficient countermeasures." *S&P More Stress Ahead*, at 2. Accordingly, hospitals that have been "successful in absorbing shocks to the system thus far through the implementation of cost savings initiatives . . . will have a more difficult time absorbing further hits to revenue." *S&P 2015 Outlook*, at 10. The "next level" and "difficult-to-achieve savings" that hospitals need to stay competitive is "increasingly unachievable" due to lack of technology or other structural barriers. *Id.* They need a partner.

Mergers often achieve two key objectives needed to survive in the transforming healthcare landscape: (1) they create economies of scale and other efficiencies, which reduce costs; and (2) they improve access to capital, which can fund IT developments and other needed projects to improve quality. Hessler, *supra* at 11.

First, "[s]ize and scale are . . . important means to gaining greater efficiencies and driving waste and costs out of the delivery systems." *Moody's Consolidation Report*, at 1. Mergers allow hospitals to gain the "size and scale" necessary to diversify revenue sources, spread costs over a larger base, seek efficiencies, and "allocate[e] . . . resources to better withstand likely future reductions in funding." Fitch Ratings, *US Hospital M&A Generally Positive for Bondholders* (July 6, 2012). *See also* Kenneth L. Davis, *Hospital Mergers Can Lower Costs and Improve Medical Care*, Wall St. J., Sept. 15, 2014

(given sector changes, "hospitals need a large pool to survive").

Second, by merging with another hospital (or joining a hospital system) struggling hospitals can also gain greater access to capital, allowing them to make the necessary IT investments to increase quality and remain competitive in the future. Crucially, bond ratings are often tied to a hospital's size; larger hospitals tend to have higher bond ratings, in part due to their ability to gain greater efficiencies. *Moody's Medians*, at 14. Hospital mergers, therefore, have a positive impact on a hospital's credit—and its corresponding ability to access capital. The Standard & Poor's Ratings Services points to "merger and acquisition (M&A) activity [as] a significant positive for many individual credit ratings." *S&P 2015 Outlook*, at 2; Kutscher, *supra* ("Struggling hospitals and systems that otherwise would have seen their credit ratings downgraded have aligned with stronger organizations.").

Particularly for many stand-alone hospitals, merging may be the only means of achieving economies of scale and access to capital. "[G]iven the ever-growing pressures [facing stand-alone hospitals]," experts deem it "imperative that each hospital be willing to perform a candid, objective assessment of its ability to continue to go it alone." Daniel M. Grauman, et al., *Access to Capital: Implications for Hospital Consolidation,* HFM Magazine, iii (Apr. 2010). Hospitals that are "left out of consolidations, especially smaller stand-alone hospitals . . ., will face greater negative rating pressure going forward," *Moody's Consolidation*

Report, at 1, making them more susceptible to the "downward spiral."

Even the ALJ in this case recognized that hospitals such as St. Luke's, which are "struggling financially prior to [a] Joinder," may "face[] significant challenges to remaining independent in the future." (Pet. App. 541a.) "[W]hile St. Luke's was not in imminent danger of failure," the ALJ concluded that, "absent Joinder, St. Luke's future viability beyond the next several years is uncertain." (*Id*. at 539a.)

As a result, many acquisitions of stand-alone hospitals result in more competition, rather than less. As one expert explains, rather than "curtail competition, ... [h]ospital mergers are the way to promote these positive trends while delivering high-quality, better-coordinated care, improving efficiency and rooting out unnecessary costs." Davis, *supra*. Accordingly, a grant of certiorari could impact this and many other cases in the rapidly changing healthcare sector, where struggling hospitals look to mergers as a crucial tool to compete.

III. BY RELEGATING THE "WEAKENED COMPETITOR" DOCTRINE TO A "HAIL MARY," THE SIXTH CIRCUIT ELIMINATES A CRUCIAL TOOL FOR MAINTAINING COMPETITIVE HOSPITALS.

The Sixth Circuit's decision ignored both the healthcare transformation and the importance of the *General Dynamics* "weakened competitor" doctrine. It should not stand.

Given the transformation of the healthcare sector, many hospitals that are viable today will not be competitive in the future, and will eventually fail if

they are unable to merge. In general, these are not hospitals that could avail themselves of the "failing company" defense; their demise is not necessarily imminent. Yet, many hospitals in financial trouble—even if not on the brink of collapse—cannot attract capital or otherwise afford to make the investments needed to remain competitive. They may be able to make some short-term cuts, but the *structural* changes in the market mean that they need to make *structural* changes to increase quality while reducing costs. Unable to meet this new challenge, these hospitals' market share will inevitably suffer.

Because the healthcare field "continues to undergo dramatic and fundamental changes," even financial experts advise that it is "increasingly important to look beyond traditional financial statement analysis" to evaluate the strength of a healthcare company. Jeffrey Loo, *Industry Surveys, Healthcare: Facilities* 27 (S&P Capital IQ, August 2014). In short, "market realities" undermine the predictive value of past performance in evaluating the future competitiveness of many hospitals.

The Supreme Court's decision in *General Dynamics* addressed precisely this type of situation—a dynamic and rapidly changing market in which past performance was not predictive of future viability. Yet the Sixth Circuit ignored its import. The Sixth Circuit—following some other circuits—relegated a "weakened company's" reliance on *General Dynamics* to a "Hail-Mary pass." (Pet. App. 28a.) Under the Sixth Circuit's standard, *General Dynamics* is eroded such that it is no longer a meaningful part of antitrust doctrine.

Although *amicus* takes no position on whether St. Luke's merger satisfies the *General Dynamics* standard (*e.g.*, if the case were remanded), it emphasizes that the "weakened competitor" doctrine should not be eviscerated by lower courts. The law should not force hospitals to wait to merge until they are in imminent danger of closing their doors. If hospitals must tumble through the downward spiral, both patients and the community will suffer. Accordingly, the Court's consideration of the continuing importance of *General Dynamics* in our modern transforming healthcare field is essential. After forty years, the time is now.

CONCLUSION

For the reasons stated above, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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