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Advancing Health in America

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September 13, 2023

The Honorable Jonathan Kanter
Assistant Attorney General
Antitrust Division
United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20580

The Honorable Lina Khan
Chair
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

Re: FTC-2023-0043: Draft Merger Guidelines

Dear Assistant Attorney General Kanter and Chair Khan:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) submits the following comments on the Federal Trade Commission's (FTC) and Department of Justice's Antitrust Division's (DOJ) (the Agencies) July 19, 2023 draft merger guidelines (Draft Guidelines). As the nation's largest association representing hospitals, the AHA is uniquely positioned to offer on-the-ground perspective about how the Draft Guidelines would impact hospitals and the communities they serve.

In general, the AHA agrees with other commenters that, similar to the Agencies' recent proposed amendments to the Hart-Scott-Rodino form and instructions, these Draft Guidelines reflect a fundamental hostility to mergers.[1] For example, citing a concurring opinion from a 50-year-old case as controlling law, the Agencies assert that the antitrust laws "reflect a preference for internal growth over acquisition."[2] That is plainly incorrect,

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[1] Letter from M. Hatton to Hon. Lina Khan (Sept. 5, 2023) (urging FTC to withdraw proposed changes to premerger notification rules) (hereinafter "AHA Comments to HSR Amendments"), *available at* https://www.aha.org/lettercomment/2023-09-05-aha-urges-ftc-withdraw-proposed-changes-premerger-notification-rules#:~:text=The%20AHA%20shares%20the%20concerns,screen%20transactions%20for%20closer%20review.

[2] Draft Guidelines at 11.

but it is revealing about how the Agencies currently think about mergers and acquisitions. The Supreme Court has repeatedly held — and the Agencies have repeatedly acknowledged — that the antitrust laws reflect a preference for *competition* as "'the best method of allocating resources in a free market.'"[3] Indeed, the Clayton Act asks whether a merger is likely to "lessen competition" or "tend to create a monopoly."[4] And, critical here, it is well-established that mergers often *promote* competition.[5] It is therefore deeply concerning that the current FTC and DOJ leadership seem to believe mergers are not a "preferred" means of growth. This policy judgment contravenes the plain text of Section 7 and decades of precedent, and it threatens the potential for competition in many fields—none more essential to the country than the hospital field.

More specifically, the AHA shares many additional concerns expressed by other commenters including:

- The new (and lower) structural presumptions in the Draft Guidelines are arbitrary and allow for too much discretion by the Agencies to indiscriminately derail a beneficial transaction;
- The Draft Guidelines place far too much weight on cases from the 1960s and 1970s, largely ignoring modern cases and economic scholarship; and
- The Draft Guidelines undervalue cost savings and other efficiencies, which are often a major driver of hospital transactions and are materially beneficial for patients and surrounding communities.

We need not repeat these comments here, and instead urge the Agencies to take them into consideration as they determine the best course to take with these problematic Draft Guidelines.

The AHA writes separately to underscore our serious concern about the Agencies' failure to provide meaningful guidance to hospitals. According to the Agencies, the Draft

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[3] Pls.' Suppl. Mem. on Buy-Side Case at 2, *United States v. Anthem, Inc.*, No. 1:16-cv-01493, (D.D.C. Dec. 19, 2016) ECF No. 410 (quoting *Nat'l Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 695 (1978)); *see also Fed. Trade Comm'n v. Superior Ct. Trial Laws. Ass'n*, 493 U.S. 411, 423-24 (1990) (noting that statutory policy "precludes inquiry into the question [of] whether competition is good or bad"); *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 695 ("The heart of our national economic policy long has been faith in the value of competition.") (quotation marks and citation omitted).

[4] 15 U.S.C. § 18.

[5] *See* U.S. Dep't of Justice & Fed. Trade Comm'n, Note by United States to Organisation for Economic Co-operation and Development, *Conglomerate effects of mergers*, at 5 (June 10, 2020) ("Mergers are one means by which firms can improve their ability to compete."), *available at* https://www.ftc.gov/system/files/attachments/us-submissions-oecd-2010-present-other-international-competition-fora/oecd-conglomerate_mergers_us_submission.pdf.

Guidelines are intended to provide "transparency" with respect to enforcement policy.[6] But if transparency is the goal, then the last two years, including the Draft Guidelines, represent a significant step backward.

During this period, the Agencies have withdrawn valuable guidance while simultaneously pursuing aggressive theories of harm. For example, the Agencies have:

- Withdrawn the 1993 Enforcement Policy Statements in the Health Care Area, the 1996 Statements of Antitrust Enforcement Policy in Health Care, and the 2011 Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (the "Health Care Statements");[7]
- Withdrawn the vertical merger guidelines only a year after they were issued;[8]
- Pursued a novel and flawed approach to defining geographic markets in a hospital merger challenge;[9] and
- Wasted party and government resources analyzing far-fetched "cross-market" theories of harm that have no basis in statutory text or case law.

Most troubling is the Agencies' decision to withdraw the Health Care Statements (Statements). The Statements were developed based on the recognition that in a field as important to the health and vitality of American people, guidance about the types of arrangements and transactions that would promote competition is highly beneficial. To make those guidelines even more effective, the AHA repeatedly asked the Agencies to update them to bring them into better alignment with "with contemporary practices in the health care and hospital field." The Agencies declined to do so and instead withdrew

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[6] Press Release, Fed. Trade Comm'n, FTC and DOJ Seek Comment on Draft Merger Guidelines (July 19, 2023), *available at* https://www.ftc.gov/news-events/news/press-releases/2023/07/ftc-doj-seek-comment-draft-merger-guidelines.

[7] *See* Press Release, Fed. Trade Comm'n, Federal Trade Commission Withdraws Health Care Enforcement Policy Statements (July 14, 2023), *available at* https://www.ftc.gov/news-events/news/press-releases/2023/07/federal-trade-commission-withdraws-health-care-enforcement-policy-statements; Press Release, U.S. Dep't of Justice, Justice Department Withdraws Outdated Enforcement Policy Statements (Feb. 3, 2023), *available at* https://www.justice.gov/opa/pr/justice-department-withdraws-outdated-enforcement-policy-statements.

[8] *See* Press Release, Fed. Trade Comm'n, Federal Trade Commission Withdraws Vertical Merger Guidelines (Sept. 15, 2021), *available at* https://www.ftc.gov/news-events/news/press-releases/2021/09/federal-trade-commission-withdraws-vertical-merger-guidelines-commentary.

[9] *See Fed. Trade Comm'n v. Hackensack Meridian Health, Inc.*, 30 F.4th 160, 168 (3d Cir. 2022) (following FTC's patient-based approach to geographic market definition, despite fact that FTC previously defined markets around hospital location and 2010 merger guidelines require the same).

them without notice.[10] This is the opposite of transparency, much less good government. Leaving health care providers without any particularized guidance on dozens of important issues has far reaching impacts on patients and communities that the Agencies never considered.

Against this backdrop, the Agencies now offer draft merger guidelines that provide virtually no meaningful guidance to hospitals and health systems. The Draft Guidelines ignore serious flaws in contemporary enforcement practice and overlook recent judicial opinions that contradict their more aggressive proposed changes. The Agencies propose a structural presumption that is arbitrarily low and potentially fatal to beneficial transactions. And the Draft Guidelines largely eschew the many benefits of horizontal and vertical integration in the health care industry — a benefit the Administration recently acknowledged when announcing a new effort to reduce fragmentation in the health care system.[11]

The Agencies should tread much more lightly. Though not perfect, the 2010 Horizontal Merger Guidelines and 2020 Vertical Merger Guidelines reflected a thoughtful balance between economic theory and antitrust law. The Draft Guidelines abandon this balanced approach, relying on outdated judicial opinions that more recent scholarship has shown to be flawed. The Draft Guidelines also abandon the bipartisan spirit of the 2010 Guidelines, replacing it with a transparently partisan approach that is far less likely to be respected by courts. **The Agencies should rethink this sharp departure from existing practice. They should focus on opportunities for incremental improvement rather than re-inventing the wheel. They should not finalize the Draft Guidelines.**

I. ANTITRUST ENFORCEMENT AGAINST HOSPITALS IS OUT OF STEP WITH THE EVOLVING HEALTH CARE LANDSCAPE AND COMMUNITY NEEDS

The Draft Guidelines come at a critical time in health care. Hospitals and health systems face an unprecedented economic crisis: Costs are rising by the day; government reimbursements are not keeping pace; and many hospitals are losing money. Community hospitals — including those serving rural communities — are especially at risk.

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[10] Letter from M. Hatton to Hon. Jonathan Kanter & Hon. Lina M. Khan at 5 (Mar. 30, 2022) (hereinafter "AHA March 2022 Letter"), *available at* https://www.aha.org/system/files/media/file/2022/03/aha-urges-two-changes-to-ftc-doj-merger-guidelines-letter-3-30-22.pdf.

[11] *See* Press Release, Centers for Medicare & Medicaid Services, CMS Announces Transformative Model to Give States Incentives and Flexibilities to Redesign Health Care Delivery, Improve Equitable Access to Care, (Sept. 5, 2023) ("'In our current health care system, fragmented care contributes to persistent, widening health disparities in underserved populations[.]" (quoting CMS Administrator Chiquita Brooks-LaSure)) *available at* https://www.cms.gov/newsroom/press-releases/cms-announces-transformative-model-give-states-incentives-and-flexibilities-redesign-health-care.

Given these challenges, many hospitals may find a strategic combination to be the only way to keep their doors open. A thoughtful, evidence-based approach to merger enforcement is therefore imperative to ensuring access to quality health care throughout the United States. Recent enforcement practices, however, reflect a misunderstanding of health care economics and a troubling hostility toward mergers. A better approach is needed to avoid deterring mergers that offer significant benefits to hospitals and the communities they serve.

A. The financial stability of America's hospitals and health systems is at risk.

As the AHA has previously reported, many of America's hospitals and health systems are in financial trouble. During the first four months of the COVID-19 pandemic, U.S. hospitals lost over *$200 billion* in revenue.[12] In the three years since, hospital have seen their costs continue to rise across the board, including substantial increases in the cost of labor, medication, medical supplies and equipment, and purchased services. These cost increases have dwarfed hospital revenue growth.

With respect to labor costs, it is well-documented that the COVID-19 pandemic led to critical workforce shortages throughout the United States, including in hospitals and health systems.[13] Yet in 2022, things got worse. Due to a combination of sustained COVID-19 surges, an outbreak of respiratory syncytial virus (RSV), and deferred care from the early days of the pandemic, patient demand for hospital care grew dramatically. To meet this demand, hospitals were forced to work with health care staffing agencies to fill necessary gaps, including for bedside nursing.[14] Gouging by staffing agencies certainly occurred before the pandemic, but the agencies quickly capitalized on the situation and increased their rates to record levels.[15] As a result, hospitals' total labor expense in 2022 was 21% higher than in 2019, driven in large part by a *258% increase* in contract labor expense.[16] These rapacious actions by staffing agencies continue today.[17]

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[12] Am. Hosp. Ass'n, *Hospital and Health Systems Face Unprecedented Financial Pressures Due to COVID-19* at 1 (May 2020), *available at* https://www.aha.org/system/files/media/file/2020/05/aha-covid19-financial-impact-0520-FINAL.pdf.

[13] *See* Am. Hosp. Ass'n, *The Financial Stability of America's Hospitals and Health Systems Is at Risk as the Costs of Caring Continue to Rise* at 1 (Apr. 2023) (hereinafter "2023 Cost of Caring Report"), *available at* https://www.aha.org/costsofcaring.

[14] *Id.* at 2.

[15] *Id.* at 2-3.

[16] Syntellis & Am. Hosp. Ass'n, *Hospital Vitals: Financial and Operational Trends* at 2 (Feb. 2023), *available at* https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf.

[17] The AHA has contacted the FTC about this issue, but the agency has done nothing about it. *See* Letter from M. Hatton to Acting Chairwoman Slaughter at 2 (Feb. 4, 2021) (noting study showing that rates for

Drug expenses also increased dramatically since the onset of COVID-19. As hospitals and health systems struggled to overcome pandemic surges and workforce shortages, drug companies raised prices dramatically.[18] According to the Department of Health and Human Services (HHS), drug companies increased prices for 1,216 drugs — including those used to treat chronic conditions like cancer and rheumatoid arthritis — by an average of 31.6%, roughly *four times* the rate of inflation.[19] All-in, average drug expenses per patient increased nearly 20% between 2019 and 2022.[20] This was the result of both increases in patient acuity (as sicker patients require more medication) and drug companies' choices to increase the prices of their products.

In addition to significant increases in labor and drug costs, hospitals and health systems have been forced to pay materially higher prices for medical supplies and equipment. Supply chain disruptions led to higher manufacturing costs, packaging costs, and shipping costs, which in turn led to higher prices for hospitals.[21] Between 2019 and 2022, laboratory expenses per patient increased by 27.1%, and expenses for emergency services — including ventilators, respirators, and other life-saving equipment — increased by nearly 31.9%.[22] At the same time, increases in patient acuity resulted in longer hospital stays and more intensive care, leading to even higher medical supply and equipment costs. Overall supply expenses per patient increased 18.5% between 2019 and 2022, nearly matching the increases in labor and drug costs.[23]

While expenses increased dramatically during the COVID-19 pandemic, hospital revenues failed to keep pace. Even though total hospital expenses increased by 17.5% between 2019 and 2022, Medicare reimbursements, for inpatient care increased by only 7.5%.[24] And hospital prices grew modestly. In 2022, for example, growth in general inflation (8%) was more than double the growth in hospital prices (2.9%).[25]

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travel nurses "in some instances had tripled"), *available at* https://www.aha.org/system/files/media/file/2021/02/aha-urges-ftc-examine-anticompetitive-behavior-nurse-staffing-agencies-commercial-insurers-2-4-21.pdf.

[18] 2023 Cost of Caring Report at 3-4.

[19] *Id.* at 4.

[20] *Id.*

[21] *Id.* at 5.

[22] *Id.* at 6.

[23] *Id.* at 5.

[24] Significantly, Medicare and Medicaid reimbursements account for the majority of hospital payments. https://www.aha.org/fact-sheets/2022-05-25-fact-sheet-majority-hospital-payments-dependent-medicare-or-medicaid.

[25] *Id.* at 2.

Unsurprisingly, rapid increases in costs coupled with modest increases in revenue have taken a severe toll on hospitals' financial performance. Eighteen rural hospitals closed in 2020 alone.[26] Over half of U.S. hospitals ended 2022 operating at a loss.[27] This trend has continued into 2023: According to one study, the first quarter of 2023 had the highest number of bond defaults by hospitals in over a decade.[28] According to another study, roughly half of all hospitals had negative operating margins through the end of May.[29]

B. Most hospital mergers and joint ventures offer significant benefits.

Sound merger guidelines must give due weight to a transaction's potential to enhance competition. This means, with respect to mergers involving hospitals or health systems, the guidelines must fairly account for the myriad ways in which mergers or joint ventures allow hospitals to provide quality care at lower cost.

Although the procompetitive benefits of hospital mergers are nothing new,[30] they receive too little attention from the FTC and state enforcers. Hospital mergers (or other forms of affiliation) can improve clinical care while preserving access to care in underserved communities. By joining a health system, a rural or community hospital can better recruit and retain clinical staff and personnel, upgrade its facilities, and offer specialty services to high-touch patients.[31] Acquired hospitals also can increase their investment in technology and equipment.[32]

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[26] University of North Carolina, The Cecil G. Sheps Center for Health Services Research. *Rural Hospital Closures, available at* https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/. Accessed on September 8, 2023.
[27] 2023 Cost of Caring Report..
[28] *Id.*
[29] Kaufman Hall, *National Hospital Flash Report* at 6 (June 2023) (showing negative median operating margins in January and February 2023 and a mediation operating margin just above zero for March, April, and May), *available at* https://www.kaufmanhall.com/sites/default/files/2023-06/National-Hospital-Flash-Report_June-2023.pdf.
[30] *See generally* AHA March 2022 Letter at 2-4 (summarizing research into benefits of hospital mergers).
[31] Testimony of the Am. Hosp. Ass'n for the Subcomm. On Competition Policy, Antitrust, and Consumer Rts. Of the Comm. On the Judiciary of the U.S. Senate, Antitrust Applied: Hospital Consolidation Concerns and Solutions, at 2, 4 (May 19, 2021) (hereinafter "Dr. Hochman Testimony"), *available at* https://www.aha.org/testimony/2021-05-19-ahatestimony-antitrust-applied-hospital-consolidation-concerns-and-solutions.
[32] *Id.* at 3; *see* Sean May, Monica Noether & Ben Sterns, *Hospital Merger Benefits: An Econometric Analysis Revisited* at 1 (Aug. 2021) (hereinafter "Hospital Merger Benefits Revisited"), *available at* https://www.aha.org/system/files/media/file/2021/08/cra-merger-benefits-revisited-0821.pdf.

Hospital mergers also can increase geographic coverage by bringing specialty services to new markets or expanding them in underserved markets.[33] Mergers can improve the quality of care by allowing acquired hospitals to standardize clinical protocols, and by subjecting acquired hospitals to greater accountability for measurable outcomes.[34] Mergers also can facilitate better coordination of care by providing acquired hospitals access to analytics, specialty care and care coordination staff who ensure that patients' needs are met. In addition, larger scale can allow smaller hospitals to adopt risk-bearing alternative payment models.[35] Such models bend the cost curve by focusing on patient outcomes rather than patient volume.[36]

Hospital mergers also can improve patient outcomes and save costs by facilitating synergies in information technology. To give one example, mergers can allow health systems to create or expand data repositories.[37] Access to aggregate clinical data allows providers to perform more sophisticated analyses and implement innovative practices.

Similarly, advanced IT systems provide accurate, real-time information for better diagnoses and treatments. But these systems are out of reach for some hospitals. Integrated health systems, by contrast, have the resources to invest in state-of-the-art IT infrastructure. Hospital mergers can thus expand access to these advanced systems, ensuring that patients of acquired hospitals (regardless of size or location) receive the highest quality of care.

These benefits are quantifiable. One recent study found that hospital mergers led to statistically significant reductions in operating expenses per admission, lower mortality and declines in inpatient readmission rates.[38] Another found that "rural hospital mergers were associated with better mortality outcomes" for several conditions.[39] Yet another study found that nearly 40% of acquired hospitals added one or more services post-

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[33] Kaufman Hall, *Partnerships, Mergers, and Acquisitions Can Provide Benefits to Certain Hospitals and Communities* at 6 (Oct. 2021) (hereinafter "Kaufman Hall Report"), *available at* https://www.aha.org/system/files/media/file/2021/10/KH-AHA-Benefitsof-Hospital-Mergers-Acquisitions-2021-10-08.pdf.

[34] Monica Noether, Sean May & Ben Sterns, *Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis – An Update* at 1 (2019) (hereinafter "Views from Hospital Leaders"), *available at* https://www.aha.org/system/files/media/file/2019/09/cra-report-merger-benefits-2019-f.pdf.

[35] Dr. Hochman Testimony at 4-5; Kaufman Hall Report at 15.

[36] *See generally* Am. Hosp. Ass'n, *Current & Emerging Payment Models* (discussing transition from fee-for-service to value-based payment models), *available at* https://www.aha.org/advocacy/current-and-emerging-payment-models.

[37] Views from Hospital Leaders at 14.

[38] *Id.*

[39] Joanna Jiang et al., *Quality of Care Before and After Mergers and Acquisitions of Rural Hospitals* at 1 (Sept. 20, 2021), *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342.

acquisition, while patients at hospitals acquired by academic medical centers or health systems "also gain[ed] … access to tertiary and quaternary services."[40] Finally, a 2021 study found not only that hospital mergers resulted in a 3.3% reduction in annual operating expenses per admission at acquired hospitals, but that "[r]evenue per admission at acquired hospitals also decline[d] … by a statistically significant 3.7 percent."[41] In other words, acquired hospitals did not just become more efficient; they were able to pass the savings on to patients.[42]

Unsurprisingly, both Agencies have previously recognized that hospital mergers are generally procompetitive. As the Agencies acknowledged in 1996, most hospital mergers "do not present competitive concerns."[43] The Agencies also noted that mergers can "allow the hospitals to realize significant cost savings that could not otherwise be realized."[44] Put simply, the Agencies recognized as early as the 1990s that hospitals mergers present little risk to competition and generate real-world benefits. In this respect at least, the past three decades have proven the Agencies right.

C. Recent enforcement practices reflect a misunderstanding of health care economics, overstating the competitive risk of hospital mergers while underestimating their benefits.

The FTC's enforcement record is difficult to square with the Agencies' prior statements on hospital mergers. As the AHA has noted before,[45] the FTC has been targeting hospitals with aggressive merger enforcement for decades. Between 1990 and 1999, the FTC filed 17 enforcement actions challenging hospital mergers.[46] Following a series of agency losses in the late 1990s, the rate of enforcement dropped during the early 2000s before rebounding — and accelerating — over the past three administrations. Since 2010, the FTC has filed over a dozen lawsuits challenging hospital mergers,

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[40] Kaufman Hall Report at 11.
[41] Hospital Merger Benefits Revisited at 1-2.
[42] *Id.* at 2. Whether commercial insurers actually passed on those savings to their customers appears unlikely considering that industry's rapacious inclinations.
[43] U.S. Dep't of Justice & Fed. Trade Comm'n, 1996 Statements of Antitrust Enforcement Policy in Health Care at 8 (Aug. 1996) (hereinafter "1996 Statements") *available at* https://www.ftc.gov/system/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf.
[44] *Id.* at 10.
[45] AHA Comments to HSR Amendments; *see also* Am. Hosp. Ass'n, Comments from the American Hospital Association on Defects in the Models Used for Evaluating Hospital Transactions (Dec. 14, 2018) (hereinafter "AHA Comments on Model Defects"), *available at* https://www.aha.org/system/files/2018-12/181217-let-ftc-defects-in-models-used-for-evaluating-hospital-transactions.pdf.
[46] Fed. Trade Comm'n, *Overview of FTC Actions in Health Care Services and Products* at 51-71 (Jan. 2023) (hereinafter "FTC Health Care Overview").

including seven in the past three years alone.[47] In at least two other instances since 2010, the FTC closed investigations after the parties (i) abandoned their transaction following staff's recommendation to sue or (ii) settled with a state attorney general.[48] And this Administration has declared hospital mergers to be a priority. As one FTC official recently stated with respect to hospital mergers in particular and health care transactions more generally: "[w]e are feeling invigorated and looking to fulfill [President Biden's] executive order's call to be aggressive on antitrust enforcement."[49]

Regrettably, the FTC has chosen to pursue these cases based on flawed economic models and speculation. In each case noted above, the FTC has focused on maximizing the profitability of commercial insurers, rather than the merger's likely impact on patients or the community at large. But the FTC's mission is not to serve the interests of massive commercial insurance companies; it is to analyze whether a given transaction is likely to harm competition. The FTC's primary economic models are ill-suited to that task.

The FTC employs two types of models when analyzing hospital mergers: demand models and supply models. As the AHA has previously detailed, the FTC's demand models overemphasize patient travel time and ignore other factors that impact consumer demand.[50] As a result, the models do a poor job of predicting consumer preferences for hospitals.[51] And the FTC's supply models, which it uses to estimate price effects, fail at every turn.

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[47] *See id.* (identifying thirteen lawsuits challenging hospital mergers since 2010, including six since 2020); Pet. for Temp. Inj. Relief, *Fed. Trade Comm'n v. La. Children's Med. Ctr.*, No. 23-cv-1103 (D.D.C. Apr. 20, 2023) ECF No. 3 (complaint filed after release of FTC Health Care Overview).

[48] *See* FTC Health Care Overview at 76 (discussing Atrium Health/Houston Healthcare); Press Release, Fed. Trade Comm'n, Statement of the Federal Trade Commission Concerning Its Vote to Close the Investigation of a Proposed Transaction Combining Massachusetts Healthcare Providers (Nov. 29, 2018), *available at* https://www.ftc.gov/news-events/news/press-releases/2018/11/statement-federal-trade-commission-concerning-its-vote-close-investigation-proposed-transaction (discussing CareGroup/Lahey Health/Seacoast/BIDCO). Moreover, in addition to cases involving mergers between hospitals, federal agencies have also challenged a number of transactions between hospitals—or health systems that own hospitals—and other provider groups. *See, e.g.*, *FTC v. Sanford Health*, No. 17-cv-133 (D.N.D. 2017); *In re CentraCare Health*, Dkt. No. C-4594 (FTC 2017); *FTC v. St. Luke's Health Sys.*, No. 13-cv-116 (D. Idaho 2013); *In re Renown Health*, Dkt. No. C-4366 (FTC 2012); *In re Reading Health Sys.*, Dkt. No. 9353 (FTC 2012); *In re Alan B. Miller*, Dkt. No. C-4309 (FTC 2010).

[49] Harris Meyer, *Antitrust Push in Health Care Must Focus on a Merger's 'Human Impact*,*'* KFF Health News (July 18, 2022), *available at* https://kffhealthnews.org/news/article/ftc-interview-antitrust-health-care-hospital-mergers-human-impact/.

[50] AHA Comments on Model Defects at 6-10.

[51] *Id.*

First, the supply models rely on the demand models for critical inputs. The result is "garbage in, garbage out": Because the demand models cannot reliably estimate consumer demand, any supply-side projections based on those demand estimates are equally unreliable.[52] Second, apart from the flawed inputs, the FTC's supply models do not fit the commercial reality of the hospital field. One model (upward pricing pressure) was designed to model price effects in industries where firms set prices; the framework simply does not work when applied to a field in which prices are negotiated with insurers or set by the federal government.[53] The other model estimates a metric — "willingness to pay" — that is not a reliable indicator of post-merger price increases.[54] In short, the FTC attempts to predict price effects using models that (i) rely on flawed inputs, and (ii) are not even designed for the task at hand.

Making matters worse, the FTC recently departed from its historical approach to geographic market definition, creating bad law in at least one federal circuit. For decades, the FTC has consistently defined geographic markets around hospital locations, rather than patient locations.[55] This follows from Section 4.2 of the 2010 Guidelines, which clarifies that geographic markets "based on the locations of suppliers" are appropriate "when customers receive goods or services at suppliers' locations."[56] Markets based on customer location, by contrast, are appropriate when "suppliers deliver their products or services to customers' locations" or suppliers engage in "price discrimination based on customer location."[57] In the context of hospital mergers, these principles all point toward supplier-based markets. Not only do patients receive services at hospitals (as opposed to in their own homes), it would be impracticable, if not impossible, for hospitals to charge different prices to patients from different cities, counties or zip codes.[58] Yet in the *Hackensack Meridian* case,[59] the FTC inexplicably defined markets around patient location. Worse, the FTC prevailed. In adopting the FTC's approach in that case, the Third Circuit noted that the 2010 Guidelines contain "permissive language" about market definition, including the terms "normally," "may,"

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[52] *Id.* at 10-11.
[53] *Id.* at 11.
[54] *Id.* at 12-14.
[55] *E.g.*, Compl. ¶¶ 18-19, *In re ProMedica Health Sys., Inc.*, Dkt. No. 9346 (F.T.C. Jan. 6, 2011) (defining general acute care market around hospital location); Initial Decision ¶ 140, *In re Hosp. Corp. of Am.*, 106 F.T.C. 361, Dkt. 9161 (F.T.C. Oct. 30, 1984) (analyzing geographic market based on hospital location).
[56] U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines* § 4.2.1 (Aug. 19, 2010) (hereinafter "2010 HMG"), *available at* https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf.
[57] *Id.* §§ 4.2, 4.2.2.
[58] Thomas McCarthy & Scott Thomas, *Geographic Market Issues in Hospital Mergers*, *in* ABA Antitrust Section, Health Care Mergers and Acquisitions Handbook 50 (2003) ("The contracts that hospitals negotiate with third-party payors constrain them to charge each payor's patients the same set of prices, regardless of where the patients live or which company the patient works for.").
[59] *Hackensack Meridian*, 30 F.4th at 168.

and "usually." This, the court reasoned, gives the FTC "flexibility" to employ different methods in different cases. Ultimately, the court held that "nothing in the Guidelines states that a customer-based geographic market may be defined *only* through price discrimination."[60]

Respectfully, that misses the point. Regardless of whether the Guidelines contain "permissive language," there remains no principled basis for defining hospital markets around patient location. Hospitals cannot charge different prices based on where a patient lives. And anyone who walks into a hospital receives the same quality of care whether they live a thousand feet or a thousand miles away. Accordingly, patient-based markets — and any resulting market shares — tell us nothing about real-world competition between hospitals.

The approach in *Hackensack Meridian* is thus indefensible for at least two reasons. First, patient-based markets fail the basic purpose of market definition: to "provide a useful framework for evaluating potential harms to competition."[61] Any market shares and concentration statistics based on patient locations are mere abstractions. Because they offer no insights into a transaction's competitive impact, any resulting "presumption" of harm would be arbitrary and untethered to the FTC's ultimate burden of proof. Second, these markets have no limiting principle. Under the methodology employed by the FTC's expert in *Hackensack Meridian*, *any* patient-based market will pass the hypothetical monopolist test.[62] The FTC's approach thus renders the hypothetical monopolist test a meaningless formality.

For years, the FTC has used invalid economic models to analyze competition between hospitals. The agency has now abandoned its longstanding approach to geographic markets, inviting judicial error along the way. The FTC should rethink its approach to hospital mergers. Regrettably, as discussed below, the Draft Merger Guidelines do nothing to right the ship. And as explained in greater detail below, the withdrawal of the Health Care Statements leaves the regulated community lost at sea.

D. Both Agencies have withdrawn critical guidance for the health care industry.

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[60] *Id.* (emphasis added).
[61] 1 ABA ANTITRUST LAW SECTION, ANTITRUST LAW DEVELOPMENTS 603 (9th ed. 2022).
[62] Ken Field & Steven Tenn, *Patients v. Hospitals: Why Define Markets At All if Every Market Satisfies the SNNIP Test?* At 6 (May 2022), *available at* https://media.crai.com/wp-content/uploads/2022/06/08152302/5-PATIENTS-v-HOSPITALS-WHY-DEFINE-MARKETS-AT-ALL-IF-EVERY-MARKET-SATISFIES-THE-SSNIP-TEST-Ken-Field-Steven-Tenn.pdf.

The FTC's pivot in *Hackensack Meridian* is not the Agencies' only recent departure from decades of enforcement practice. In February 2023, the DOJ withdrew a series of joint statements of enforcement policy in health care (the "Health Care Statements" or "Statements"). In so doing, the DOJ asserted it would not replace the Statements with new guidance.[63] Instead, DOJ instructed health care providers to monitor its enforcement actions to divine its current thinking on health care antitrust issues.[64] The FTC followed suit and withdrew the Health Care Statements a few months later.[65]

Withdrawing the Health Care Statements is a troubling step backward. The 1996 Statements, in particular, provided helpful guidance related to mergers and joint ventures among health care providers.[66] Withdrawing these Statements without input from industry participants was reckless.

The Agencies' purported justifications for withdrawing the Health Care Statements do not hold water. In its press release withdrawing the Statements, the FTC argued that "general principles of antitrust enforcement" suffice when analyzing health care competition.[67] But that is a red herring. The 1996 Statements already made clear that the Agencies would analyze health care transactions under "general antitrust principles."[68] The point of industry-specific guidance was not that health care should have a different set of rules; the point was that sound enforcement must "take into account the particular characteristics of health care markets and the rapid changes that are occurring in those markets."[69] That need for industry-specific analysis is no less important today than it was in the 1990s.

The DOJ's explanation for withdrawing the Statements is even less helpful. Claiming the Statements are "overly permissive on certain subjects, such as information sharing," the DOJ asserts that withdrawing them "best serves the interest of transparency with

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[63] Press Release, U.S. Dep't of Justice, Justice Department Withdraws Outdated Enforcement Policy Statements (Feb. 3, 2023), *available at* https://www.justice.gov/opa/pr/justice-department-withdraws-outdated-enforcement-policy-statements.
[64] *Id.*
[65] Press Release, Fed. Trade Comm'n, Federal Trade Commission Withdraws Health Care Enforcement Policy Statements (July 14, 2023), *available at* https://www.ftc.gov/news-events/news/press-releases/2023/07/federal-trade-commission-withdraws-health-care-enforcement-policy-statements. It is exactly this attitude by antitrust officials and the adverse impact it had on health care services that led to the creation of the Statements.
[66] This guidance included a series of safe harbors – i.e., circumstances under which the Agencies would not bring enforcement actions absent extraordinary circumstances. One of those safe harbors related to hospital mergers. In prior correspondence, the AHA asked the Agencies to incorporate this safe harbor into the new merger guidelines given its importance to small hospitals. *See* AHA March 2022 Letter at 8.
[67] *See* Press Release, Fed. Trade Comm'n, *supra* note 64.
[68] 1996 Statements at 3.
[69] *Id.*

respect to the Antitrust Division's enforcement policy in healthcare markets."[70] The DOJ then advises that it prefers a "case-by-case enforcement approach."[71] This doesn't add up. If DOJ believes the Statements are too permissive on information sharing, the solution is to revise the Statements, not withdraw them entirely (including those many aspects of the Statements that had nothing to do with information sharing). The reference to case-by-case enforcement is another red herring, as both Agencies have *always* employed a case-by-case approach to enforcement in health care.[72] And most importantly, withdrawing prior guidance without replacing it is the exact opposite of transparency: It tells those hoping to comply with the antitrust laws precisely nothing about enforcement policy in this industry. It forces the regulated community to guess at the Agencies' next enforcement action, arrogating more power to the Agencies and giving less guidance to the health care markets. While this approach is entirely consistent with the Agencies' apparent anti-merger sentiments discussed above (at 1), it is entirely inconsistent with decades of practice and basic principles of good government.

II. THE DRAFT GUIDELINES PROVIDE NO MEANINGFUL GUIDANCE ABOUT HOSPITAL-RELATED MERGERS.

The Agencies' decision to withdraw the Health Care Statements just begs the question: How should enforcers apply general antitrust principles to an industry that is heavily regulated, involves competition shaped by underfunded nonnegotiable government payments and programs, complex negotiations with commercial payors with market power, and accounts for 18% of gross domestic product (GDP)? Unfortunately, the Draft Guidelines do nothing to answer this question. Making matters worse, they fail to repudiate *Hackensack Meridian* and contain several provisions that, if applied to hospital-related transactions, would foster confusion and deter procompetitive mergers. These include the lower threshold for a structural presumption, the so-called "conglomerate" theories of harm, the skepticism toward efficiencies, and the overly rigid "failing firm" defense.

A. The Draft Guidelines should clearly repudiate the FTC's error in *Hackensack Meridian*.

Like the 2010 Guidelines, the Draft Guidelines address the distinction between geographic markets based on supplier locations versus those based on customer locations. And like the 2010 Guidelines, the Draft Guidelines make clear that (i)

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[70] *See* Press Release, U.S. Dep't of Justice, *supra* note 62.
[71] *Id.*
[72] *E.g.*, 1996 Statements at 47 ("In their case-by-case analysis, the Agencies will look at all the facts and circumstances surrounding the provision of the information . . . .").

supplier-based markets are appropriate where customers travel to the supplier, while (ii) customer-based markets are appropriate where suppliers travel to the customer or can price-discriminate based on customer location.[73] Indeed, the Draft Guidelines arguably draw a sharper distinction between these methods, suggesting that customer-based markets are appropriate only where "targeting based on customer location is feasible."[74] This language, like its analogue in the 2010 Guidelines, suggests that hospital markets must be defined around provider location, not patient location.

In the AHA's view, however, the Draft Guidelines do not go far enough to repudiate the FTC's error in *Hackensack Meridian*. Although the Draft Guidelines arguably require provider-based markets in hospital mergers, so did the 2010 Guidelines. And like the 2010 Guidelines, the Draft Guidelines contain hedging language that could invite judicial confusion. For example, the Draft Guidelines state that supplier-based markets are "often" used when customers receive services at supplier locations, and that customer-based markets "*may sometimes* be defined" when suppliers "deliver their products or services to customers' locations, or tailor terms of trade based on customers' locations."[75] This creates the risk that the FTC may continue to push for patient-based markets in hospital mergers — and the risk that courts may approve this misguided approach.

Having invited the error in *Hackensack Meridian*, the FTC should fix it. The Draft Guidelines should be revised to make clear that, absent evidence of price discrimination based on patient location, the Agencies will continue to define health care markets around provider location.

B. The new concentration thresholds for presumptive harm are far too low for hospital-related transactions.

With respect to the new — and much lower — structural presumption of harm, the AHA shares the criticisms offered by other commenters. In particular, the AHA agrees that the lower concentration thresholds are arbitrary and without basis in modern economics

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[73] *See* Draft Guidelines at 12 (providing that geographic markets based on supplier location "often apply when customers receive goods or services at suppliers' facilities," while markets based on customer location "may sometimes be defined . . . when suppliers deliver their products or services to customers' locations, or tailor terms of trade based on customers' locations").
[74] *Id.*
[75] *Id.* (emphasis added).

or case law. These concerns are shared by other knowledgeable commentators and further underscore why these lower presumptions should not be finalized.[76]

In addition, given the Agencies' narrow approach to defining hospital markets and the patient-based approach in *Hackensack Meridian*, the proposed lower thresholds are downright unworkable. Consider a merger between Hospital A, located in the southern half of a major city, and Hospital B, located in a northern suburb. Hospital A faces competition from four other hospitals within city limits, along with four more hospitals in the southern suburbs. Hospital B mostly competes with a half-dozen hospitals in the northern suburbs, but draws some patients from the northernmost neighborhood in the city. Suppose Hospital A has a 28% share of general acute care services sold to city residents, while Hospital B has a 2% share. Under this scenario, there is no reason to believe the merger would present any risk to competition. Both hospitals continue to face robust competition in their respective service areas. And the fact that Hospital B picks up a small fraction of city residents does not, in any way, imply that these facilities are meaningful competitors.

Under the FTC's traditional, provider-based approach to hospital markets, this merger would not even draw a Second Request. If the relevant market is as narrow as the city, Hospital B would fall outside the market. There would be no horizontal overlap. And if the relevant market were broad enough to include the entire metro area — or even just the city and the northern suburbs — the merged firm would continue to face competition from 10 to 14 other hospitals. Yet under the patient-based approach in *Hackensack Meridian*, coupled with the lower concentration threshold in the Draft Guidelines, this merger would be *presumptively illegal* in a market for general acute care services sold to patients who live in the city.

The lower concentration threshold thus invites gamesmanship by the Agencies. Rather than define markets that would serve as a meaningful lens for analyzing competition, the Agencies will be tempted to define arbitrary markets simply to avail themselves of the presumption.[77] The result is that both market definition and the structural

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[76] *See, e.g.*, Gregory J. Werden, Competition Policy International, Two Bridges Too Far: First Take on the Draft Merger Guidelines (Sept. 5, 2023) (comment by former DOJ economist noting that Draft Guideline 1 has "no basis in experience or economics"), *available at* https://www.pymnts.com/cpi_posts/two-bridges-too-far-first-take-on-the-draft-merger-guidelines/#_ftnref14.

[77] This is no hypothetical concern. In several recent cases, the DOJ and FTC have pursued geographic markets with little bearing on commercial reality, simply because those markets (if valid) would have resulted in a structural presumption. *See, e.g.*, *Fed. Trade Comm'n v. Thomas Jefferson Univ.*, 505 F. Supp. 3d 522, 541-47 (E.D. Pa. 2020) (rejecting proposed geographic markets because payor testimony critical to FTC's argument on commercial reality was "not corroborated by the record evidence"); *see also United States v. U.S. Sugar Corp.*, No. 21-1644, 2022 WL 4544025, at *16 (D. Del. Sept. 28, 2022)

presumption will become, at best, a meaningless abstraction, and at worst, a way for the Agencies to end-run their burden of proof.

C. The guidelines on non-horizontal theories provide no clear guidance about health care transactions.

Three of the Draft Guidelines — Guidelines 5, 6, and 7 — address non-horizontal theories of harm. Guideline 5 addresses mergers that give one firm "control over access to a product, service, or customers that its rivals use to compete." Guideline 6 addresses vertical foreclosure. And Guideline 7 addresses transactions that could extend a dominant position into new markets. The AHA will defer to other commenters with respect to vertical theories. But to the extent the Draft Guidelines are intended to promote so-called "conglomerate" theories of harm,[78] it is unclear whether or how such theories could apply to a hospital merger.

In this regard, the Agencies' silence is telling. It is no secret that the FTC has been exploring "cross-market" effects in hospital mergers, suggesting that even mergers of non-competing hospitals could somehow lead to higher prices.[79] The myriad problems with such a theory are beyond the scope of these comments.[80] What matters here is that, apart from sweeping language about "extending" or "entrenching" a dominant position, the Draft Guidelines largely ignore these novel theories of harm. The Draft Guidelines thus fail in their basic purpose of advising the public how the Agencies intend to enforce Clayton Act § 7.

D. The Draft Guidelines' comments about buy-side markets (including labor markets) are unsupported by case law and economic theory.

The Agencies have long recognized that Clayton Act § 7 applies with equal force to competition between buyers. The 2010 Guidelines, for example, note that mergers of competing buyers "can enhance market power on the buying side of the market, just as mergers of competing sellers can enhance market power on the selling side of the

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("[B]oth of the Government's proposed geographic markets are too narrow and ignore the commercial realities that exist in the U.S. with regard to sugar supply, namely that sugar flows freely throughout the country."), *aff'd*, 73 F.4th 197 (3d Cir. 2023).

[78] *See* Draft Guidelines at 21 (noting potential for merged firm to use "tying, bundling, conditioning, or other linkage of … two products" to "extend the firm's dominant position").

[79] *See* U.S. Dep't of Justice & Fed. Trade Comm'n, *supra* note 5, at 5, 7.

[80] For an examination of several flaws in the FTC's "cross-market" theories, *see* David A. Argue & Lona Fowdur, *An Examination of New Theories on Price Effects of Cross-Market Hospital Mergers*, *available at* https://www.aha.org/position-paper/2021-05-10-examination-new-theories-price-effects-cross-market-hospital-mergers.

market."[81] Draft Guideline 11 retains this theory but departs from prior Agency practice in at least two ways: first, by suggesting that buy-side harm is more likely than sell-side harm; and second, by focusing on harm in labor markets. Neither change is justified.

Throughout prior administrations, the Agencies have consistently applied the "mirror-image" principle to buy-side theories. Under this principle, buy-side claims are governed by "similar legal standards" as sell-side claims.[82] Thus, when analyzing a merger of competing buyers, the Agencies have employed "essentially the [same] framework" used when "evaluating whether a merger is likely to enhance market power on the selling side of the market."[83]

The Antitrust Division followed this approach faithfully in *Anthem-Cigna*. In that case, the DOJ challenged a merger of commercial health insurers using the "mirror image" of the FTC's approach to hospital mergers: *i.e*., much like the FTC asks whether a hospital merger would give the hospitals "substantially increased leverage" they could use to "extract higher reimbursement rates from insurers," the DOJ analyzed whether the merger of two giant insurers would give them "substantially increased leverage to extract lower reimbursement rates from hospitals."[84] The DOJ also investigated non-price theories of harm, finding that the merged firm would have reduced incentives to collaborate and share economic risk with hospitals.[85] Ultimately, the DOJ determined that the proposed merger violated the Clayton Act in at least 35 upstream markets.[86]

The DOJ was right to be concerned about insurer monopsonists. As the trial record in *Anthem-Cigna* confirmed, when forced to compete with each other, commercial insurers are far more likely to collaborate with providers and support innovations designed to bend the cost curve.[87] And when insulated from competition, as Anthem expected to be, insurers focus on driving down reimbursement rates at all costs, hoping to capture any resulting "savings" for themselves (as opposed to sharing those savings with the employers and employees who buy their insurance).[88]

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[81] 2010 HMG § 12.
[82] DOJ Buy-Side Mem. at 5, *United States v. Anthem, Inc.*, No. 1:16-cv-01493, ECF No. 410.
[83] 2010 HMG § 12.
[84] DOJ Buy-Side Mem. at 6.
[85] Pls.' Proposed Findings of Fact: Phase II 150-159, *United States v. Anthem, Inc.*, No. 1:16-cv-01493 (D.D.C. Jan. 17, 2017).
[86] *Id.* 132-147.
[87] *Id.* 150-156.
[88] *See United States v. Anthem, Inc.*, 855 F.3d 345, 362 (D.C. Cir. 2017) ("The district court highlighted internal Anthem documents that discussed ways to keep those savings for itself, in particular where Anthem listed seven alternatives with 100% pass-through to ASO customers considered last.").

The Draft Guidelines' comments about buy-side competition, however, go too far. As an initial matter, the Agencies have no basis for claiming the bar should be lower for buy-side harm. The 2010 Guidelines recognized that, although similar legal standards apply to buy-side cases, market power on the buying side "is not a significant concern" if suppliers have "numerous attractive outlets for their goods or services."[89] This statement was not pulled from thin air; it reflected the Agencies' combined wisdom from decades of merger enforcement. Yet the Agencies now claim that "[t]he level of concentration at which competition concerns arise may be *lower* in buyer markets than in seller markets."[90] They offer no economic or legal support for this about-face.

The Agencies also err by excessively focusing on labor markets. Despite all of its rhetoric, the Draft Guidelines do not identify any real-world evidence that mergers or acquisitions present a meaningful risk of harm to workers. Instead, the guidelines focus on theoretical concerns, such as switching costs and geographic constraints, that the Agencies claim might "exacerbate the competitive effects of a merger between competing employers."[91] But these concerns are by no means unique to labor markets. To the contrary, they are present in many downstream markets, and there is no reason to believe competition for labor is any less vigorous than competition to sell goods or services. Indeed, there is at least one good reason to find the opposite: As the Agencies pronounce elsewhere, the set of relevant competitors in labor markets is often broader than in downstream markets.[92]

The Agencies' new focus on labor competition is even less credible with respect to hospital mergers. It is well-documented that hospitals face severe staffing shortages.[93] As a result, hospitals are paying higher wages to their own employees; they also are forced to pay exorbitant rates to outside staffing agencies.[94] The notion that a hospital could act as a monopsonist, choosing to hire even fewer practitioners, bears no relation to the real world. Moreover, as the AHA noted in its comments to the proposed HSR amendments, it is inconceivable that a hospital merger could harm competition for labor without also presenting risk in a traditional downstream market. The Agencies' focus in health care transactions should therefore be on competition to sell health care services, rather than on labor concerns that exist only in theory.

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[89] 2010 HMG § 12.
[90] Draft Guidelines at 25 (emphasis added).
[91] *Id.* at 26.
[92] U.S. Dep't of Justice & Fed. Trade Comm'n, *Antitrust Guidance for Human Resource Professionals* at 2 (Oct. 2016) ("[F]irms that compete to hire or retain employees are competitors in the employment marketplace, regardless of whether the firms make the same products or compete to provide the same services."), *available at* https://www.justice.gov/atr/file/903511/download.
[93] 2023 Cost of Caring Report at 1.
[94] *Id.* at 2-3.

E. The Draft Guidelines undervalue efficiencies.

Mergers can promote competition by making the parties more efficient. As the Agencies recognized in the 2010 Guidelines, efficiencies can "enhance the merged firm's ability and incentive to compete," resulting in "lower prices, improved quality, enhanced service, or new products."[95] Merger-generated efficiencies may increase competition "by permitting two ineffective competitors to form a more effective competitor, e.g., by combining complementary assets." They also can increase competition by reducing or reversing "any increases in the merged firm's incentive to elevate price," by "enhancing the incentive of a maverick to lower price," or by "creating a new maverick firm."[96] Thus, the Agencies have long-recognized that a complete analysis under § 7 must account for merger-specific efficiencies.

Despite the fact that mergers can promote competition, the Draft Guidelines contain several provisions suggesting a deep skepticism toward the efficiencies defense. The Agencies appear to believe that efficiencies are (1) often speculative; (2) rarely passed through to customers; and (3) in some cases may even be anticompetitive. Indeed, the Agencies seem more concerned with protecting the merged firm's "trading partners" than with ensuring a merger does not harm consumer welfare.[97] The Draft Guidelines thus raise serious questions about whether the Agencies will give any weight to efficiencies whatsoever.

Even more troubling, the Agencies' proposed efficiencies framework is vague and unworkable. Under the 2010 Guidelines, the standard was clear: Cost savings do not count if they arise from an anticompetitive reduction in output or service. This makes sense. If a merger is procompetitive, economic theory suggests it will lead to increased output; if a merger is anticompetitive, economic theory suggests the opposite. Framing the efficiencies inquiry in terms of output thus tracks the ultimate question the Agencies must answer. Under the Draft Guidelines, by contrast, the Agencies examine whether a claimed efficiency would "result from the anticompetitive worsening of terms."[98] This merely begs the question: When is a "worsening of terms" anticompetitive? If the answer is simply "when it results from a reduction in output or service," then the Agencies should stick with the language in the 2010 Guidelines. And if the answer is something else, then the Agencies need to explain the other circumstances in which a "worsening of terms" could somehow be anticompetitive. At a minimum, this addition does not lend itself to easy quantification and, like other aspects of the Draft Guidelines,

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[95] 2010 HMG § 10.
[96] *Id.*
[97] Draft Guidelines at 34.
[98] *Id.*

serves only to give the Agencies maximum flexibility while creating uncertainty for merging parties.

The Draft Guidelines also suggest that the efficiencies defense is illusory. According to Section IV.3, efficiencies count only if they are passed through to customers. Yet at the same time, efficiencies do *not* count if they "will accelerate a trend toward concentration (see Guideline 8) or vertical integration (see Guideline 6)."[99] This presents merging parties with a no-win situation. On one hand, they must show that cost savings will lead to lower prices; on the other hand, if those lower prices would help them gain share at the expense of smaller rivals, the merger could violate Guideline 8. The result is a framework in which efficiencies count only if the merged firm has a relatively small combined share — that is, if the merger presents minimal risk to competition in the first place.

This is especially problematic for hospitals. Efficiencies in the form of lower costs and improved quality are key drivers of hospital mergers. These efficiencies create tremendous benefits that are achievable only through full financial integration of hospitals.[100] Yet under the Draft Guidelines, merging hospitals could be penalized for these benefits to the extent they would make the combined firm a more formidable competitor. Such a perverse outcome would undermine the entire point of the antitrust laws.

F. As in the 2010 Guidelines, the Agencies' approach to financially distressed firms fails to confront the economic realities of the hospital field.

Lastly, the Draft Guidelines provide the Agencies with insufficient flexibility to consider evidence of financial distress. As noted above, the hospital field is in an economic tailspin. Many hospitals are losing money; many others are struggling to break even. And for at least some of these hospitals, a strategic transaction may be the only path forward. But rather than confront this economic reality, as in the 2010 Guidelines, the Agencies pretend that a merging party's financial plight is relevant only as an affirmative defense.[101]

This approach conflates the standard of proof at trial with the question of whether the Agencies should sue in the first place. Regardless of who must prove what in court, the

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[99] *Id.*
[100] Kaufman Hall Report at 5.
[101] *See* Draft Guidelines at 31 ("When merging parties suggest the weak or weakening financial position of one of the merging parties will prevent a lessening of competition, the Agencies examine that evidence under the 'failing firm' defense established by the Supreme Court.").

Agencies' mandate is to analyze a transaction's likely effects (if any) on competition. Absent credible evidence that a transaction will, in fact, harm competition, the Agencies should decline to take enforcement action. Any suggestion to the contrary would contravene both sound public policy and the plain text of Section 7.

Compounding the problem, under the Agencies' approach to the failing firm defense, a business must wait until it is on the brink of collapse before pursuing a merger.[102] This is especially problematic when applied to hospital mergers. To state the obvious, we need hospitals to stay open. But staying open is not good enough. We need hospitals to thrive: to improve the quality of care; to attract and retain staff; to invest in necessary equipment; and to collaborate with payors to bend the cost curve. These all require investment and commitment, both by hospitals and by third parties (including payors). But this is not possible under the shadow of impending failure, and it is unfair to patients and communities to insist that hospitals be pushed to the brink before they can attract a merger partner.

The Draft Guidelines should thus provide sufficient flexibility for the Agencies to assess the likely effects of a merger. Where the evidence shows that a financially distressed party's past or current market shares do not reflect its future competitive significance, the Agencies should give such evidence due weight, regardless of whether the party can thoroughly prove each element of the failing firm defense. This does not require the Agencies to set aside Supreme Court precedent about the failing firm defense. All it asks is for the Agencies to apply common sense and sound policy judgment when choosing which cases to bring.

III. CONCLUSION

The Draft Guidelines fail to address severe problems in the FTC's approach to hospital mergers, while leaving hospitals and health systems in the dark on several key issues. More generally, the Draft Guidelines seek to effect drastic (and unnecessary) change to merger enforcement generally, turning back the clock on decades of court precedent and advances in economic analysis. A general counsel advising her CEO about a potential merger could not provide sound advice based on these Draft Guidelines. And a law clerk who handed her federal judge a copy of the Draft Guidelines would be laughed out of chambers for completely disregarding modern case law and citing concurrences as controlling law.[103]

For these reasons, the only possible explanation for the Draft Guidelines is that they are designed to give the Agencies maximum enforcement flexibility, with the resultant effect

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[102] *See id.* ("The Agencies typically look for evidence in support of this element that the allegedly failing firm would be unable to meet its financial obligations in the near future.").
[103] *See supra* at 1 (discussing Draft Guidelines at 11 (citing *United States v. Falstaff Brewing Corp*., 410 U.S. 526, 559 n.13 (1973) (Marshall, J., concurring))).

that they provide only minimal direction to the public and regulated communities. America's health care system — and the millions of patients it serves every day — deserve better. The Agencies should go back to the drawing board and rewrite the Draft Guidelines with a focus on opportunities for incremental improvement.

Sincerely

/s/

Melinda Hatton
General Counsel and Secretary