Federal Trade Commission Staff Submission to New York State Health Department Regarding the Certificate of Public Advantage Application of State University of New York Upstate Medical University and Crouse Health System, Inc.

Pursuant to New York Public Health Law Article 29-F and
Rules implemented thereunder at 10 NYCRR Subpart 83-2 *et seq.*

PUBLIC VERSION (REDACTED)
October 7, 2022

Bureau of Competition
Bureau of Economics
Office of Policy Planning

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The staff of the Federal Trade Commission's ("FTC") Bureau of Competition, Bureau of Economics, and Office of Policy Planning (collectively, "FTC staff")[1] respectfully submits this public comment regarding the Certificate of Public Advantage application ("COPA Application") submitted by State University of New York Upstate Medical University ("SUNY Upstate") and Crouse Health System, Inc. ("Crouse") (collectively, the "Parties") to the New York State Department of Health ("NY DOH")[2] pursuant to New York Public Health Law Article 29-F.[3] This comment supplements the information we sent to the NY DOH on August 17, 2022, which included an FTC staff policy paper describing empirical support for the FTC's long-standing concerns with COPA legislation.[4] We appreciate the opportunity to present our views on SUNY Upstate's proposed acquisition of Crouse (also referred to as "proposed merger") in connection with the NY DOH's review of their COPA Application.

I. Executive Summary

FTC staff submits this comment to express our concern that the proposed merger presents substantial risk of serious competitive and consumer harm in the form of higher healthcare costs, lower quality, reduced innovation, reduced access to care, and depressed wages for hospital employees. Applying the standard of the New York COPA Act and Regulations, there is not sufficient evidence to conclude that the potential harms are likely to be outweighed by the potential benefits of the merger. Furthermore, it is doubtful that the regulatory conditions imposed by the NY DOH would effectively mitigate all of the potential anticompetitive harms to patients in the Syracuse area – both in the short term and in the decades to come.

The New York state legislature passed the New York COPA Act allowing collaborations among healthcare providers, including hospital mergers, with an ultimate aim "to promote improved quality and efficiency of, and access to, health care services and to promote improved clinical outcomes to the residents of New York."[5] However, supplanting competition with a COPA regulatory scheme that shields specific hospital transactions from vigorous antitrust enforcement and allows for anticompetitive provider consolidation in highly concentrated markets likely undermines these laudable goals. As discussed below, competition has proven to

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[1] These comments express the views of the FTC's Bureau of Competition, Bureau of Economics, and Office of Policy Planning. These comments do not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.
[2] Application for Certificate of Public Advantage Submitted by SUNY Upstate and Crouse to New York State Department of Health (posted Aug. 10, 2022).
[3] New York Public Health Law, Chapter 45, Article 29-F, §§ 2999-aa, 2999-bb, Improved Integration of Health Care and Financing [hereinafter New York COPA Act]. *See also* 10 NYCRR Subpart 83-2 *et seq.*, Certificate of Public Advantage (effective Dec. 17, 2014), https://regs health.ny.gov/content/subpart-83-2-certificate-public-advantage [hereinafter New York COPA Regulations].
[4] *See* Federal Trade Commission, *FTC Policy Perspectives on Certificates of Public Advantage* (Aug. 15, 2022) and *Key COPA Facts*, both available at www.ftc.gov/copa (Attachment A). FTC staff had previously raised concerns with COPA applications submitted to the NY DOH under the Delivery System Reform Incentive Payment program. *See* FTC Staff Comment to New York State Department of Health Regarding DSRIP COPA Applications, https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-center-health-care-policy-resource-development-office-primary-care-health-systems/150422newyorkhealth.pdf (Apr. 22, 2015).
[5] New York COPA Act § 2999-aa.

be a more reliable and effective mechanism for controlling healthcare costs while preserving quality of care.

New York has engaged in statewide initiatives to reduce excess hospital bed capacity, consolidate competing healthcare services, and encourage collaboration and clinical integration among healthcare providers. FTC staff understands that, per the recommendations of the Commission on Health Care Facilities in the 21st Century (also known as the "Berger Commission"), SUNY Upstate and Crouse already entered an Affiliation and Collaborative Agreement, which required joint planning and service sharing under the supervision of the NY DOH.[6] In addition, it is our understanding that SUNY Upstate and Crouse were jointly involved in the Delivery System Reform Incentive Payment ("DSRIP") program, as members of the Central New York Care Collaborative Performing Provider System, which encouraged collaboration among competing healthcare providers under the supervision of the NY DOH to improve New York's Medicaid program.[7] Indeed, the NY DOH appears to have invested substantial time and resources to implement these healthcare delivery reform initiatives, which granted significant public funding for participating healthcare providers, including SUNY Upstate and Crouse.[8] With the Parties already participating in state programs designed to reduce costs and improve quality and accessibility, we question whether a full merger between the Parties under the NY DOH's supervision would confer meaningful benefits that could not already be achieved through these prior initiatives or other less restrictive alternatives that do not permanently eliminate close competition.

FTC staff's concerns detailed in this submission are based on our assessment to date of the proposed merger and the limited information available,[9] applying the analytical framework described in the *Horizontal Merger Guidelines* ("*Merger Guidelines*") that antitrust agencies, state courts, and federal courts use to evaluate mergers.[10] We have conducted preliminary evaluations of both the potential harm to patients and employees from the loss of competition as well as the potential benefits, including clinical quality benefits and cost savings, that the Parties claim they will be able to achieve through the proposed merger. The NY DOH considers these

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[6] *See* New York State Department of Health, REPORT ON THE IMPLEMENTATION OF THE REPORT OF THE COMMISSION ON HEALTH CARE FACILITIES IN THE TWENTY-FIRST CENTURY at 65-66, https://www health.ny.gov/facilities/commission/docs/implementation_of_the_report_of_the_commission.pdf (describing the Affiliation and Collaborative Agreement between SUNY Upstate and Crouse).

[7] *See* New York State Department of Health, *Delivery System Reform Incentive Payment (DSRIP) Program*, https://www health.ny.gov/health_care/medicaid/redesign/dsrip/index.htm.

[8] *See, e.g.*, New York State Department of Health, *Central New York Care Collaborative, Inc.*, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/county/co_cny htm (stating that the CNYCC received total DSRIP award dollars in excess of $323 million from 2015 through 2020); New York State Department of Health, *NYS DSRIP Quarterly Reports* (2014-2020), https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/quarterly_reports htm (indicating that the CNYCC may have received total DSRIP related funding in excess of $500 million from 2014 through 2020).

[9] Despite requests from FTC staff to the Parties seeking detailed information typical for evaluating a transaction of this magnitude, the Parties have not supplied any information to the FTC.

[10] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES (2010), https://www ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf [hereinafter *Merger Guidelines*]. As discussed further in Section II, if the Commission were to challenge a merger in court, the FTC would follow the legal standard in Section 7 of the Clayton Act.

same factors when reviewing COPA applications. Thus, the goals of our analysis are closely aligned with the analysis that the NY DOH will undertake. For ease of reference, we present our analysis using the specific review factors contained in the New York COPA Regulations. [11]

Competition between SUNY Upstate and Crouse appears to benefit area patients and employers, by enabling health insurers to negotiate lower hospital reimbursement rates (i.e., prices) on behalf of their customers. This competition ultimately reduces the prices that patients must pay in premiums, copayments, deductibles, and other out-of-pocket expenses. Furthermore, competition between the Parties likely improves healthcare quality, as well as the availability of services and new healthcare technologies, as the hospitals compete to attract patients to their respective systems. This competition likely also results in optimal wages and benefits for hospital employees. FTC staff has interviewed numerous market stakeholders who expressed concerns that the proposed merger between SUNY Upstate and Crouse will lead to higher prices and reduced quality of care, reduced access to healthcare services, and worsened working conditions and wages for hospital employees.

FTC staff's quantitative economic analyses confirm that SUNY Upstate competes closely with Crouse, and that the proposed merger will result in high market shares. To measure the degree of lost competition likely to result from the proposed merger, we calculated diversion ratios to estimate the extent to which patients view SUNY Upstate and Crouse as substitutes. The diversion ratios show a high degree of substitutability – i.e., extremely close competition – between SUNY Upstate and Crouse. More than 35% of each hospital's patients view the other merging party as their next best choice. Diversion ratios of this magnitude indicate that the proposed merger would likely lead to significant price increases, as well as reduced business incentives to maintain or improve quality. [12] FTC staff also estimates that post-merger, SUNY Upstate and Crouse would have a combined share of greater than 45% of commercially insured inpatient hospital services in the Primary Service Area ("PSA"), which would increase market concentration to a level that triggers a legal presumption of significant anticompetitive effects. And in Onondaga County, where the effects of the proposed merger likely would be felt most acutely by patients, the Parties would have a combined share of nearly 67% of commercially insured inpatient hospital services. [13]

The Parties assert that the merger would "create a coordinated, highly integrated system with the objective of improving quality of care, increasing access to care, and lowering the costs of health care in the communities served by the Parties." [14] The Parties, however, have not provided sufficient information to substantiate many of these claims, nor have they demonstrated that the claimed benefits and cost savings would offset the merger's substantial harm to competition. Moreover, the proposed merger does not appear necessary to achieve many of these

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[11] NY COPA Regulations § 83-2.5, https://regs.health.ny.gov/content/section-83-25-review-process.
[12] *See* Section V.A.3 for further discussion of diversion ratios.
[13] *See* Section V.A.4 for further discussion of market shares and concentration analyses. In the COPA Application, the Parties refer to a 17-county area as "Central New York" and inaccurately assert that this constitutes the PSA. FTC staff does not believe this broad of an area constitutes either the PSA or a relevant geographic market for antitrust purposes. *See* Section V.A.2 for further discussion of the PSA.
[14] COPA Application at 41.

claimed benefits, which may be realized through arrangements that are less restrictive to competition.

To the extent that the COPA must offer public advantages in order to be approved, the impact of the proposed merger on employee pay and benefits may be relevant to the NY DOH's review.[15] Consider, for example, the likelihood that the proposed merger will depress wage growth for registered nurses and respiratory therapists due to increased employer consolidation. Consolidation of these systems may also leave certain healthcare professionals with fewer employment and training opportunities. Furthermore, any wage depression resulting from the merger may exacerbate the current challenges of recruiting and retaining healthcare professionals in this region.

The Parties propose some conditions that they claim will limit the potential for any unintended negative consequences.[16] These conditions are vague and unenforceable, and appear to be nothing more than aspirational goals that fall short of the types of "conduct remedies" that other state health authorities have attempted as part of COPA oversight.[17] Furthermore, the Parties suggest that filing an Annual Performance Report and developing a framework for measuring progress *after* the COPA is approved will constitute sufficient monitoring and supervision. Such an *ex-post* framework is unlikely to hold the Parties accountable or mitigate the potential disadvantages or anticompetitive effects associated with the proposed merger.

Finally, we note our concern about the lack of transparency surrounding this COPA process.[18] The COPA Application has not yet been made readily available to the public. The FTC has found that it benefits from broad stakeholder input, and has reason to believe the NY DOH would benefit from such input as well. This is particularly true given the significant impact this merger is likely to have on the delivery of healthcare services in the region. Based on the foregoing reasons which are fully supported below, we urge the NY DOH to deny the Parties' COPA Application.

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[15] *See* Section V.C for further discussion of wage effects.
[16] *See* COPA Application at 69.
[17] *See* Section VII for further discussion of the Parties' proposed conditions and conduct remedies more generally. In merger challenges, the FTC prefers "structural remedies" (*i.e.*, an injunction preventing consummation of a merger or a divestiture of assets) rather than "conduct remedies" (*i.e.*, restrictions intended to regulate the conduct of a merged firm).
[18] *See, e.g.*, James Mulder, *SUNY Upstate Hides Huge Amounts of Information About Merger With Crouse*, Syracuse.com (Aug. 25, 2022), https://www.syracuse.com/health/2022/08/suny-upstate-hiding-huge-amounts-of-information-about-merger-with-crouse html; James Mulder, *SUNY Upstate, Crouse Officials Stay Mum on Biggest Hospital Merger in Syracuse History*, Syracuse.com (Aug. 26, 2022), https://www.syracuse.com/health/2022/04/suny-upstate-crouse-officials-stay-mum-on-biggest-hospital-merger-in-syracuse-history html.

II. FTC's Interest and Experience

The FTC's mission includes promoting fair competition in healthcare markets that will benefit patients, hospital employees, and the public at large.[19] To carry out this mission, Congress has charged the FTC with enforcing the Clayton Act, which prohibits mergers and acquisitions that may substantially lessen competition or tend to create a monopoly.[20] In addition, the FTC enforces the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[21] Pursuant to its statutory mandate, the FTC seeks to identify mergers and acquisitions, business practices, laws, and regulations that may lessen competition.

Vigorous competition among healthcare providers in an open marketplace provides patients with the benefits of lower prices, higher quality, greater access, innovation for goods and services, and improved wages and benefits for employees.[22] Anticompetitive mergers and conduct in healthcare markets have long been a focus of FTC law enforcement, research, and advocacy.[23] A critical part of the FTC's role in protecting the public is reviewing proposed mergers and acquisitions in the healthcare industry. The FTC has considerable experience in evaluating proposed hospital, outpatient facility, and physician group mergers, to determine whether they may substantially lessen competition.[24]

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[19] Commissioner Wilson has reservations regarding the use of "fair competition" rather than "competition." Although there may be a future debate regarding the differences between "fair competition" and "unfair methods of competition," the substance of today's comment is not impacted by this distinction.

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

[21] *Id*.

[22] *See* Nat'l Soc. of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978) (The antitrust laws reflect "a legislative judgment that, ultimately, competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain – quality, service, safety, and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[23] *See, e.g.*, FED. TRADE COMM'N, *Competition in the Health Care Marketplace*, https://www ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care; FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2022), https://www ftc.gov/system/files/ftc_gov/pdf/2022.04.08%20Overview%20Healthcare%20%28final%29.pdf; Joseph Farrell, Paul A. Pautler & Michael G. Vita, Fed. Trade Comm'n, *Economics at the FTC: Retrospective Merger Analysis with a Focus on Hospitals,* 35 REV. INDUS. ORG. 369 (2009), http://link.springer.com/content/pdf/10.1007%2Fs11151-009-9231-2.pdf; FED. TRADE COMM'N, *Examining Health Care Competition*, (Mar. 20-21, 2014), https://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition; FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *Examining Health Care Competition*, (Feb. 24-25, 2015), https://www ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition. These workshops focused on the competition implications of various issues that are central to healthcare reform, including the challenges of measuring healthcare quality, as well as evolving healthcare provider and payment models. The workshop record suggests that neither a transition to value-based payment models nor improved population health management require anticompetitive levels of provider consolidation. *See also* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf [hereinafter DOSE OF COMPETITION REPORT].

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

The FTC advocates against the use of COPAs through comments and testimony submitted to state legislators and other stakeholders due to concerns that COPAs may enable activity that would substantially reduce competition.[25] In 2017, the FTC announced a policy project to assess the impact of COPAs on prices, quality, access, and innovation for healthcare services.[26] This project has included empirical research of past COPAs, a public workshop highlighting practical experiences with COPAs and related policy considerations, and an ongoing study of recently approved COPAs.[27]

FTC staff recently released a paper, *FTC Policy Perspectives on Certificates of Public Advantage*, and a brief information sheet, *Key COPA Facts*, which summarize empirical research on COPAs approved in other states and findings from our COPA assessment policy project.[28] In particular, we have learned that COPAs can be difficult to monitor and regulate over a long period, and that COPA oversight regimes are not always successful in mitigating price and quality harms resulting from a loss in competition. Indeed, several COPAs have resulted in substantial price increases for patients, as well as declines in quality of care. Furthermore, when COPA oversight is removed, the risk of price and quality harms increases significantly.

III. FTC Evaluates Healthcare Mergers Similarly to the Approach Outlined in the New York COPA Act and Regulations

The FTC's goal to promote fair competition in healthcare markets for patients, employees, and the public at large is similar to the NY DOH's mission to "protect, improve and promote the health, productivity and wellbeing of all New Yorkers."[29] Likewise, the approach that the NY DOH must use to review a COPA application is similar to the approach FTC staff uses to review hospital mergers.

The New York COPA Act describes a state policy "to encourage, where appropriate, cooperative, collaborative and integrative arrangements including but not limited to, mergers and

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

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

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

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

[29] New York State Department of Health, *About the New York State Department of Health: Mission, Vision and Values*, https://www health ny.gov/about/ (last accessed Aug. 17, 2022).

acquisitions among health care providers . . . under the active supervision of the [NY DOH] commissioner . . . where the benefits of such active supervision, arrangements and actions of the commissioner outweigh any disadvantages likely to result from a reduction of competition."[30] The NY DOH promulgated regulations to implement the New York COPA Act, which lay out several factors to be considered when reviewing COPA applications, including: the financial condition of the hospitals, the competitive dynamics of the relevant geographic area, the potential benefits and disadvantages of the COPA, and whether there are less restrictive alternatives that would result in a more favorable balance of the potential benefits and disadvantages.[31]

The FTC and U.S. Department of Justice ("DOJ") have jointly issued *Merger Guidelines* that outline the analytical framework used by the antitrust agencies to evaluate the competitive impact of a proposed merger. These guidelines reflect experience in analyzing a wide variety of mergers – including many hospital and other healthcare-related mergers, both proposed and consummated – as well as economic and other relevant research. Federal and state courts routinely rely on the *Merger Guidelines* framework to analyze the likely competitive effects of a proposed hospital merger. Ultimately, as stated in the *Merger Guidelines*, the "Agencies seek to identify and challenge competitively harmful mergers while avoiding unnecessary interference with mergers that are either competitively beneficial or neutral."[32]

When reviewing a proposed hospital merger, FTC staff devotes significant resources to understand the transaction's potential efficiencies and other benefits (e.g., lower costs, improved quality, capacity expansion, entry into new treatment areas), as well as its potential competitive harm (e.g., higher prices, reduced quality, less access to care, and depressed wages). Some hospital mergers, including those that raise competitive concerns, may yield meaningful clinical quality improvements, cost savings, and other benefits that might not be possible without the merger. Taking this into account, FTC staff's merger analysis typically includes a thorough assessment of the potential efficiencies and other benefits, as well as the disadvantages and harms resulting from a reduction in competition.

FTC staff has an ongoing investigation of the proposed merger. As is customary in our investigations of hospital mergers, a team of attorneys, economists, and financial analysts has interviewed market participants and stakeholders, including health insurers, employers, physician practices, trade groups, unions, and other affected entities. We have performed economic analyses using hospital discharge data and a labor market analysis. To the extent we have been able to access relevant information,[33] we have considered the financial condition of the hospitals, as well as some of the potential clinical quality benefits and cost savings that the Parties claim

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[30] New York COPA Act § 2999-aa. *See also* NY COPA Regulations § 83-2.6 (stating that the NY DOH "may issue a Certificate of Public Advantage for the Cooperative Agreement or planning process, if it determines that the benefits likely to result from the Agreement or planning process outweigh the disadvantages.").
[31] *See* New York COPA Regulations § 83-2.5, https://regs.health.ny.gov/content/section-83-25-review-process.
[32] *Merger Guidelines* § 1.
[33] FTC staff has issued Civil Investigative Demands to the Parties and requested information that would allow us to assess the proposed merger and the claims they make in their COPA Application, but they have not been forthcoming with this information to date.

they will be able to achieve through the proposed merger. Although our investigation is ongoing and the FTC is prohibited from disclosing confidential information obtained during an investigation, we are nonetheless able to provide an initial assessment of the proposed merger based on public sources. Our assessment is also supported by non-public data and information that we have obtained and reviewed. It is important to provide this assessment now, even though our investigation is still underway, to meet the NY DOH's public comment period deadline.

With this context in place, we next present FTC staff's assessment of the factors that the NY DOH must consider under the New York COPA Regulations.

IV. Parties Have Not Adequately Shown the COPA Is Necessary to Prevent a Cessation of Operations or Elimination of Services Due to Financial Distress

> ***NY DOH COPA FACTOR (a):*** *The financial condition of the Parties to the Cooperative Agreement, including whether any health care provider party is experiencing financial distress and may be forced to cease operations or eliminate a service in the absence of the Cooperative Agreement*

ASSESSMENT: The Parties have asserted that the proposed merger is necessary to preserve Crouse's assets in the market, and that without the merger, [redacted] the Parties may have to eliminate some services due to financial distress.[34] After reviewing the financial documents provided by the Parties in the COPA and Certificate of Need ("CON") Applications, [redacted], there likely are alternative ways for it to continue operations that would not require a merger with SUNY Upstate. Such a determination would require further documentation and information, as we have described below. Based on the information provided to date, however, the Parties have not made a convincing case that this merger is necessary to prevent a cessation of operations or elimination of services. [redacted]

The FTC's financial analysts rely on a comprehensive approach when assessing an entity's financial condition and viability, which includes a review of standard documentation that is customary for such an analysis, as well as any additional materials that may provide adequate support for assertions made by the Parties. Such documentation typically includes, but is not limited to, audited financial statements for the past several years including all notes and

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[34] *See* [redacted] *See also* Public Community Discussions on the SUNY Upstate/Crouse Acquisition (Aug. 15 and 18, 2022) (comments of Patrick Mannion, Crouse Health Board Chair); James Mulder, *Upstate, Crouse Hospital Officials Reveal Financial Details of Proposed Merger*, SYRACUSE.COM (Aug. 15, 2022) (describing Crouse's financial liabilities and quoting Crouse's Chair: "Crouse's board of directors began talking about finding a merger partner 10 years ago to ensure the hospital could survive over the long term without eliminating some of its specialized services like the neonatal intensive care unit.").

[35] [redacted]

attachments, year-to-date unaudited financial statements, operating and capital budgets/projections, valuation and liquidation analyses, synergy/efficiencies analyses, reorganization/restructuring plans, closure or service reduction plans, loan documents, correspondence with creditors including any applicable covenant compliance certificates and waivers, and all relevant documentation regarding any recent efforts undertaken to divest or sell assets, issue debt and obtain funding from investors, establish strategic partnerships and find alternative (less anti-competitive) purchasers than the proposed merger. Follow-up requests for additional information and meetings or calls to discuss such materials are a typical part of the review process. The FTC often utilizes formal requests such as Civil Investigative Demands to obtain these materials and any additional documentation needed for its investigations.

Based on the FTC staff's review of the materials provided in the COPA Application and CON Application, significantly more information is needed to adequately assess the financial viability of the Parties. To date, the scope of supporting financial documentation that has been provided is quite limited. Audited financial statements for 2018-2020 were provided for Crouse and its affiliates, which includes Crouse Health Hospital, Inc., Crouse Health Network, LLC and Crouse Medical Practice, PLLC.[36] Unaudited financial statements for 2021 were provided for Crouse Health Hospital, Inc. and Crouse Medical Practice, PLLC.[37] Audited financial statements for 2018-2020 and unaudited financial statements for 2021 were provided for the University Hospital ("UH"), an affiliate of SUNY Upstate.[38] Financial statements were not provided for any other SUNY Upstate affiliates.[39]

FTC staff believes that to adequately assess the financial condition and viability of each of the Parties, the following information should be obtained, if available:

- 2021 audited financial statements. In addition to audited financial statements being presented in accordance with U.S. Generally Accepted Accounting Principles ("GAAP"), the notes and attached schedules included with audited financial statements provide

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[36] [redacted] *See* CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Audited Financial Statements December 31, 2020 and 2019 at 6. Unaudited financial statements for 2021 were provided for only Crouse Health Hospital, Inc. and Crouse Medical Practice, PLLC.

[37] COPA Application Attachments 8-10 (CHS audited financial statements for 2018-2020); CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Audited Financial Statements December 31, 2020 and 2019); CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Statistics & Financial Statements December 2021.

[38] COPA Application Attachment 2 (UH audited financial statements for 2018-2020); COPA Application Attachment 5 (UH unaudited financial statements for 2021); CON Application Schedule 9 Attachment, University Hospital Audited Financial Statements December 31, 2020 and 2019; CON Application Schedule 9 Attachment, University Hospital Financial Statements December 31, 2021.

[39] UH is a department of the State University of New York Upstate Medical University ("SUNY Upstate"). SUNY Upstate is a medical campus of The State University of New York. SUNY Upstate operates a single inpatient hospital with two separate campuses: UH and Upstate Community Hospital. *See* COPA Application at 15.

important information that is not included with unaudited financial statements. It is important to understand any new disclosures and significant changes since the 2020 audited statements were provided. For instance, [redacted] It would be useful to understand how that particular liquidity measure may have changed during 2021 based on updated data and in conjunction with 2021 financial statements prepared in accordance with GAAP. And to the extent either Party is claiming financial distress, [redacted] Verification of the existence or absence of such a disclosure in the 2021 audited financial statements would be important. Among other useful disclosures, the notes to the 2021 audited financial statements would also include updated schedules regarding the amount of each company's long-term debt, its pension obligations, and its minimum required debt and pension payments.

- 2022 year-to-date unaudited financial statements. Given the passage of time since the end of fiscal year 2021, it is important to understand the most recent financial details of each company. Monthly and/or quarterly internal financial statements (balance sheets, income statements, cash flow statements) are often generated in the normal course of business, and if so, should be readily available.

- Operating and capital budgets/projections. It is important to understand how each of the Parties expected to operate independently of the proposed merger. Contemporaneous, standalone operating and capital budgets prepared by each of the Parties in the normal course of business should be provided and reviewed to properly make such an assessment. Those documents may also provide a necessary, additional level of detail not typically provided in the financial statements. [redacted] It would be important to identify and understand those expenses when considering the profitability of Crouse.

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[40] [redacted] *See* COPA Application Attachment 10 at 14; CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Audited Financial Statements December 31, 2020 and 2019 at 14.

[41] *See, e.g.*, CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Statistics & Financial Statements December 2021 at 5; CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Audited Financial Statements December 31, 2020 and 2019 at 3; COPA Application Attachment 10 at 3.

- Valuations and liquidation analyses. It is important to understand the market value of any real estate and other significant assets that may be available as a source of funds for each of the Parties. [redacted] it is important to understand the market value of all of the properties Crouse currently holds, which would be facilitated by a review of any available valuation analyses or similar market assessments of such property. It is also important to review any recent enterprise valuations (including any underlying native financial models) or liquidation analyses that may have been conducted for Crouse as an entity, which would be useful in determining the attractiveness of the hospital to other potential acquirers.

- Synergy/efficiencies analyses. Although the Parties provided several presentations that discussed and summarized the expected benefits and synergies expected from the combination, no supporting documentation or underlying native financial models that may have been relied upon were provided. This information is critical in understanding the key inputs, assumptions, and robustness of such analyses. In addition, FTC staff requires sufficient and reasonable support to show whether such benefits are likely cognizable and specific to the proposed merger, which also has not been included in the COPA and CON Applications.

- Reorganization/restructuring plans. It is also important to understand what restructuring and reorganization plans have been contemplated and attempted by reviewing contemporaneous documents that support such claims.

- Closure or service reduction plans. To the extent either of the Parties are claiming that only the proposed merger would prevent a cessation of operations and reduction of service lines, it is important to obtain and review contemporaneous documentation that will support such claims.

- Loan documents. A review of current loan documents and related agreements (e.g., security agreements, promissory notes) is customary to understand the terms, obligations, and the rights of the Parties pursuant to those agreements.

- Correspondence with creditors including any applicable covenant compliance certificates and waivers. It is important to review correspondence from lenders regarding the status of existing obligations, periodic compliance reports, events of default, requests for loan modifications, requests for waivers to loan covenants, and requests for additional

[42] *See* COPA Application Attachment 14, Asset Purchase Agreement (July 6, 2022), Schedule 1.1.84 (Hospital Real Property); COPA Application Attachment 14, Lease Agreement (July 6, 2022) at 2.
[43] COPA Application at 52; CON Application Schedule 9 Attachment, Crouse Health System, Inc. and Affiliates Statistics & Financial Statements December 2021 at 5.

funding. [redacted], it is certainly reasonable to explore whether Crouse, independent of the proposed merger, could re-negotiate or replace its current bond debt to obtain debt with more favorable terms.[48]

- Relevant documentation regarding any recent efforts undertaken to divest or sell assets. The COPA Application stated: [redacted] As noted previously, it is important to determine the market value of any remaining significant assets held by Crouse (including the hospital real property) to determine their prospects to generate funds. For instance, it is unclear whether, independent of the proposed merger, the Crouse hospital real property could be sold to a third-party and leased back to Crouse.

- Relevant documentation regarding any recent efforts undertaken to issue debt and obtain funding from investors. As noted above, it is important to explore the prospects of issuing new debt and attracting investors, [redacted].

- Relevant documentation regarding any recent efforts undertaken to establish strategic partnerships and find alternative (less anti-competitive) purchasers than the proposed merger. To determine whether a less anti-competitive alternative may be available, it is important to understand the efforts undertaken to establish any such strategic partnerships and find alternative purchasers. [redacted]

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[44] COPA Application at 52.
[45] [redacted] *See* COPA Application Attachment 4I-5 at 5.
[46] COPA Application Attachment 19 at 8.
[47] COPA Application at 52.
[48] [redacted]. *See* COPA Application Attachment 4I-4 at 13; COPA Application Attachment 4I-5 at 8.
[49] COPA Application at 52-53.

[redacted] Apparently, comments made by Crouse Health Board Chair Patrick Mannion during a public forum during the week of August 15, 2022 indicated that Crouse's board of directors had issued a request for proposal and held conversations with many interested organizations before SUNY Upstate was selected. Similarly, [redacted] No supporting or contemporaneous documentation has been provided to indicate whether such options were viable alternatives to the proposed merger.

V. Competitive Dynamics of the Primary Service Area: The Proposed COPA Is Likely to Result in Significant Disadvantages Due to a Reduction in Competition Between SUNY Upstate and Crouse

NY DOH COPA FACTOR (b): *The dynamics of the relevant primary service area, including the availability of suitable and accessible health care services and the level of competition in the primary service area, the likelihood that other health care providers will enter or exit the primary service area, the health care workforce and the existence of unique challenges such as difficulties in recruiting and retaining health care professionals*

ASSESSMENT: In this section, FTC staff describes our economic analyses of the proposed merger, which includes information about how the merger is likely to affect the availability of healthcare services and the level of competition in the PSA, as well as entry conditions and unique workforce challenges. At the outset, we note that the Parties have asserted a PSA that is much broader than the commonly accepted definition. As we explain in more detail below, the actual PSA includes portions of nine counties – *not* the 17 counties asserted by the Parties.[52] FTC staff has evaluated the competitive dynamics in the PSA as it is defined in the New York COPA Regulations.[53] In addition, FTC staff has evaluated the competitive dynamics in Onondaga County separately from the PSA, as this is the likely locus of the merger's effects.

Our preliminary analyses suggest that the proposed combination of SUNY Upstate and Crouse would eliminate close competition between the hospital systems for patients residing in the combined PSA, and particularly in Onondaga County. SUNY Upstate appears to routinely compete with Crouse on price, quality, innovation, and patient experience for inclusion in health

[50] COPA Application at 65.
[51] COPA Application Attachment 4I-1 at 3.
[52] *See* COPA Application at 37. In the COPA Application, the Parties refer to a 17-county area as "Central New York" and inaccurately assert that this constitutes the PSA. FTC staff does not believe this broad of an area constitutes either the PSA or a relevant geographic market for antitrust purposes. *See* Section V.B. for further discussion.
[53] FTC staff does not believe the PSA necessarily represents a "relevant geographic market" under the *Merger Guidelines* or antitrust case law, which analyze how insurers (and in turn, their members) would respond to price increases imposed by a hypothetical monopolist.

insurer networks and to attract patients to their respective hospital system for inpatient, outpatient, and physician services. Contrary to the Parties' claims that their service offerings are complementary,[54] SUNY Upstate and Crouse offer similar facility locations, service offerings, and quality of care.[55] Each system operates acute care hospitals that provide inpatient services, as well as outpatient facilities, and they employ physicians across a number of specialties. There is significant geographic overlap between these hospitals' facilities in the areas from which they draw patients.[56] Indeed, SUNY Upstate University Hospital and Crouse Hospital are located across the street from one another and share a medical campus. Consistent with our economic analyses, empirical research indicates that mergers among hospitals in close proximity are likely to result in particularly significant price increases.[57] By eliminating this competition, the proposed merger would substantially increase the combined system's ability to exercise its market power, enabling it to extract higher prices in negotiations with health insurers, which in turn would likely lead to higher healthcare costs for employers and patients. The proposed merger also would reduce the combined system's business incentives to maintain or improve the quality or availability of healthcare services.

Because SUNY Upstate and Crouse also compete as participants in healthcare labor markets, the proposed merger will reduce competition to recruit and retain healthcare employees. The reduction in labor market competition could lead to reduced wages and benefits for healthcare employees.

The Parties list several goals of the COPA, including preserving and enhancing access to care; improved utilization of existing capacity at Crouse facilities, while avoiding a costly facility expansion at SUNY Upstate's facilities; supporting SUNY Upstate's academic and research mission; preserving critical services and jobs; and improving health equity.[58] They claim that "[o]ther than the investments Upstate is committing to make in Crouse facilities and infrastructure, the Parties are not aware of any increased costs or prices that will result from the Transaction."[59] They further claim that they "have not identified any disadvantages to quality, access, or cost, associated with the Transaction,"[60] These statements are not supported by the available evidence. As we discuss in more detail below, the cost savings and efficiencies claimed by the Parties are speculative and unsubstantiated at this point. Indeed, as context, studies show that mergers often do not achieve projected cost savings and efficiencies.[61] Furthermore, [redacted]

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[54] *See* COPA Application at 21-22, 31-32, 57.
[55] *See* Table 6 depicting the vast majority of all patients treated at SUNY Upstate are treated for conditions that are also treated at Crouse, and vice-versa.
[56] *See generally* COPA Application at 37-38. *See also* PSA Analysis and Diversion Ratio Analysis, *infra* Sections V.A.2-3; FTC Map: SUNY Upstate and Crouse Individual and Combined Primary Service Areas (Attachment C).
[57] *See, e.g.*, WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., RESEARCH SYNTHESIS REPORT NO. 9: HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? 7 (2006), http://www rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1 ("Mergers among hospitals that are close together geographically generate greater price increases than do mergers among distant hospitals.").
[58] COPA Application at 34-35.
[59] COPA Application at 61.
[60] COPA Application at 65.
[61] *See infra* note 156.

[redacted], so it is difficult to understand how this merger could nevertheless foster the creation of jobs or improve access to healthcare. Finally, contrary to what the Parties claim, there is *substantial* danger of competitive harm from the merger and insufficient evidence to demonstrate it would be outweighed by any potential benefits. Moreover, the commitments offered by the Parties are unlikely to mitigate this harm, or do so in a timely fashion.

The bases for FTC staff's assessment of the competitive effects of the proposed merger are described in the following subsections. Subsection A describes the geographic and services areas in which the Parties currently compete for patients, and characterizes the likely effects of the post-merger reduction in competition for residents of the Parties' combined PSA, as well as Onondaga County. Subsection B describes entry conditions in the relevant geographic area and explains that entry of new healthcare providers is not likely to occur. Subsection C describes the impact the merger could have on wage growth for hospital employees, which could exacerbate any challenges with recruiting and retaining healthcare professionals.

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

We first describe the generally accepted economic framework for analyzing hospital competition in subsection A.1. We then describe the Parties' PSA in subsection A.2. In subsection A.3, we present the diversion ratio analysis using 2019 patient discharge data from the Statewide Planning and Research Cooperative System ("SPARCS")[62] to assess the competitive effects of the proposed merger. In subsection A.4, we present market share and concentration analysis using the SPARCS data. Finally, in subsection A.5, we present an analysis of service overlaps using the SPARCS data.

1. Economic Framework for Analyzing Hospital Competition

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

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[62] *See* New York Department of Health, *Statewide Planning and Research Cooperative System (SPARCS) Overview*, https://www health.ny.gov/statistics/sparcs/. FTC staff includes the following disclaimer from NY DOH: "This publication was produced from raw data purchased from or provided by the New York State Department of Health (NYS DOH). However, the conclusions derived, and views expressed herein are those of the author(s) and do not reflect the conclusions or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here."

compete to attract patients. Competition between hospitals to attract patients and physician referrals leads to increased quality and availability of healthcare services. This second-stage competition benefits all commercially insured patients as well as those covered by Medicare, Medicaid, and other forms of government pay.

Thus, hospital systems compete on both price and quality. When competing hospitals merge, two different kinds of adverse effects may occur: higher prices charged to insurance companies (which are then passed on to employers and patients) and non-price effects such as reduced quality and availability of services.[63] These anticompetitive effects are larger when the merging hospitals are closer (*i.e.*, more intense) competitors, and when non-merging hospitals are less significant competitors.

This framework is consistent with a large and growing body of empirical research finding that mergers between close competitors in concentrated healthcare provider markets are likely to result in substantial consumer harm, without offsetting improvements in quality.[64] For example, one paper discussing several studies of hospital mergers concludes that "the magnitude of price increases when hospitals merge in concentrated markets is typically quite large, most exceeding 20 percent."[65] Notably, this empirical finding holds for both for-profit and not-for-profit hospitals.[66] In other words, non-profit hospitals can and do exercise market power and raise prices, similar to for-profit hospitals.[67] Thus, as most courts have recognized, the non-profit status of merging hospitals does not mitigate the potential for anticompetitive harm.[68]

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[63] *Merger Guidelines* §§ 1, 6.

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

[65] GAYNOR & TOWN, *supra* note 64, at 2.

[66] *See, e.g.*, Robert Town, *The Economists' Supreme Court Amicus Brief in the Phoebe Putney Hospital Acquisition Case*, 1 HEALTH MGMT. POL'Y & INNOVATION 60 (2012), http://www hmpi.org/pdf/HMPI-%20Town,%20Phoebe%20Putney.pdf; Gaynor, Ho & Town, *supra* note 64.

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

[68] *See, e.g.*, Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1081 (N.D. Ill. 2012) ("[T]he evidence in this case reflects that nonprofit hospitals do seek to maximize the reimbursement rates they receive.");

2. Primary Service Area

The NY DOH defines the PSA to be "the lowest number of zip codes from which the party draws at least 75 percent of its patients."[69] In our experience this is the generally accepted definition, and other state health authorities and hospitals define the PSA in the same or similar manner. We calculated the combined 75 percent PSA for the Parties (i.e., the lowest number of zip codes from which SUNY Upstate and Crouse combined draw 75 percent of their patients) using 2019 SPARCS data. Using this definition, the Parties' PSA consists of portions of nine counties in central New York: Onondaga, Oneida, Oswego, Jefferson, Cayuga, Madison, Tompkins, Cortland, and St. Lawrence. It is unclear why the Parties' COPA Application asserts that the PSA includes 17 counties; a larger so-called PSA would of course understate their actual competitive significance in the area that they serve. The geographic extent of the combined PSA is shown in Attachment C and described in Table 1 below.

Table 1: SUNY Upstate-Crouse Combined PSA
(Based on 2019 SPARCS Data)

County	# Zip Codes in PSA	# Discharges in PSA	Parties' Share of Discharges in PSA
Onondaga	33	44,720	62.5%
Oneida	3	12,301	12.3%
Oswego	6	9,257	37.6%
Jefferson	2	5,956	14.6%
Cayuga	1	4,912	23.5%
Madison	4	3,706	39.4%
Tompkins	1	3,248	7.0%
Cortland	1	3,038	23.0%
St. Lawrence	1	1,946	13.7%
Total	52	89,084	42.2%

Fed. Trade Comm'n v. ProMedica, No. 3:11 CV 47, 2011 WL 1219281, at *22 (N.D. Ohio Mar. 29, 2011) (finding that a nonprofit hospital entity "exercises its bargaining leverage to obtain the most favorable reimbursement rates possible from commercial health plans."); United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1284-87 (7th Cir. 1990) (rejecting the contention that nonprofit hospitals would not seek to maximize profits by exercising their market power); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1213-14 (11th Cir. 1991) ("[T]he district court's assumption that University Health, as a nonprofit entity, would not act anticompetitively was improper."); Hospital Corp. of America v. Fed. Trade Comm'n, 807 F.2d 1381, 1390-91 (7th Cir. 1986) (rejecting the contention that nonprofit hospitals would not engage in anticompetitive behavior). *See also* DOSE OF COMPETITION REPORT, *supra* note 23, ch. 4, at 29-33 (discussing the significance of nonprofit status in hospital merger cases, and concluding that the best available empirical evidence indicates that nonprofit hospitals exploit market power when given the opportunity and that "the profit/nonprofit status of the merging hospitals should not be considered a factor in predicting whether a hospital merger is likely to be anticompetitive.").

[69] New York COPA Regulations § 83-2.2(i).

While the combined PSA includes patients from 52 zip codes (see Table 1) in nine counties, most of those zip codes are in Onondaga County, and most patients in the PSA reside in Onondaga County. Overall, SUNY Upstate and Crouse account for 42.2% of all patient discharges from zip codes within the combined PSA.

In addition to the combined PSA, we separately calculated the individual PSAs for SUNY Upstate and Crouse. A map of the zip codes included in the combined PSA, in SUNY Upstate's individual PSA, and in Crouse's individual PSA is included as Attachment C to this comment.[70] We find that Crouse's individual PSA is contained almost entirely within SUNY Upstate's PSA. Crouse's individual PSA includes 39 zip codes, 37 of which overlap with the SUNY Upstate PSA. SUNY Upstate's individual PSA is broader, containing 57 zip codes. SUNY Upstate's broader individual PSA reflects the fact that SUNY Upstate offers some services that Crouse does not,[71] and some patients with higher-acuity conditions are willing to travel further to visit SUNY Upstate as a result.

While there are other hospitals located within the area of the Parties' combined PSA, these hospitals are generally smaller, located far away from Syracuse, and do not draw patients from a wide area. As we describe below, patients do not consider these other hospitals to be close substitutes for SUNY Upstate or Crouse, and these hospitals have little or no competitive significance for SUNY Upstate and Crouse. The one exception is St. Joseph's Health Hospital ("St. Joseph's"), which is owned by Trinity Health and also located within Syracuse.

3. Diversion Ratio Analysis Confirms that SUNY Upstate and Crouse Are Close Competitors

To directly measure the degree of competition between the merging hospitals, FTC staff performed a diversion ratio analysis.[72] This analysis calculates what would happen if, hypothetically, one of the merging hospital systems were removed from an insurer's network and was no longer an option for that insurer's patient members. The patients who would have used their preferred hospital system must now use another. The fraction of a hospital's former patients who would now go to another particular hospital is the diversion ratio from the first hospital to

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[70] *See* FTC Map: SUNY Upstate and Crouse Individual and Combined Primary Service Areas (Attachment C).
[71] For example, SUNY Upstate has one of three burn units in New York State to the west of the Hudson River.
[72] To calculate diversion ratios, we estimate a patient choice model using SPARCS data for commercially insured patients covering calendar year 2019. We focus on the hospital choices of commercially insured patients because they determine the negotiated prices between hospitals and insurers. We also focus on general acute care services (mental health and addiction services, for example, may be negotiated separately and also have different market dynamics with different sets of providers). For a discussion of the underlying methodology used to calculate diversion ratios, see Joseph Farrell, David J. Balan, Keith Brand & Brett W. Wendling, *Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets*, 39 Rev. Indus. Org. 271 (2011), http://link.springer.com/content/pdf/10.1007%2Fs11151-011-9320-x.pdf; Devesh Raval, Ted Rosenbaum & Steve Tenn, *A Semiparametric Discrete Choice Model: An Application to Hospital Mergers*, 55 Econ. Inquiry 1919 (2017), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3026754.

the second.[73] The estimated diversion ratio between two hospitals accounts for patients' geographic location (as determined by the 5-digit zip code of the patient), health condition (as determined by the diagnosis-related-group ("DRG") codes used for the patient), and other patient characteristics such as gender and age. All hospitals in the state of New York are included in FTC staff's diversion ratio analysis as possible alternatives for patients. Thus, unlike the market share and concentration estimates described in the next subsection, the diversion ratio calculation reflects the importance of geographic proximity for patients' choices without constraining the analysis to a particular geographic area.

The diversion ratio is a useful measure of the degree of patient overlap between merging hospitals, and the relative bargaining positions of the hospital systems and insurers. If a significant fraction of the patients "diverted" from SUNY Upstate (Crouse) would choose Crouse (SUNY Upstate), then the two merging parties are considered close competitors and close substitutes for inclusion in an insurer's network. Before the merger, the presence of Crouse (SUNY Upstate) in the insurer's network constrains the reimbursement rate that SUNY Upstate (Crouse) can obtain in negotiations with the insurer. The merger would remove this competitive constraint on negotiated prices, and likely cause prices to rise. The degree of the price increase depends on the diversion ratio – a higher diversion ratio likely means a larger anticompetitive price increase post-merger. FTC staff's diversion ratio analysis is presented in Table 2.

Table 2: Diversion Ratio Analysis in Combined PSA
(Based on 2019 SPARCS Data)

	Diversion Ratios	
Hospital / Health System	**Remove Upstate**	**Remove Crouse**
SUNY Upstate	N/A	35.4%
Crouse	38.4%	N/A
St. Joseph's	43.8%	53.1%
Mohawk Valley Health System	1.7%	1.2%
Auburn Community Hospital	3.8%	1.3%
Samaritan Health	0.8%	0.4%
Oswego Health	3.2%	3.1%
Oneida Health	1.7%	1.0%
Guthrie	1.7%	0.8%
Rome Health	0.7%	0.4%
University of Rochester Medical Center	1.1%	1.2%
Cayuga Health System	0.4%	0.3%
Other Hospitals and Systems	2.6%	1.8%
Total	**100.0%**	**100.0%**

[73] *See Merger Guidelines* § 6.1 ("Diversion ratios between products sold by one merging firm and products sold by the other merging firm can be very informative for assessing unilateral price effects, with higher diversion ratios indicating a greater likelihood of such effects."). Unilateral price effects refer to the ability of a merged firm to raise prices on its own, without colluding with other competitors.

The diversion analysis confirms that SUNY Upstate and Crouse are close substitutes from the perspective of patients and payers. FTC staff calculates that if SUNY Upstate were no longer an option for area residents, 38% of the patients who currently use SUNY Upstate would seek care at Crouse. Conversely, if Crouse were no longer an option for area residents, 35% of the patients who currently use Crouse would seek care at SUNY Upstate.[74] These high diversion ratios are not surprising, given that SUNY Upstate and Crouse serve patients from a similar geographic area with similar health conditions, and there are very few nearby third-party hospitals. These diversion ratios indicate that a merger between SUNY Upstate and Crouse would eliminate direct head-to-head competition and likely lead to significant price increases, as well as reduced business incentives to maintain or improve quality. These diversion ratios equal or exceed many recent hospital merger cases where courts found the proposed mergers to be anticompetitive.[75]

The same analysis also confirms that only one other hospital, St. Joseph's in Onondaga County, closely competes with SUNY Upstate and Crouse. That is, if SUNY Upstate (Crouse) were no longer an option, nearly all of the patients who currently use SUNY Upstate (Crouse) and would *not* seek care at Crouse (SUNY Upstate) would instead seek care at St. Joseph's. The estimated diversion of SUNY and Crouse patients to any other particular hospital system in New York State is less than 4%. These diversion ratios strongly indicate that a merger between SUNY Upstate and Crouse would reduce the number of options available for most of their patients from three to two. It is also worth noting that the presence of St. Joseph's as a close competitor to SUNY Upstate and Crouse does not mitigate concerns about the proposed acquisition. After the acquisition, health insurers would have only two hospital options to include in a provider network for Syracuse area patients, and those patients would only have two local hospital systems providing general acute care ("GAC") inpatient services.

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

General principles of antitrust law and economics indicate that mergers between close competitors in highly concentrated hospital markets are likely to result in significant harm to

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[74] These diversion ratios are estimated using the observed choices of patients within the combined PSA. The same analysis can be performed using a wider geographic area. We have estimated the same statistical model on the Parties' combined 90 percent service area and find very similar diversion ratios. In other words, the calculated diversion ratios are not particularly sensitive to the geographic area used to estimate the model.

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

competition, resulting in higher prices, lower quality care, or reduced wages for hospital staff.[76] For this reason, market shares and concentration are also important tools for assessing the potential for adverse competitive effects resulting from a merger. Consistent with the diversion ratio analysis discussed above, the proposed merger would create a system with a high market share and lead to a highly concentrated market, likely resulting in substantial harm to patients due to lost competition.

Courts and antitrust agencies use a standard measure, the Herfindahl-Hirschman Index ("HHI"), to gauge a merger's effect on market concentration.[77] Under the *Merger Guideline*s and relevant case law, mergers resulting in a post-merger HHI above 2,500 and an increase in HHI of more than 200 points are presumed likely to enhance the merged firm's market power and to be anticompetitive.[78]

The concentration analysis is most appropriate when applied to a properly defined relevant antitrust market. The generally accepted definition of a "relevant antitrust market" is a set of substitute products over which a hypothetical monopolist could exercise market power by negotiating a small but significant non-transitory increase in price. This test for whether a set of substitute products constitutes a relevant antitrust market is sometimes called the "hypothetical monopolist test."[79] The geographic boundaries of a relevant antitrust market for the analysis of hospital competition are not necessarily the same as those of a PSA.

In merger investigations, defining the relevant antitrust market is a fact-intensive exercise involving interviews with market participants and reviewing confidential documents, in addition to data analyses. While we have not formally defined a relevant antitrust market in this comment, the diversion analysis, which shows that SUNY Upstate, Crouse, and St. Joseph's are close

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[76] *See, e.g.*, *Merger Guidelines* §§ 5-6; United States v. Phil. Nat'l Bank, 374 U.S. 321, 363-66 (1963) ("Specifically, we think that a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market, is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects.").

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

[78] *Merger Guidelines* § 5.3. Courts accept this presumption of illegality when evaluating hospital mergers. *See, e.g.*, ProMedica Health Sys., Inc. v. Fed. Trade Comm'n, 749 F.3d 559, 570 (6th Cir. 2014) ("[T]he Commission is entitled to take seriously the alarm sounded by a merger's HHI data."); *id.* ("These two aspects of this case – the strong correlation between market share and price, and the degree to which this merger would further concentrate markets that are already highly concentrated – converge in a manner that fully supports the Commission's application of a presumption of illegality."); Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1079 (N.D. Ill. 2012) ("High levels of concentration raise anticompetitive concerns, and the HHI calculation provides one way to identify mergers that are likely to invoke these concerns."); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1211 n.12 (11th Cir. 1991) ("The most prominent method of measuring market concentration is the Herfindahl-Hirschman Index (HHI)."); *id*. at 1218 n.24 ("Significant market concentration makes it easier for firms in the market to collude, expressly or tacitly, and thereby force price above or farther above the competitive level.") (quotation marks omitted); United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990) ("The defendants' immense shares in a reasonably defined market create a presumption of illegality.").

[79] *See Merger Guidelines* § 4.2.1. Agencies typically consider a "small but significant price increase" to be five percent. *Id.*

substitutes for one another (while no other hospitals are), suggests that Onondaga County likely constitutes a relevant antitrust market. [redacted]

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

Table 3 contains the results of our concentration analysis for hospitals serving patients residing in the combined PSA. The post-merger HHI for all discharges is 2,457 and the increase in HHI is 836. The combined SUNY Upstate-Crouse hospital system would have a share of 42.2% of inpatient hospital services for patients living in the combined PSA.[82] These metrics are even higher when looking specifically at commercially insured GAC patients, with a post-merger HHI of 2,769, an increase in HHI of 1,034, and a combined share for SUNY Upstate and Crouse of 45.5%. The combined share and HHI calculations exceed the thresholds that would create a presumption of illegality under the *Merger Guidelines* and the relevant case law,[83] and also exceed some of the levels in past hospital mergers that courts have found to be anticompetitive and blocked.[84] As with the diversion ratio analysis, all hospitals in the state of New York are included in the shares and concentration analysis for patients residing in the combined PSA.

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[80] COPA Application Attachment 4I-6 at 17.
[81] COPA Application Attachment 4I-1 at 14.
[82] Crouse has affiliations with three hospitals smaller hospitals in rural areas in central and Northern New York: Claxton-Hepburn Medical Center in Ogdensburg (the 11th row in Table 3), Carthage Area Hospital in Carthage, and Community Memorial Hospital in Ithaca. *See* https://www.crouse.org/north-country-hospitals-affiliation. For the purposes of the share analysis, these are considered separate hospitals. If they were included as part of Crouse, the Parties' combined share and the increase in HHI would be even greater.
[83] *See supra* note 78. The concentration levels in the Syracuse area had already increased in recent years, including from SUNY Upstate's 2011 purchase of Community General Hospital. *See, e.g.*, Katie Keith, Sabrina Corlette & Olivia Hoppe, Assessing Responses to Increased Provider Consolidation in Three Markets: Detroit, Syracuse, and Northern Virginia; Case Study Analysis: The Syracuse Health Care Market, Center on Health Insurance Reforms at 6 (Nov. 2018), https://georgetown.app.box.com/s/38whcvigzyytlzznecxz0oq9qklsaitq ("Syracuse's provider market has become increasingly concentrated over the last several years.").
[84] *See* Table B1: Market Shares and HHIs in Prior Healthcare Merger Cases (Attachment B).

Table 3: Shares and Concentration Analysis
Hospitals Serving Patients Residing in the Combined PSA
(Based on 2019 SPARCS Data)

Hospital / System	Share of All Discharges	Share of Commercially Insured GAC Discharges
SUNY Upstate	26.4%	23.9%
St. Joseph's	22.8%	24.3%
Crouse	15.8%	21.7%
Mohawk Valley Health System	9.0%	7.8%
Samaritan Health	4.3%	2.8%
Oswego Health	4.0%	2.1%
Auburn Community Hospital	3.5%	2.7%
Cayuga Health System	3.2%	3.5%
Rome Health	2.4%	1.9%
Guthrie	2.0%	1.6%
Claxton-Hepburn Medical Center	1.4%	1.9%
Oneida Health	1.3%	2.0%
All Others (<1.0% of All Discharges)	*3.9%*	*3.9%*
Combined SUNY Upstate - Crouse Share	42.2%	45.5%
Pre-merger HHI	1,621	1,735
Post-merger HHI	2,457	2,769
Change in HHI	836	1,034

FTC staff has assessed concentration using the combined PSA because this is the geographic area specifically referenced in the New York COPA Regulations. As we explained above, this area is likely broader than a market properly defined for antitrust purposes, meaning the shares listed in Table 3 likely overstate the competitive significance of hospitals outside of Syracuse and understate the likely anticompetitive impact of the proposed merger. In Table 4 below we report the results of the concentration analysis for Onondaga County. As we explained above, this potential relevant antitrust market definition likely satisfies the hypothetical monopolist test.

Table 4: Shares and Concentration Analysis
Hospitals Located in Onondaga County
(Based on 2019 SPARCS Data)

Hospital	Share of All Discharges	Share of Commercially Insured GAC Discharges
SUNY Upstate	43.6%	36.9%
St. Joseph's	33.2%	33.3%
Crouse	23.2%	29.7%
Combined SUNY Upstate - Crouse Share	66.8%	66.7%
Pre-merger HHI	3,541	3,359
Post-merger HHI	5,564	5,556
Change in HHI	2,024	2,197

The results for all discharges and GAC services for commercially insured patients are very similar. For commercially insured GAC discharges, the post-merger HHI is 5,556 and the increase in HHI is 2,197. The combined SUNY Upstate-Crouse hospital system would have a share of 66.7% of GAC inpatient hospital services for commercially insured patients seeking care in Onondaga County.

Finally, we performed the same share and concentration analysis for all patients residing in Onondaga County, regardless of which hospital they chose (as opposed to all hospitals located in Onondaga County, regardless of the origin of the patients, as shown above in Table 4). The results of this analysis are shown in Table 5 below and are broadly similar to the results of the concentration analysis in Table 4. For patients residing in Onondaga County (which is where most patients in the PSA reside), the proposed merger would reduce the number of available hospitals from three to two for nearly all patients.

Table 5: Shares and Concentration Analysis
Hospitals Serving Patients Residing in Onondaga County
(Based on 2019 SPARCS Data)

Hospital	Share of All Discharges	Share of Commercially Insured GAC Discharges
SUNY Upstate	37.1%	31.6%
St. Joseph's	34.6%	33.2%
Crouse	25.4%	31.9%
All Others (<1.0% of All Discharges)	*2.9%*	*3.3%*
Combined SUNY Upstate - Crouse Share	62.5%	63.5%
Pre-merger HHI	3,218	3,123
Post-merger HHI	5,101	5,141
Change in HHI	1,883	2,019

5. Analysis of Service Overlaps Confirms that SUNY Upstate and Crouse Are Close Competitors

In addition to the diversion ratio and concentration analyses described above, FTC staff also performed an analysis of the 2019 SPARCS inpatient discharge data to evaluate the overlap in the Parties' services. We find that, contrary to the Parties' claims that their service offerings are complementary,[85] the patient conditions they treat (and hence the services they provide) are very similar.

Using the 2019 SPARCS inpatient discharge data, FTC staff measured service overlaps as the DRG codes that are common to both hospitals.[86] DRG codes are used to classify patients according to diagnosis and medical complexity and are a common way to classify sets of services offered by hospitals. Any DRG code that appears in the data for both hospitals for at least X inpatient events is included in the overlap set, where X is equal to 1, 3, or 5 patients. Table 6 reports the number of DRG codes in each overlap set along with the percentage of all patients treated at both SUNY Upstate and Crouse that are in the overlap set.

[85] *See* COPA Application at 21-22, 31-32, 57.
[86] *See* CMS Guidance, *Design and development of the Diagnosis Related Group* (DRG), https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf.

Table 6: SUNY Upstate and Crouse Patients with Overlapping DRGs (Based on 2019 SPARCS Data)

DRG Overlap Set	DRG Codes in Overlap Set	Patients in Overlap Set	
		Upstate	Crouse
>=1	562	94.5%	99.3%
>=3	421	89.6%	95.6%
>=5	341	85.2%	93.4%

Table 6 shows that the vast majority of all patients treated at SUNY Upstate are treated for conditions that are also treated at Crouse, and vice-versa. For example, the 421 DRGs for which both SUNY Upstate and Crouse treated at least three patients account for 90% of all Upstate patients and 96% of all Crouse patients. The 341 DRGs for which both SUNY Upstate and Crouse treated at least five patients account for 85% of all SUNY Upstate patients and 93% of all Crouse patients.[87] In other words, SUNY Upstate and Crouse treat similar types of patients with similar health conditions.[88] This suggests that most patients view SUNY Upstate and Crouse as competing options for the treatment of their health conditions. The proposed merger would leave those patients with one fewer competing option.

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

Another factor that the NY DOH must consider when evaluating the COPA Application is the likelihood that other healthcare providers will enter or exit the PSA.[89] Under the *Merger Guidelines* framework, the FTC considers whether entry by a new competitor would be timely, likely, and sufficient to alleviate the harm to competition caused by the proposed merger.[90] FTC staff acknowledges that such entry – if it would be timely, likely, and sufficient – could offset or reduce concerns in years to come from the elimination of competition between SUNY Upstate and Crouse.

The evidence obtained to date shows, however, that new entry would not be timely, likely, or sufficient to offset the competitive harm of the proposed merger. Construction and

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

[88] FTC staff also evaluated the degree of overlap in Major Diagnostic Categories ("MDCs") treated by each hospital. SUNY Upstate and Crouse both treat patients with conditions that fall within each MDC, with one exception: SUNY Upstate has the only burn unit in the central New York region, so Crouse (along with all other hospitals in this region) must send burn patients to SUNY Upstate or Strong Memorial in Rochester (which is not located in this region).

[89] New York COPA Regulations § 83-2.5(b).

[90] *Merger Guidelines* § 9.

operation of new acute care hospitals involve significant capital investment and take many years from the initial planning stage to opening. Furthermore, new entry or expansion by acute care hospitals would have to meet the requirements of New York's CON program, which is overseen by the NY DOH and the Public Health and Health Planning Council.[91] It is unlikely that any firm could overcome the entry barriers necessary to build a new acute care hospital in the Syracuse area in the foreseeable future. Unsurprisingly, FTC staff's investigation to date has revealed no such plans for new entry by acute care hospitals.

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

In evaluating the dynamics of the healthcare workforce in the PSA, the NY DOH should consider the impact of the proposed merger on healthcare employee wages, and how that could exacerbate the current challenges with recruiting and retaining employees that the Parties have claimed.[92] Indeed, it is part of the NY DOH's vision to consider the "wellbeing of all New Yorkers."[93] SUNY Upstate and Crouse assert that the COVID-19 pandemic created unprecedented challenges, particularly staffing shortages.[94] The FTC agrees that it is critically important to preserve access to healthcare services during the COVID-19 pandemic, and has issued statements clarifying the role of antitrust enforcement during this difficult time.[95]

The impact of hospital consolidation on competition in labor markets has garnered particular attention during recent FTC merger reviews and is relevant to the NY DOH's analysis, as this can affect employee pay and community access to healthcare services.[96] A recent academic study found that hospital mergers generating large increases in employer concentration have meaningful and statistically significant effects on employee wages.[97] Depression of wage

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[91] *See* New York State Department of Health, *CON Review Types as Determined by Facility Type*, https://www.health.ny.gov/facilities/cons/more_information/review_process.htm.
[92] COPA Application at 43, 64 (describing higher attrition rate of clinical and administrative staff due to alternative higher-wage employment opportunities, health care worker burnout, and early retirement, as well as the difficulties of recruiting providers that have not already trained in the central New York area).
[93] New York State Department of Health, *About the New York State Department of Health: Mission, Vision and Values*, https://www health ny.gov/about/ (last accessed Aug. 17, 2022).
[94] COPA Application at 43.
[95] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, JOINT ANTITRUST STATEMENT REGARDING COVID-19, https://www.ftc.gov/system/files/documents/public_statements/1569593/statement_on_coronavirus_ftc-doj-3-24-20.pdf (Mar. 24, 2020).
[96] *See e.g.,* FTC COPA Workshop Transcript: Session 2 (Afternoon) at 29 (Jun. 18, 2019), https://www ftc.gov/system/files/documents/public_events/1508753/session2_transcript_copa.pdf [hereinafter FTC COPA Workshop Transcript: Session 2] (remarks by Elena Prager describing how labor market effects are a relevant consideration for states who are evaluating COPAs, and may care about constituent pay and community access, among other policy goals; for states that have a broad public interest mandate and want to take these issues into account, there is sufficient evidence of "substantial and detectable effect on worker pay").
[97] *See* Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, American Economic Review (2021), https://www.aeaweb.org/articles?id=10.1257/aer.20190690 [hereinafter Prager & Schmitt Study]. *See also* David Arnold, *Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes*, Working Paper (2020), https://darnold199.github.io/jmp.pdf;Elena Prager Presentation at FTC COPA

growth could dissuade qualified hospital employees (already in short supply in many parts of the country) from seeking employment, which could create or exacerbate a shortage of qualified workers and undermine the quality of patient care and access to services.[98] Lower income levels for hospital employees may also worsen population health in local communities where hospitals are leading employers.[99] According to the Parties, SUNY Upstate is currently the largest employer in the central New York region and Crouse is among the ten largest.[100] According to data from Onondaga County, SUNY Upstate is by far the largest employer in the county and Crouse is the fifth largest.[101] Likewise, a 2018 study of the Syracuse healthcare market by the Center for Health Insurance Reform found that the healthcare sector is a key economic driver for the region, and "many residents [are] employed by one of the three health systems."[102] FTC staff is not aware that this proposed COPA, or any COPA for that matter, has imposed conditions or incorporated provisions that would mitigate the merger's potentially negative impact on hospital employee wages.

FTC staff conducted a preliminary analysis of the likely competitive effects of the proposed merger in healthcare labor markets using 2020 American Hospital Association ("AHA") data on employment of registered nurses and respiratory therapists.[103] FTC staff

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Workshop, *Effects of Hospital Mergers on Employee Pay* (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/slides-copa-jun_19.pdf at 109 (describing the study and methodology).

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

[99] *See* FTC COPA Workshop Transcript: Session 2, *supra* note 96, Christopher Garmon remarks at 30-31 (discussing the impact of the Prager & Schmitt Study as applied to COPAs). *See also* Mikael Lindahl, *Estimating the Effect of Income on Health and Mortality Using Lottery Prizes as an Exogenous Source of Variation in Income*, 40 J. HUM. RESOUR. 144 (2005), http://jhr.uwpress.org/content/XL/1/144 (finding higher income generates better health); J. Paul Leigh & Juan Du, *Effects of Minimum Wages on Population Health*, HEALTH AFFAIRS HEALTH POLICY BRIEF (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180622.107025/ (suggesting higher income is correlated to improved population health).

[100] *See* COPA Application at 43; Crouse Health, *Upstate Medical University Seeks Approval to Acquire Crouse Health* (Apr. 14, 2022), https://www.crouse.org/news/upstate-medical-university-seeks-approval-to-acquire-crouse-health/.

[101] *See* Onondaga County Website, *Major Employers*, http://www.ongov.net/about/majorEmployers.html.

[102] Katie Keith, Sabrina Corlette & Olivia Hoppe, ASSESSING RESPONSES TO INCREASED PROVIDER CONSOLIDATION IN THREE MARKETS: DETROIT, SYRACUSE, AND NORTHERN VIRGINIA; CASE STUDY ANALYSIS: THE SYRACUSE HEALTH CARE MARKET, Center on Health Insurance Reforms at 3 (Nov. 2018), https://georgetown.app.box.com/s/38whcvigzyytlzznecxz0oq9qklsaitq.

[103] *See* AHA Data Solutions, https://www.aha.org/data-insights/aha-data-products (representing information provided by nearly 6,300 hospitals and more than 400 health care systems). While the AHA data report on several different categories of employees, respiratory therapists and registered nurses may be most relevant because a majority of them are employed in hospitals. *See* Mayo Clinic College of Medicine and Science, *Explore Health Care Careers: Respiratory Therapist*, https://college mayo.edu/academics/explore-health-care-careers/careers-a-z/respiratory-therapist/ (last accessed Oct. 3, 2022); U.S. Bureau of Labor Statistics, *Occupational Workplace Handbook: Registered Nurses*, https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-3 (last accessed Oct. 3, 2022). Moreover, registered nurses make up more than 30% of hospital employment. *See* U.S. Bureau of Labor Statistics: The Economics Daily, *Registered nurses made up 30 percent of hospital employment in May 2019* (Apr. 27, 2020), https://www.bls.gov/opub/ted/2020/registered-nurses-made-up-30-percent-of-hospital-employment-in-may-2019 htm.

evaluated labor concentration in the commuting zone for nursing labor, as developed by the U.S. Department of Agriculture. [104] For the proposed merger, this commuting zone consists of the following six counties: Cayuga, Cortland, Madison, Onondaga, Oswego, and Tompkins. While this commuting zone may not necessarily represent a relevant antitrust market, it is consistent with other empirical research on the effects of concentration in hospital labor markets. FTC staff used these data to calculate the number and share of employees working at all hospital facilities in this commuting zone, as well as pre- and post-merger HHIs for the proposed merger.

FTC staff found that the labor markets for both registered nurses and respiratory therapists will be highly concentrated after the proposed merger, and that the merger would increase concentration significantly. Using the AHA data, Table 7 shows that SUNY Upstate and Crouse have a combined share in the commuting zone of 50.1% for registered nurses and 45.0% for respiratory therapists. The post-merger HHIs are 3,093 and 2,734, respectively, and the increases in HHI are 949 and 874, respectively. The post-merger HHIs and changes in HHIs suggest that the proposed merger may cause harm to competition for registered nurses and respiratory therapists. [105]

Using the exact data and methodology employed in the Prager and Schmitt study of concentration in hospital labor markets cited above, FTC staff also calculated employment shares using total hospital employment as reported to the Centers for Medicare & Medicaid Services ("CMS") in hospitals' annual cost reports. [106] Using the CMS data, Table 7 also shows that SUNY Upstate and Crouse would account for nearly 50% of total hospital employment within the commuting zone, and that the combination of their shares would lead to a post-merger HHI of 3,015 and an increase in HHI of 1,027. This analysis suggests that harm to competition for labor as an input caused by the proposed merger will not be limited to registered nurses and respiratory therapists. [107]

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[104] The U.S. Department of Agriculture developed commuting zones using 2000 census data on commuting patterns. FTC staff's definition of the labor market for registered nurses follows much of the recent literature, which shows that around 80% of job applications on career websites are submitted by residents living within the commuting zone. *See, e.g.*, Prager & Schmitt Study; José Azar, Ioana Marinescu & Marshall I. Steinbaum, *Labor Market Concentration*, NBER Working Paper No. 24147 (2019), https://www.nber.org/papers/w24147; Ioana Marinescu & Roland Rathelot, *Mismatch Unemployment and the Geography of Job Search*, 10 AM. ECON. J. MACROECON. 42 (2018), https://www.aeaweb.org/articles?id=10.1257/mac.20160312.

[105] For context, these increases in HHI are very close to the 75th percentile among hospital mergers calculated in the Prager and Schmitt study, which found negative effects on hospital employee wage growth for mergers causing an increase in concentration above the 75th percentile.

[106] *See* CMS, *Hospital Cost Report Public Use File*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Cost-Report/HospitalCostPUF (last accessed Oct. 3, 2022). FTC staff used data from 2018, the most recent year available.

[107] Only hospitals that report data to both AHA and CMS are included in the labor concentration analysis. This includes non-GAC hospitals such as psychiatric centers and long-term care facilities and excludes Veterans Affairs hospitals.

Table 7: Hospital Employment Shares in SUNY Upstate-Crouse Commuting Zone (Based on 2020 AHA Data and 2018 CMS Data)

		Registered Nurses		Respiratory Therapists		Hospital Employees	
Hospital / System	**County**	**FTE**	**Share**	**FTE**	**Share**	**FTE**	**Share**
SUNY Upstate	Onondaga	1,587	37.4%	74	30.8%	5,591	35.2%
St. Joseph's	Onondaga	843	19.9%	52	21.7%	3,107	19.5%
Crouse	Onondaga	538	12.7%	34	14.2%	2,322	14.6%
Cayuga Medical Center	Tompkins	434	10.2%	25	10.4%	1,203	7.6%
Oswego Health	Oswego	263	6.2%	18	7.5%	854	5.4%
Auburn Community Hospital	Cayuga	178	4.2%	9	3.8%	702	4.4%
Oneida Health	Madison	162	3.8%	17	7.1%	703	4.4%
Guthrie Cortland Medical Center	Cortland	122	2.9%	6	2.5%	612	3.8%
Community Memorial Hospital	Madison	72	1.7%	5	2.1%	218	1.4%
Richard H. Hutchings Psychiatric Center	Onondaga	42	1.0%	0	0.0%	585	3.7%
Combined SUNY Upstate - Crouse Share:		50.1%		45.0%		49.8%	
Pre-merger HHI:		2,144		1,860		1,988	
Post-merger HHI:		3,093		2,734		3,015	
Change in HHI:		949		874		1,027	

In addition to significantly increasing concentration in the labor markets for registered nurses and respiratory therapists, the merger would combine two significant nursing schools. SUNY Upstate is the largest provider of training for healthcare professionals in the central New York region, and its proposed acquisition of Crouse's nursing school would further strengthen its position. [redacted]

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

In conjunction with our standard analysis under the *Merger Guidelines*, FTC staff evaluated the proposed merger applying the benefits and disadvantages factors that the NY DOH must consider when reviewing the COPA Application. [109] Based on the information we have obtained to date, we do not have reason to believe the Parties' claimed benefits of the COPA are likely to outweigh the significant disadvantages that would result from a reduction in competition between SUNY Upstate and Crouse. Furthermore, we have considered "the availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition." [110] Under this factor, we believe there may be less restrictive alternative arrangements available.

[108] COPA Attachment 4I-1 at 14.
[109] New York COPA Regulation 83-2.5 (c)-(d).
[110] New York COPA Regulation 83-2.5 (e).

Under the New York COPA Act and Regulations, the NY DOH must consider whether the proposed COPA is likely to generate sufficient public benefits to offset the likely harm to consumers. This inquiry is similar to the analysis that courts and antitrust agencies perform when assessing the competitive impact of mergers. [111] As noted above, the *Merger Guidelines* reflect the combined experience of the antitrust agencies when assessing mergers. In addition to considering competitive harm, that assessment also explicitly includes consideration of the potential benefits resulting from the proposed merger.

For cost savings and quality benefits to be recognized as cognizable efficiencies under the *Merger Guidelines*, they must be sufficiently substantiated by the merging hospitals so that courts and antitrust agencies "can verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific." [112] Rigorous substantiation of efficiency claims is critical because efficiencies are difficult to verify and quantify, in part because much of the information is in the hands of the Parties, and because efficiencies may not be realized. [113] Efficiency claims also must be "merger-specific" – meaning they can only be achieved by this particular merger and not through other means having the same or lesser anticompetitive effects.

Any cost savings and quality benefits that are substantiated and merger-specific must then be balanced against the likely competitive harm. Under the *Merger Guidelines*, the greater the potential anticompetitive effects from a merger, the greater the efficiencies need to be to outweigh the anticipated harm from the merger, and the more certain it must be that any efficiencies would be passed through to consumers. Where the proposed merger is likely to result in substantial harm to competition, the *Merger Guidelines* require a showing of extraordinary efficiencies to overcome that harm. [114] Experience has shown that "[e]fficiencies almost never justify a merger to monopoly or near-monopoly." [115]

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[111] *See Merger Guidelines* § 10; Fed. Trade Comm'n v. ProMedica, No. 3:11 CV 47, 2011 WL 1219281, at *57 (N.D. Ohio Mar. 29, 2011) (finding that the defendant's efficiencies claims did not rebut a presumption of anticompetitive effects); Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1088-89 (N.D. Ill. 2012) (recognizing the *Merger Guidelines* approach for evaluating efficiencies); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1222 (11th Cir. 1991) (recognizing that efficiencies are an important consideration in predicting whether a transaction would substantially lessen competition).

[112] *Merger Guidelines* § 10.

[113] Indeed, legal cases indicate that efficiency claims based on "speculation and promises about post-merger behavior" are not sufficient. United States v. H&R Block, Inc., 833 F. Supp. 2d 36, 89 (D.D.C. 2011) (quoting Fed. Trade Comm'n v. H.J. Heinz, 246 F.3d 708, 720-721 (D.C. Cir. 2001)).

[114] *Merger Guidelines* § 10. *See also ProMedica*, 2011 WL 1219281, at *57 ("Efficiencies must be 'extraordinary' to overcome high concentration levels") (quoting Fed. Trade Comm'n v. H.J. Heinz, 246 F.3d 708, 721 (D.C. Cir. 2001)); *OSF Healthcare Sys*., 852 F. Supp. 2d at 1089 ("'[h]igh market concentration levels require proof of extraordinary efficiencies'") (quoting *H&R Block*, 833 F. Supp. 2d at 89).

[115] *Merger Guidelines* § 10.

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

NY DOH COPA BENEFIT FACTOR (c)(3): *Enhancement of the quality of health care provided by the Parties to the Cooperative Agreement*

NY DOH COPA DISADVANTAGE FACTOR (d)(1): *Increased costs or prices of health care in the primary service area resulting from the Cooperative Agreement, after taking into consideration improvements in quality and outcomes*

NY DOH COPA DISADVANTAGE FACTOR (d)(2): *Diminished quality, availability, and efficiency of health care services*

ASSESSMENT: As described above, our analysis indicates that SUNY Upstate and Crouse are close competitors and that the geographic service area is highly concentrated. As a result, the proposed merger would give the combined hospital system increased bargaining leverage with insurers to negotiate significantly higher reimbursement rates, because insurers would no longer be able to play two competitors off of each other during negotiations. These price increases typically are passed through from insurers to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses. [116] Thus, contrary to the statements by the Parties that they "are not aware of any increased costs or prices that will result from the Transaction," [117] the proposed merger likely would have a substantial adverse impact on patients with respect to the price of healthcare services. [redacted] As described in Section VII, the Parties have not proposed any enforceable terms or conditions that would mitigate this harm.

The elimination of competition between SUNY Upstate and Crouse would also significantly diminish the Parties' business incentives to maintain or improve current levels of quality, patient experience, and access to services and innovative technology, because the combined hospital system would no longer risk losing patients to its pre-merger rival. These non-price dimensions of competition greatly benefit patients and are among the factors by which employers and consumers evaluate the desirability of a provider network. Today, these hospitals know that patients can choose to seek care at, and physicians can send their referrals to, another system if they are not satisfied with the quality, patient experience, or services offered by one of the hospital systems. That threat of losing patients and physician referrals to a rival system incentivizes each system to provide the best possible quality and patient experience, to add new services and technology, and to enhance the availability and convenience of care. Thus, the

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[116] *See infra* Section VI.D, for further discussion of this dynamic.
[117] COPA Application at 61.
[118] [redacted]

proposed merger could reduce the quality of care, all other things equal. Importantly, a reduction in quality of care can have an adverse effect on patient outcomes such as mortality, readmissions, and length of stay. Reduced availability of services may result in decreased patient access, increased travel time to receive services, increased emergency room wait times, and other negative consequences.

In the COPA Application, the Parties argue that the merger generally would lead to improved availability and quality of care, as well as enhanced clinical coordination throughout the merged entity. [119] Assessing potential quality improvements has long been a central element of FTC hospital merger investigations because we recognize that a hospital merger could improve patient health outcomes under certain circumstances. We often analyze the clinical quality effects likely to occur as a result of consolidation with guidance from leading academic and policy experts in healthcare quality. We also evaluate how the merger affects the hospitals' business incentives to deliver higher quality care, and whether changes brought about by the merger would enable the combined hospitals to provide higher quality care more cheaply or efficiently than they could achieve individually.

Empirical literature evaluating the relationship between competition and various measures of hospital quality of care does not support the conclusion that hospital consolidation generally improves clinical quality of healthcare services. To the contrary, studies demonstrate the net effect of mergers of competing hospitals on quality is often negative, and increased competition is associated with better quality. [120] Based on the available evidence, we cannot presume that any given hospital merger is likely to improve quality or reduce costs by enough to offset a price increase.

As we have stated previously, FTC staff needs more information to fully assess the Parties' claims and the Parties have not supplied this information to date. Based on FTC staff's deep experience in evaluating these types of quality justifications, however, it appears that many of the Parties' claims about the likely quality benefits from the merger are unsubstantiated or the benefits appear modest in scope. Furthermore, it appears that many of the claimed quality

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[119] *See, e.g.*, COPA Application at 39-41 (describing how the proposed merger will lead to "improvements in cancer screening, prevention, and treatment services, retention of vital cardiac services, better care coordination for newborns, and integration of behavioral health services;" clinical synergies, such as nurse navigators providing services across the care continuum at the combined organization, "through which best practices and service line offerings of each institution can be adopted for the combined enterprise as a whole;" and reduced wait times and improved patient access and experience).

[120] *See* Romano & Balan, *supra* note 128; Gaynor, Ho & Town, *supra* note 64; GAYNOR & TOWN, *supra* note 64; Beaulieu, Dafny, Landon, Dalton, Kuye & McWilliams, *supra* note 64, at 56 (finding "no evidence of quality improvement attributable to changes in ownership. Our findings corroborate and expand on previous research on hospital mergers and acquisitions in the 1990s and early 2000s and are consistent with a recent finding that increased concentration of the hospital market has been associated with worsening patient experiences."); Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, Medical Care Research and Review 1-18, at 14 (2019), https://journals.sagepub.com/doi/pdf/10.1177/1077558719828938 (finding "increased hospital market concentration is strongly associated with reduced quality across multiple measures. With this result in mind, regulators should continue to focus scrutiny on proposed hospital mergers, take steps to maintain competition, and reduce counterproductive barriers to entry.").

enhancements may be achieved through less restrictive alternatives that would not eliminate the valuable competition between the Parties – either by the Parties independently, through another form of collaboration between the Parties, or through an alternative merger or affiliation with a different partner that would not meaningfully reduce competition.

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

Although the Parties contend that they [redacted] as a result of the proposed merger, the COPA Application includes numerous examples of planned consolidation of clinical services. The Parties acknowledge that "[w]ith respect to those services that are currently offered by both Parties, the Transaction will enable the Parties to consolidate those service lines which can reduce duplicative costs and administrative burden." [122] Duplicative service lines that appear to be targeted for consolidation include: neurology, neurosurgery, and stroke care; labor and delivery services; cardiac surgery services; surgical oncology services; and emergency department services. [123] In addition, several service lines that the Parties describe as complementary appear to be targeted for consolidation, including: cardiology and cardiac surgery; pediatric specialty care and NICU services; and inpatient and outpatient behavioral health services and addiction treatment services. [124] This proposed consolidation of clinical services likely would require considerable effort, money, and time. The Parties have not provided sufficiently detailed information in the COPA Application, so it remains unclear whether the merged entity could successfully consolidate clinical services so as to improve patient outcomes, or when the merging hospitals might expect to realize any purported quality benefits.

Moreover, although the Parties claim they are pursuing the COPA "to proactively preserve critical services and workforce," [125] it is entirely possible that consolidation could reduce the availability of, and patient access to, healthcare services – for example, due to the closure of hospital facilities or a reduction in hospital staff. If this were to occur, then the consolidation of clinical services could be more harmful to patients than beneficial.

The Parties suggest that a post-merger consolidation of the cardiac surgery programs is necessary to maintain sufficient volumes of procedures "to ensure the longevity of the cardiac surgery program and to meet the corresponding minimum requirements for the structure heart program," and that without this consolidation, SUNY Upstate's program is at risk of closing. [126] The Parties claim that over the last two years, both hospitals' cardiac surgical volumes have

[121] COPA Application at 64.
[122] COPA Application at 57.
[123] COPA Application at 42, 45-49, 57, 59-61.
[124] COPA Application at 41-42, 45-49, 63.
[125] COPA Application at 35.
[126] COPA Application at 42.

fallen below minimum requirements. [127] While FTC staff would need more information to fully assess these claims, the research literature shows that a "volume/outcome" relationship only exists for a limited set of procedures and services, including trauma and certain other complex procedures. [128] Any quality benefits from the Parties' proposed clinical consolidation would, therefore, be confined to those services for which there is a demonstrated volume/outcome relationship.

The Parties also suggest that shifting SUNY Upstate's low-acuity services to Crouse, thereby opening up beds for higher-acuity and more specialized care at the main Upstate Hospital, will improve utilization and grow several priority service lines, including: neurosciences, cardiac services, hematology and oncology, behavioral health, pediatrics/labor and delivery, primary care, and physician medicine and rehabilitation. [129] However, repurposing acute care beds and consolidating co-located facilities are unlikely to have a volume/outcome relationship. As a result, although these other types of consolidation could result in some cost savings, they would be unlikely to significantly improve quality.

Moreover, even for procedures where there is a volume/outcome relationship, consolidation that might improve clinical quality outcomes would only be merger-specific if it would enable the merged hospital system to surpass certain volume thresholds that the hospitals could not otherwise meet independently. Further, even if the merging hospital systems were able to obtain substantiated, merger-specific volume/outcome related improvements in clinical outcomes by consolidating services, those benefits must be weighed against any potential disadvantages that could result from the consolidation. [130] For example, if closing some facilities would be necessary to consolidate volume at a more limited number of facilities, the increased travel time to these consolidated facilities could have an adverse impact on some patients.

Finally, to consolidate clinical services, the Parties must be able to integrate successfully and this involves achieving sufficient cultural compatibility. Indeed, the difficulty of unifying organizational cultures has been identified as a significant challenge to integrating facilities and a primary reason that anticipated benefits of hospital mergers may fail to materialize. [131] [redacted]

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[127] The Parties state that according to CMS, structural heart programs must perform at least 1,000 cath lab procedures and 400 percutaneous coronary intervention ("PCI") procedures. Over the last two years, SUNY Upstate claims to have performed 981 and 993 cath lab procedures and 323 and 292 PCIs, respectively. Crouse claims to have performed 390 cath lab and 763 PCI procedures during this time frame. COPA Application at 42.

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

[129] COPA Application at 42-43.

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

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

[redacted]

2. Hospitals Can Pursue Clinical Standardization without the COPA

The Parties claim the COPA "is anticipated to result in substantial benefits for the combined organizations, for patients, and the community at large," and that "a central objective of this Transaction is to utilize existing resources in a more efficient manner, reducing duplication of operational efforts currently in place, and to more closely coordinate the manner in which care is delivered across the sites of care within the combined organization." [133] Yet beyond such general statements regarding various service lines, the Parties do not identify any specific areas targeted for quality improvement or detailed plans for achieving improvements. A hospital merger may generate overall quality improvements when the merging hospitals have very different clinical quality levels if the merger allows the clinically inferior hospital to come under the management, and adopt the practices, of the clinically superior hospital, thereby improving quality at the inferior hospital. Based on the information FTC staff has obtained to date, neither hospital appears to suffer from low quality levels, meaning the potential for overall quality improvements may be limited. FTC staff will continue to assess this issue in its ongoing investigation.

Having said that, if SUNY Upstate and Crouse want to engage in greater efforts to coordinate care with one another and improve health outcomes for patients, they have other options without having to merge. Although standardizing clinical policies and procedures may lead to quality improvements, the Parties can achieve these either on their own, through some collaboration short of a merger, or through mergers or affiliations with alternative partners that raise fewer competitive concerns. As the antitrust agencies have consistently made clear, the antitrust laws are not an impediment to legitimate, procompetitive collaboration that would benefit consumers. Indeed, the FTC has issued extensive guidance to healthcare providers about ways that they can collaborate without running afoul of the antitrust laws. [134] Generally, most of the benefits from the merger may be achieved through alternatives that are less restrictive to competition and achieve comparable benefits or a more favorable balance of benefits over disadvantages. [135]

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[132] COPA Application Attachment 4I-3 at 14.
[133] COPA Application at 57.
[134] *See, e.g.*, U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), https://www ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf (see specifically Statement 6 regarding provider participation in exchanges of price and cost information, Statement 7 regarding joint purchasing arrangements among providers of health care services, and Statement 8 regarding physician network joint ventures); Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Fed. Trade Comm'n & U.S. Dep't of Justice Oct. 28, 2011), http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf.
[135] This assumes that benefits would be achieved as a result of the merger. FTC staff believes that any benefits resulting from the merger that are substantiated and merger-specific are likely to be modest.

Indeed, the Parties have collaborated in numerous ways over the last fifteen years pursuant to the Berger Commission recommendations and the DSRIP program. Such efforts include a Clinical Affiliation Agreement, an AAMC Uniform Clinical Training Affiliation Agreement, and several additional clinical or operational agreements intended "to take advantage of the proximity between the hospitals and avoid unnecessary duplicative capital expenditure." [136] These statewide initiatives were implemented and supervised by the NY DOH, and appear to have required substantial resources and public funding. [redacted] Furthermore, they claim that other than the proposed merger, there are "no other available arrangements that would have a less restrictive impact on competition in the primary service area and achieve the same benefits, including that preserve Crouse as a safety-net hospital in the community for the long term, or that could achieve a more favorable balance of benefits." [137] Despite the FTC's requests for more information from the Parties about these arrangements, the Parties have not supplied the documents and information that would be necessary to evaluate their claims. As we noted previously, if the Parties were unable to achieve the purported goals of these prior state initiatives – namely, to reduce costs and improve quality and accessibility – then we question whether they can now achieve these goals through the proposed merger.

Furthermore, it appears that [redacted]. It is possible, therefore, that there were other partners Crouse could have selected that may have raised fewer antitrust concerns. [redacted], the FTC has no way of evaluating this claim without more detailed information. Indeed, as we described previously, it appears that Crouse had conversations with several interested organizations, [redacted] FTC staff encourages the NY DOH to request additional documents and information about prior collaborative arrangements between the Parties and Crouse's partner search, to determine whether the Parties' claims in the COPA Application are accurate.

3. COPA Is Unnecessary for Population Health Improvement

The Parties claim that the COPA will "enhance Upstate's ability to provide care to under-served populations" and "align two health systems already committed to health equity, but who, when combined, will be able to achieve greater advances in health equity." [139] They suggest that combining Upstate's Global Health and Crouse's Population Health capabilities will enable them to enhance access to care across central New York. [140]

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[136] COPA Application at 36. *See* COPA Application Attachment 14 for complete list of contractual relationships between the Parties. *See also* Berger Commission Report, *supra* note 6; DSRIP Program Overview, *supra* note 7.
[137] COPA Application at 65.
[138] *See* discussion of Crouse's partner search, *supra* at 13.
[139] COPA Application at 44.
[140] COPA Application at 44.

However, both Parties appear to *already* engage in extensive population health initiatives. For example, SUNY Upstate and Crouse both participated in the development of the Onondaga County Community Health Assessment and Improvement Plan, along with many other providers and community stakeholders. [141] And the COPA Application lists numerous population health initiatives that both hospitals have engaged in to prevent chronic disease; promote a healthy and safe environment; promote healthy women, infants, and children; promote well-being and prevent mental and substance abuse disorders; prevent communicable diseases; and address health equity. [142] It is unclear why the proposed merger is necessary for any of these population health management initiatives. The relevant question is whether SUNY Upstate and Crouse would be more likely to participate in such initiatives, or participate more effectively, with this merger than they would without it. The Parties present no evidence that this is the case. It appears that the region can continue to benefit from these initiatives without incurring the disadvantages associated with the proposed merger. Antitrust laws do not prevent these hospitals from pursuing population health initiatives in the absence of the merger. Furthermore, there does not appear to be any enforceable commitment requiring the combined hospital system to achieve these goals post-merger.

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

According the Parties, [redacted]. [143] Instead, SUNY Upstate has agreed to install its EMR system, EPIC, at Crouse as part of the proposed merger. [144] Without more detailed information from the Parties, FTC staff has been unable to verify any of these details and [redacted]. Nevertheless, FTC staff has attempted to evaluate the Parties' claim that bringing patient medical records onto a unified EMR will enable them to better coordinate care for patients.

For several reasons, the Parties' claims regarding a uniform EMR system may be overstated. First, they have not demonstrated that the incremental benefit of a common IT platform would be of sufficient magnitude to significantly improve patient health outcomes. Patients who will only use facilities in one of the current hospital systems are not likely to benefit from the combination of the EMR platforms. There are ways for hospitals to effectively share information with each other, even with separate EMR systems, further limiting the benefits of a common system. Moreover, it is possible that federal legislation regarding EMR

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[141] COPA Application at 41. *See also* Onondaga County Community Health Assessment and Improvement Plan 2019-2021, http://www.ongov.net/health/documents/OnondagaCountyCHA-CHIP.pdf.
[142] COPA Application at 53-56.
[143] COPA Application at 49-50.
[144] COPA Application at 41, 46.

interoperability may reduce or obviate the need for a common EMR platform between the Parties. [145]

Second, any benefit of a common EMR system would have to be compared to its costs. Converting to a common EMR system can be extremely expensive and time consuming, [146] and the conversion process can delay access to critical patient information. [redacted] All told, the time, difficulties, and expense of converting to a common EMR system may outweigh the potential benefit.

Third, a Health Information Exchange ("HIE") already exists in central New York, which enables secure access to patient information across the continuum of care, thereby improving patient health outcomes. [149] HealtheConnections appears to have been available since 2011, and both SUNY Upstate and Crouse appear to be participants. The Parties have not adequately explained the incremental benefit of the information accessible on a combined EMR system versus that available on the existing HIE. Furthermore, under the Affiliation and Collaborative Agreement, the Parties received a $5.1 million HEAL4 grant in 2007 from the NY DOH for information technology updates at SUNY Upstate, so that both hospitals could share electronic information. [150] The Parties have not adequately explained how this money was used and why they now need a combined EMR system.

In summary of Section VI.A, the proposed merger appears to eliminate direct head-to-head competition between SUNY Upstate and Crouse, and will likely lead to significantly higher

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

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

[147] COPA Application at 49.

[redacted]

[149] Healthe Connections, *About Us*, https://www healtheconnections.org/about-us/ (listing SUNY Upstate, Crouse, and St. Joseph's as hospital participants in Onondaga County). *See also*, Health IT Connections, *Central New York's Health Information Exchange Connects Four Area Hospitals, Lab To Improve Patient Care And Continues Its Expansion Across CNY* (May 3, 2011), https://www healthitoutcomes.com/doc/central-new-yorks-health-information-0001.

[150] *See* New York State Department of Health, REPORT ON THE IMPLEMENTATION OF THE REPORT OF THE COMMISSION ON HEALTH CARE FACILITIES IN THE TWENTY-FIRST CENTURY at 66, *supra* note 6.

prices and reduced business incentives to maintain or improve quality and access to care. Importantly, the benefits of competition among healthcare providers are not confined to those patients covered by commercial insurance plans. Competition benefits *all* patients, including those who are covered by government insurance programs (*i.e.*, Medicare and Medicaid) or are uninsured. By far, the most important such benefit is improved quality of care. As noted above, competition-reducing mergers often reduce quality. Those quality reductions could affect all of the hospitals' patients, not just those with commercial insurance. Competition may also indirectly restrain the prices or premiums paid by patients covered by a government insurance program or who are uninsured. [151]

B. Proposed Merger Likely Would Reduce Patient Access to Healthcare Services in the Syracuse Area

NY DOH COPA BENEFIT FACTOR (c)(1): *Preservation of needed health care services in the relevant primary service area that would be at risk of elimination in the absence of a Cooperative Agreement*

NY DOH COPA BENEFIT FACTOR (c)(2): *Improvement in the nature or distribution of health care services in the primary service area, including expansion of needed health care services or elimination of unnecessary health care services*

NY DOH COPA BENEFIT FACTOR (c)(4): *Expansion of access to care by medically-underserved populations*

ASSESSMENT: The Parties claim they must consolidate certain clinical services in order to preserve them and that integration, along with the use of a single EMR system, will generally improve coordination of care and offer enhanced access to vulnerable patient populations. [152] However, as FTC staff has already noted, consolidation of services could just as likely lead to a reduction in access to care. For example, the Parties cite concerns about changing demographics and the financial pressures and capacity constraints they will face as utilization

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

[152] *See, e.g.*, COPA Application at 41-42.

increases from a growing 65-and-older population, and claim the proposed merger is necessary to alleviate these concerns and preserve access to healthcare services. [153] However, the Parties have not presented sufficient evidence that they lack the financial resources to continue operating independently and to maintain quality and access to healthcare services. We urge the NY DOH to consider whether any challenges the Parties face in response to the changing delivery and payment landscape can be addressed in less restrictive ways than the proposed merger, without reducing valuable competition in this region.

Notably, the Parties have made no firm commitments to keep open or maintain current service levels at hospitals and other facilities. Indeed, they would likely need to consolidate facilities and services to achieve projected cost savings and efficiencies, which would likely lead to a reduction in access to healthcare services, including potentially urgent care. The Parties have identified some general service areas in which they expect to consolidate volume at one hospital or the other following the merger, including: neurology, neurosurgery, and stroke care; labor and delivery services; cardiology and cardiac surgery services; surgical oncology services; emergency department services; pediatric specialty care and NICU services; and inpatient and outpatient behavioral health services and addiction treatment services. We encourage NY DOH to weigh carefully the potential benefits of consolidating volume against the potential harms, including reduced capacity and increased patient drive times.

The Parties' efficiencies claims also raise concerns about reduced capacity and access for healthcare. For example, the Parties claim that absent the proposed merger, SUNY Upstate would have to build additional inpatient space [redacted] to meet increasing inpatient demands. SUNY Upstate claims to be severely capacity constrained and Crouse claims to consistently have excess capacity, [redacted]. Following the proposed merger, SUNY Upstate intends to utilize all of Crouse's existing beds and does not expect to request any additional beds from the NY DOH in the near future. The Parties claim that this plan will make 134 beds available to the system, immediately alleviating SUNY Upstate's capacity constraints and avoiding the "costly" inpatient bed tower expansion. [154] Without more detailed information from the Parties, FTC staff is unable to verify the accuracy of these claims. To be clear, this plan does not mean that bed capacity in the Syracuse area will actually increase under the merger. In fact, rather than constructing new facilities as SUNY Upstate had considered prior to proposing the merger, the Parties now plan to use the available capacity at Crouse to alleviate capacity constraints. Thus, the merger will likely lead to a reduction in capacity in the Syracuse area, which could result in less patient access to healthcare facilities and services.

Furthermore, SUNY Upstate can already refer patients to Crouse if it is capacity constrained at any given time. As previously discussed, there is significant overlap between SUNY Upstate and Crouse in terms of the health conditions of the patients they treat. Therefore, absent the merger, Crouse is already a good alternative for potential transfers from SUNY Upstate for the vast majority of patients treated there. At best, the Parties' claims are limited to

[153] COPA Application at 38-39.
[154] COPA Application at 34-35, 46.

the extent that they can leverage higher acuity service offerings and physician coverage capabilities available only at SUNY Upstate, and not Crouse. However, the Parties do not quantify the impact of this claim, nor do they assess the likely number of patients who would be transferred from Crouse to SUNY Upstate post-merger who could not be transferred pre-merger.

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

NY DOH COPA BENEFIT FACTOR (c)(5): *Lower costs and improved efficiency of delivering health care services, including reductions in administrative and capital costs and improvements in the utilization of health care provider resources and equipment*

ASSESSMENT: The Parties claim that the merger will generate substantial cost savings and efficiencies through avoidance of capital expenditures, consolidation of clinical services, elimination of redundancies, reductions in labor expenses, and reductions in purchasing and other non-labor expenses. [155] For the reasons below, the purported gains in cost savings may be overstated and may not outweigh the lost competition. Furthermore, experience and evidence demonstrate that many hospital mergers do not result in significant efficiencies, despite company projections that they will. [156]

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

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[155] *See* COPA Application at 45-49, 57, 59-61, 64, 67; COPA Application Attachment 19.

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

some cost savings, it is unclear how much would be passed through to healthcare consumers in the form of lower prices.

In addition, many of the claimed savings are the type that likely are achievable without the proposed merger. The Parties have not shown that all of the claimed benefits are both merger-specific and incremental to the benefits the Parties would have achieved without the merger. The Parties pledge to use cost savings derived from the merger to invest in quality and healthcare initiatives, including population health improvement initiatives. However, it is unclear what portion of the savings is truly incremental compared to the current or future investments that the hospitals would have made independently, absent the merger. SUNY Upstate and Crouse already make significant investments in quality and healthcare initiatives, and likely would continue to do so without the merger.

There do not appear to be any enforceable commitments to achieve cost savings or efficiencies, or to use these savings to fund quality and access improvements. Even if the Parties were able to reduce their costs by eliminating competing clinical services, that is not an unqualified benefit. Those cost savings may be derived from a reduction in staff or closure of facilities, thereby reducing patient access to healthcare services and forcing some patients to travel further to receive care or wait longer for appointments, which may reduce quality of care and patient satisfaction. The Parties claim that "Upstate not only intends to preserve the jobs at Crouse, it will grow the employee population, contributing high-value jobs to the community."[157] However, the COPA Application also acknowledges that [redacted] Notably, much of the efficiencies section of the COPA Application is redacted so the public has no way of evaluating the Parties' plans to consolidate or eliminate services to achieve cost savings. Any detrimental impact this consolidation would have on the quality of patient care should receive appropriate consideration.

The Parties claim the proposed merger will enable them to utilize resources in a more efficient manner and reduce duplicative costs and administrative burden.[159] Yet, although they describe plans to avoid future capital expenditures, they have not identified any specific past expenditures that they believe to have been unnecessary or duplicative. To the contrary, [redacted]

[157] COPA Application at 43.
[158] *See, e.g.*, [redacted]
[159] COPA Application at 45-49, 57, [redacted].

[redacted]

Economic research indicates that hospital competition leads to lower costs, more effective resource utilization, and improved patient health outcomes, as compared to highly concentrated markets with less competition. [161] Competition between hospitals often leads to investments that improve patient care and access to healthcare services. Thus, to the extent that hospital competition results in facility expansions and new equipment purchases that improve access and quality, competition is good for consumers, not unnecessary or wasteful. Eliminating this competition could lead to a less productive allocation of resources and thereby deny consumers these benefits. [162] For example, although new equipment can be costly, the quality benefits associated with technology advances may justify these expenditures. [163] Investments in facilities, technology, and equipment can result in shorter wait times, more convenient service options for physicians and patients, and the continued availability of services when a piece of equipment fails, all of which are far from wasteful, but quite beneficial. In contrast, to the extent that the combined system's future plans include the consolidation of clinical services, including reduced facility and equipment investments, this could result in reduced patient choice and

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[160] [redacted]. The SUNY Master Capital Plan for 2021-22 lists approximately $50 million for projects under design at SUNY Upstate's University Hospital, $208.8 million for projects under construction, including building a new Health and Wellness Center on the SUNY Upstate campus, and $15.2 million in seven Capital Plan Projects for SUNY Upstate. *See* SUNY Master Capital Plan Report, State-Operated Campuses, Fiscal Year 2021-22, at 79-82. [redacted]

[161] *See* Dan P. Kessler & Mark B. McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q. J. ECON. 577 (2000), http://qje.oxfordjournals.org/content/115/2/577 full.pdf+html (finding that hospital competition unambiguously improves social welfare: competition leads to substantially lower costs and lower levels of resource use, as well as lower rates of adverse patient health outcomes); Martin Gaynor, Rodrigo Moreno-Serra & Carol Propper, *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service*, 5 AM. ECON. J.: ECON. POL'Y 134 (2013), https://www.aeaweb.org/atypon.php?doi=10.1257/pol.5.4.134 (finding that hospital competition leads to improved quality and resource utilization).

[162] At the FTC COPA Workshop, participants discussed the impact of state regulatory approaches for reducing duplication of healthcare services. Robert Fromberg from Kaufman Hall, an organization that represents health systems, emphasized the importance of reducing duplicative or underused clinical services, and the role of COPAs as a mechanism for health systems to accomplish this goal. FTC COPA Workshop Transcript: Session 2, *supra* note 96, Robert Fromberg remarks at 31-33. *See also* Kaufman Hall Submission to the FTC (Jun. 4, 2019), https://www regulations.gov/document?D=FTC-2019-0016-0010. Professor Thomas Stratmann then presented his economic research on the effects of CON laws. While CON laws are distinct from COPA laws, they both have the effect of restricting competition among healthcare providers in order to rationalize certain services. The policy goals of CON and COPA laws are also similar – to achieve cost savings by reducing duplicative or underused services, to improve quality of care, and to improve access for services. Thus, CON research may be relevant for considering the impact of COPA laws and regulations. Professor Stratmann's research indicates that states with CON laws have reduced access to care and reduced quality, as compared to states without CON laws. *See also* Vivian Ho Submission to the FTC (Jun. 5, 2019), https://www.regulations.gov/document?D=FTC-2019-0016-0012 (describing empirical research that demonstrates "[w]ell-intentioned state CON regulations have not improved patient outcomes or lowered costs for patients. Healthy market competition amongst hospitals is a better strategy for improving patient welfare.").

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

access to healthcare services. For example, as discussed above, the Parties' plans to forego an expansion of SUNY Upstate's inpatient facility appears to be a reduction of capacity that could reduce patient access.

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

NY DOH COPA DISADVANTAGE FACTOR (d)(3): *Inability of health care payers or health care providers to negotiate reasonable payment and service arrangements*

NY DOH COPA BENEFIT FACTOR (c)(6): *Implementation of payment methodologies that control excess utilization and costs, while improving outcomes*

ASSESSMENT: The New York COPA Regulations require the NY DOH to consider whether the proposed merger would have an adverse impact on the ability of health insurers to negotiate payment and service arrangements with healthcare providers. Ultimately, this is an important indicator of how the merger is likely to impact consumers because health insurers negotiate on behalf of their customers – area residents and employers. When hospitals obtain greater bargaining leverage, they are able to negotiate higher reimbursement rates (i.e., prices) with insurers. Insurers typically pass on these higher prices to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses. This affects fully insured employers who offer coverage to their employees, self-insured employers who pay their employees' healthcare claims, employees who pay some portion of their health insurance benefits, and individuals who purchase health insurance directly. [164] Furthermore, employers facing higher costs may reduce insurance coverage for their employees or eliminate insurance coverage altogether. Higher healthcare costs can also be passed through to employees in the form of lower wages and total compensation. [165] Because the FTC is concerned about the impact that

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

[165] *See, e.g.*, Gaynor, Ho & Town, *supra* note 64, at 236 (stating that employers pass through higher health care costs dollar for dollar to workers, either by reducing wages or fringe benefits, or even dropping health insurance coverage entirely); GAYNOR & TOWN, *supra* note 64, at 1 ("Ultimately, increases in health care costs (which are generally paid directly by insurers or self-insured employers) are passed on to health care consumers in the form of higher premiums, lower benefits and lower wages[.]"); Daniel Arnold & Christopher Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages*, (2021 working paper), https://www.ehealthecon.org/pdfs/Whaley.pdf; Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LAB. ECON. 609 (2006), https://www hks harvard.edu/fs/achandr/JLE_LaborMktEffectsRisingHealthInsurancePremiums_2006.pdf (finding that increased health insurance costs lead to reduced wages and employment); Priyanka Anand, *Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey*, 26 Health Econ. 1601 (2017), https://onlinelibrary.wiley.com/doi/10.1002/hec.3452 (finding that as health insurance costs increase, employers that offer health insurance reduce total employee compensation); Jay Bhattacharya & M. Kate Bundorf, *The Incidence of the Healthcare Costs of Obesity*, 28 J. HEALTH ECON. 649 (2009),

healthcare mergers will have on consumers, we take seriously the impact that a hospital merger will have on the ability of insurers to negotiate competitive prices and other contractual terms on consumers' behalf.

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

Today, SUNY Upstate and Crouse independently have substantial bargaining leverage in negotiations with health insurers. An insurer network that lacks the hospitals of either system is less attractive to employers and consumers than a network that includes the hospitals of both systems, and this gives each system significant bargaining power today relative to insurers. However, the bargaining leverage of each hospital system is limited by the availability of the *other* system (as well as St. Joseph's) as an alternative. That is, an insurer could still offer a fairly attractive network if it included only two of these three Syracuse area hospital systems, especially because that more limited network would likely be offered at a discount. [166] After the proposed merger, an insurer would have to agree to SUNY Upstate's rates or offer a health plan consisting of just one Syracuse area health system. Moreover, there is some indication from a recent study that SUNY Upstate raised rates at Community General after it acquired the independent hospital system in 2011:

> SUNY Upstate was reportedly aggressive after its 2011 merger with Community General in increasing prices and refusing, for instance, to phase in cost increases over time. As one insurer respondent noted, "my most expensive hospital took over my cheapest

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http://www.sciencedirect.com/science/article/pii/S0167629609000113 (finding that increased health insurance costs can be passed to employees in the form of lower wages); and Jonathan Gruber, *The Incidence of Mandated Maternity Benefits*, 84 AM. ECON. REV. 622 (1994), http://economics.mit.edu/files/6484 (finding that increased health insurance costs can be passed to employees in the form of lower wages).

[166] It is important to note that, even in this case, both the hospital system and the insurer still benefit from reaching an agreement, and so agreement is usually reached. But the *terms* on which agreement is reached depend on the relative bargaining power of the hospital system and the insurer, which in turn will depend on the degree of hospital competition.

> hospital so the pricing of my cheapest hospital is now the same as my most expensive hospital." [167]

Despite the Parties' vague assurance that they "do not anticipate an *immediate* change in commercial reimbursement rates," (emphasis added) [168] the proposed merger would give the combined hospital system the ability to extract substantially higher reimbursement rates from health insurers during contract negotiations, whether or not it occurs immediately. [redacted]

The Parties also assert the proposed merger would facilitate the expansion of value-based payment arrangements with government and commercial payers. [171] However, it is unclear exactly how the merger would affect the combined hospital system's business incentives to enter into value-based payment models. It is possible that the COPA, by increasing the combined hospital system's bargaining leverage, could diminish its willingness to cooperate with payers' attempts to lower costs through value-based and risk-based contracting models, if adopting such an approach would prove less profitable than traditional fee-for-service models. Thus, with its substantial post-merger market power, the combined hospital system may be able to resist certain efforts to negotiate beneficial value-based or risk-based contracts that make it worse off than fee-for-service contracts because insurers will have no viable alternatives than to contract with the combined hospital system. Supporting this conclusion, recent empirical research suggests that consolidation among healthcare providers has not facilitated the increased use of value-based payment models, and that providers in concentrated markets may be able to resist such initiatives. [172] On a related note, recent literature suggests that health systems with increased

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[167] Katie Keith, Sabrina Corlette & Olivia Hoppe, ASSESSING RESPONSES TO INCREASED PROVIDER CONSOLIDATION IN THREE MARKETS: DETROIT, SYRACUSE, AND NORTHERN VIRGINIA; CASE STUDY ANALYSIS: THE SYRACUSE HEALTH CARE MARKET, Center on Health Insurance Reforms at 6 (Nov. 2018), https://georgetown.app.box.com/s/38whcvigzyytlzznecxz0oq9qklsaitq.

[168] COPA Application at 59.

[169] COPA Application Attachment 4I-1 at 16.

[170] COPA Application Attachment 4I-4 at 10 [redacted].

[171] COPA Application at 60-61.

[172] *See* Hannah Neprash, Michael Chernew & J. Michael McWilliams, *Little Evidence Exists to Support the Expectation that Providers Would Consolidate to Enter New Payment Models*, 36 HEALTH AFFAIRS 346, 353 (2017), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0840 ("These findings suggest that new payment models may have triggered some consolidation as a defensive reaction to the threat these models could pose, rather than as a way to achieve efficiencies in response to the new incentives. Hospitals and specialists in particular might consolidate both horizontally and vertically to achieve sufficient market share to resist payer pressure to enter risk contracts or weaken ACOs' ability to exploit competition in hospital and specialty markets, and compel reductions in prices and service volume. . . . Specifically, our study supports skepticism of claims by providers that they are consolidating primarily to engage in risk contracts and achieve efficiencies."); Cooper, Craig, Gaynor & Reenen, *supra* note 64, at 104 ("Finally, there is widespread agreement that payment reform (shifting to contracts where providers bear more risk) is crucial to increasing hospital productivity (McClellan et al. 2017). Our analysis suggests that providers who have fewer potential competitors will be more able to resist attempts at such payment reform.").

scale are not more likely to engage in or be more successful at value-based contracting. [173]

Furthermore, the shift to value-based initiatives is already occurring among many hospital systems and insurers nationwide, and is mandated by CMS in some circumstances. [174] [redacted] In keeping with this trend, SUNY Upstate and Crouse likely would continue to transition to value-based initiatives independently. Crouse admits that it "maintains four value-based payment arrangements with government and commercial payors, and intends to expand those arrangements following the Transaction." [176] [redacted] By pairing Crouse's primary care base and population health infrastructure with SUNY Upstate's specialists, the Parties contend the proposed merger would "greatly accelerate Upstate's ability to participate in value-based arrangements and enhance Crouse's current capabilities." [177] Without more detailed information from the Parties, FTC staff is unable to verify the accuracy of these claims. However, to the extent these hospitals have already transitioned to value-based initiatives and would have continued to expand value-based initiatives independently, this cannot be considered a merger-specific benefit. [178]

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[173] *See, e.g.,* Anil Kaul, K.R. Prabha & Suman Katragadda, *Size Should Matter: Five Ways to Help Healthcare Systems Realize the Benefits of Scale*, PWC STRATEGY& (2016), http://www.strategyand.pwc.com/reports/size-should-matter (finding that greater size has not led to lower costs or better quality outcomes for consolidated health systems); David Muhlestein, Robert Saunders & Mark McClellan, *Medical Accountable Care Organization Results for 2015: The Journey to Better Quality and Lower Costs Continues*, HEALTH AFFAIRS BLOG (Sept. 9, 2016), http://healthaffairs.org/blog/2016/09/09/medicare-accountable-care-organization-results-for-2015-the-journey-to-better-quality-and-lower-costs-continues/ ("Also consistent with last year, large, consolidated ACOs did not necessarily achieve the best performance. In fact, we found that the opposite was often true, as smaller, physician-led ACOs were more likely to improve quality and lower cost enough to earn shared savings. **This result is a cautionary note given the trend toward mergers and consolidations among health systems; consolidation and larger size do not necessarily lead to the functional integration and efficiency needed to succeed under alternative payment models.**") (emphasis added).

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

[175] COPA Attachment 4I-1 at 16.

[176] COPA Application at 60.

[177] COPA Application at 61.

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

E. Merger Likely Would Substantially Reduce Competition for Physician Services and Ancillary Healthcare Services

NY DOH COPA DISADVANTAGE FACTOR (d)(4): *Reduced competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, health care providers and the potential for adverse health system quality, accessibility and cost consequences*

ASSESSMENT: The framework to evaluate outpatient providers and physician services mergers is essentially the same as that described above for inpatient hospitals. Like hospitals, providers of outpatient services and physician services compete for inclusion in health plan networks and to attract patients. These providers negotiate reimbursement rates with insurers, and the rates negotiated depend on their relative bargaining leverage. When there are adequate alternatives to a particular provider, an insurer has a greater ability to resist demands for higher rates by a particular outpatient provider and physician-services provider.

Based on the information FTC staff has obtained to date, SUNY Upstate and Crouse appear to be close competitors for outpatient and physician services. The systems operate competing outpatient centers that serve the Syracuse area, and each system employs physicians across numerous specialties. The systems compete for inclusion in insurer networks and negotiate with insurers to establish rates for outpatient and physician services. The proposed merger would eliminate the competition between the systems for outpatient and physician services and would further consolidate those markets. Post-merger, the combined system's negotiating leverage is likely to increase substantially, which is likely to lead to higher prices and reduced quality and availability of physician and outpatient services to the serious detriment of area residents and employers.

In summary of Section VI, it appears that the proposed merger is likely to result in serious disadvantages resulting from the loss of competition, while any benefits are likely to be modest and may be largely achievable by other means that are less restrictive to competition. Again, FTC staff notes that to fully assess these issues during our ongoing investigation, we need more detailed information that the Parties have not yet provided. In the following section, we assess whether regulatory terms and conditions could mitigate the likely disadvantages of the COPA.

VII. Possible Terms and Conditions Imposed Under Active Supervision Are Unlikely to Mitigate the Disadvantages Resulting from Loss of Competition

NY DOH COPA FACTOR (g): *The extent to which active supervision is likely to mitigate the disadvantages*

ASSESSMENT: The Parties do not appear to offer any enforceable commitments to mitigate the potential anticompetitive harms resulting from the merger. Instead, the Parties offer the following vague conditions they claim will limit the potential for unintended negative

impacts following the merger – most of which are merely aspirational promises to continue what they are already doing or would have to do under current laws, regardless of the COPA.

- Continuing to operate and provide a full range of essential health care services at Crouse;
- Maintaining or enhancing essential health care services in all counties Upstate serves;
- Bringing a Comprehensive Heart Institute to the region;
- Treating Medicare and Medicaid patients at all inpatient and outpatient locations;
- Publicly reporting quality information and other key metrics through reporting;
- Committing to good faith negotiations with all payors; and
- Reporting changes in prices on negotiated rates consistent with price transparency laws – this will allow the Department to monitor changes in prices on negotiated rates. [179]

A. Parties' Proposed Conditions and Monitoring Plan Are Insufficient

The Parties claim their proposed conditions and monitoring approach "will mitigate any potential disadvantages of a Cooperative Agreement by ensuring that the proposed goals and benefits of the Cooperative Agreement are tracked, measured and achieved." [180] FTC staff strenuously disagrees with this characterization. To the contrary, the proposed conditions fail to define exactly what would be required of the Parties, provide no objective assurance that any of these conditions will actually be achieved, and lack any mechanism for holding the combined hospital system accountable if it does not fulfill the conditions. The Parties' proposal for monitoring the impact of the COPA consists of little more than an offer to file an Annual Performance Report that will include a written narrative describing the benefits achieved under the COPA. The quality metrics the Parties propose to track their progress are quite limited, [181] and although the Parties offer to provide supporting "data and metrics" in their annual reports, they do not specify which data and metrics will be used. Instead, the Parties suggest that *after* the COPA is approved, they would work collaboratively with the NY DOH to jointly develop targets that would measure progress towards program goals. [182] This kind of post-transaction determination of performance metrics does not allow for public evaluation of active state supervision. It also, critically, delays measuring or monitoring of those metrics by the state.

While FTC staff has raised concerns about COPA conditions attempted in other states, the Parties' proposed conditions fall short of what we have observed elsewhere. In particular, although price regulation is not a substitute for market competition, in this case, there does not even appear to be any mechanism for the NY DOH to regulate prices for healthcare services. Unenforceable commitments to negotiate with payers in good faith and comply with price

[179] COPA Application at 70.
[180] COPA Application at 71.
[181] *See* COPA Application Attachment 22 [redacted].
[182] *See* COPA Application at 69-70.

transparency law reporting requirements will do nothing to prevent anticompetitive price increases that are likely to occur as a result of the merger.

Furthermore, measuring healthcare quality can be challenging and the NY COPA Regulations do not specify objective, quantitative quality of care benchmarks by which claimed benefits can be evaluated, much less weighed against the disadvantages likely to result from the COPA. It is unclear how the NY DOH could objectively determine whether the hospital attestations regarding quality benefits are accurate, and thus whether the combined hospital entity is complying with the requirements of the COPA. [183] Critically, there appear to be no meaningful enforcement mechanisms if the hospital fails to achieve its promises regarding quality improvements, other than revoking the COPA. And it should be noted that revoking the COPA does not really punish the Parties for failing to achieve quality improvements. Indeed, the Parties may consider this outcome desirable because it would leave them unconstrained in their ability to exercise market power to the detriment of Syracuse area patients.

The Parties propose that in the event the NY DOH determines there are any material deviations from the COPA terms and conditions, that the hospital system would have 30 days to adopt a remediation plan intended to correct any deficiencies. [184] However, no further details are specified as to what would be required in a remediation plan and it is unclear what happens if a remediation plan proves inadequate for resolving a problem with the COPA.

Finally, the Parties suggest that the NY DOH implement a monitoring plan similar to what was used for COPAs approved under the DSRIP program. [185] FTC staff is aware of only one Performing Provider System ("PPS") that received COPA approval under the DSRIP program in 2015 – Staten Island PPS. [186] However, it is unclear exactly what the NY DOH did to monitor this COPA, which expired when the DSRIP program ended in 2020. Some of the NY DOH's quarterly DSRIP reports reference plans to monitor the Staten Island PPS COPA. [187] We have not been able to confirm that the NY DOH accomplished these plans or how the NY DOH assessed any information it may have obtained. Without greater transparency into the specific details of the NY DOH's active supervision for this COPA, we cannot say whether it would be sufficient for monitoring the proposed hospital merger to mitigate the potential for anticompetitive harms and disadvantages. However, we note that monitoring a fully merged hospital system in perpetuity presumably would be quite different than monitoring a DSRIP provider collaboration for a limited duration as part of a broader statewide initiative aimed only at the Medicaid program.

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[183] *See* New York COPA Regulations § 83-2.9 (requesting that COPA recipients address several factors in their annual performance reports, but not specifying any objective data or metrics that must be provided).
[184] *See* COPA Application at 69.
[185] *See* COPA Application at 71.
[186] *See* New York State Department of Health Public Health and Health Planning Council, *Executive Summary for the Staten Island PPS COPA Application*, https://www health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2016-11-17/docs/copa-sipps_staten_island_pps.pdf.
[187] *See* New York State Department of Health, *NYS DSRIP Quarterly Reports* (2014-2020), https://www health.ny.gov/health_care/medicaid/redesign/dsrip/quarterly_reports htm.

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

Under the New York COPA Regulations, the hospital can voluntarily terminate its COPA by giving 30 days' notice after the COPA has been in effect for a minimum of two years. [188] This means that once all of the hospital assets are combined, the hospital could terminate the COPA and therefore no longer be constrained by any meaningful competition or state regulation of potentially anticompetitive conduct. At this point, antitrust enforcement would not be a likely remedy. Indeed, as we discuss below, we have significant concerns about the difficulty and feasibility of separating a hospital system after assets have been integrated.

The New York COPA Regulations require the NY DOH to review periodic reports submitted by the hospitals and allow the NY DOH to revoke the COPA if it investigates the hospital's activities and determines that the hospital is not complying with the terms of the COPA or the benefits of the merger no longer outweigh the disadvantages attributable to a reduction in competition. [189] Unfortunately, there is no certainty that this provision would protect the public if the COPA does not fulfill its promised benefits.

Even if the NY DOH attempted to order a divestiture of assets as part of the revocation of a COPA, this is unlikely to return the hospital systems to their pre-merger status and fully restore the lost competition once the merger has already been consummated. Hospital mergers can involve a significant degree of integration. For example, the combined entity could consolidate or close hospitals; consolidate and transfer service lines; reorganize physician and other staffing at hospitals (with some physicians potentially leaving the area); negotiate new, consolidated contracts with health insurers; integrate EHR and other IT systems; integrate accounting and other financial systems; eliminate management and other staff; consolidate administrative services and vendors; and change many aspects of daily operations at these hospitals. These changes likely would alter patient travel patterns and facility preferences, as well. Reversing all of this integration and these changes through revocation of the COPA would be highly disruptive, and quite likely impossible. [190]

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[188] New York COPA Regulations § 83-2.14.

[189] New York COPA Regulations § 83-2.10.

[190] Recent FTC and DOJ statements have indicated that the agencies are willing to seek post-consummation structural relief in appropriate circumstances. *See* ANTITRUST DIV., U.S. DEP'T OF JUSTICE, MERGER REMEDIES MANUAL 19 (2020), https://www.justice.gov/atr/page/file/1312416/download ("If the acquired assets are integrated, crafting an effective divestiture to eliminate the anticompetitive effects may be difficult, but nonetheless necessary to undo the illegal effects of the merger."); Ian Conner, Former Director, Bureau of Competition, FTC, Remarks at GCR Live 9th Annual Antitrust Law Leaders Forum: *Fixer Upper: Using the FTC's Remedial Toolbox to Restore Competition* 4 (Feb. 8, 2020), https://www.ftc.gov/system/files/documents/public_statements/1565915/conner_gcr_live_conduct_remedies_2-8-20.pdf ("For many reasons, it may be hard to resurrect a competitor or form a new player that is able to exert the same competitive intensity that the target would have provided, but for the merger in question. The recent Remedy Study noted that the Commission may face significant challenges in crafting a remedy for a consummated merger, especially if the acquired business has been merged and its assets combined with those of the acquiring firm. . . . Nevertheless, even when it is hard and may require assets and services beyond those acquired, breakup of the merged company to reestablish competition is still the most likely remedy for a consummated merger."); FED.

For that reason, antitrust agencies typically seek to prevent or remedy problematic mergers *before* they are consummated because it is inherently challenging, and rarely feasible, to "unscramble the eggs" and unwind the assets of companies after they have been integrated. [191] Historically, the FTC has faced difficulties in obtaining effective remedial relief after assets have been combined through a merger, including hospital and other healthcare provider mergers. Indeed, even in certain cases where the FTC has proven that such a merger was anticompetitive and resulted in higher prices without offsetting quality improvements or enhanced patient experience, the FTC has been unable to obtain a viable divestiture remedy for these harms. [192] Similarly, if the COPA is approved, and SUNY Upstate is allowed to merge its operations with Crouse, the remedies available if the merger does not yield its promised benefits would be severely limited.

The revocation provision does not guarantee a restoration of pre-consolidation market competition, nor does it guarantee an adequate timeline for restoring pre-consolidation market competition. Based on recent FTC experience, it can take a year or more to finalize divestitures, even when there has not been significant facility, clinical, and other integration between the Parties. [193]

C. General Concerns with Conduct Remedies

Beyond what the Parties offered in the COPA application, the NY DOH has independent discretion to impose terms and conditions on recipients of COPAs in an attempt to mitigate the disadvantages resulting from loss of competition, although we do not know whether this will happen or what possible terms might entail. Other states have imposed various types of terms and conditions on recipients of COPAs, including rate regulation, mechanisms for sharing cost savings and efficiencies with local residents, public reporting of quality metrics, and

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TRADE COMM'N, THE FTC'S MERGER REMEDIES 2006-2012: A REPORT OF THE BUREAUS OF COMPETITION AND ECONOMICS 12, 18-19 (2017), https://www.ftc.gov/system/files/documents/reports/ftcs-merger-remedies-2006-2012-report-bureaus-competition-economics/p143100_ftc_merger_remedies_2006-2012.pdf (describing the significant challenges in crafting a remedy for a consummated merger when assets have been combined)..

[191] *See, e.g.,* Deborah L. Feinstein, Former Director, Bureau of Competition, FTC, Remarks at the Fifth National Accountable Care Organization Summit: Antitrust Enforcement in Health Care: *Proscription, not Prescription* (Jun. 19, 2014), https://www ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf

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

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

commitments regarding certain contractual provisions between the hospitals and commercial health insurers. Such terms and conditions are often referred to as "conduct remedies" because they attempt to ameliorate the harm to competition and consumers resulting from a merger by imposing restrictions on the merged entity's conduct. [194]

It is doubtful that conduct remedies can drive meaningful cost savings and quality improvements with as much force as maintaining a competitive environment. Conduct remedies that purport to restrain price increases are unlikely to replicate the pricing dynamics that would have prevailed absent the merger because such a remedy cannot replace the competitive conditions that otherwise would have existed. Rate review cannot simulate the nuanced, iterative responses that competitors make in response to each other during the negotiation process. [195] In addition, a conduct remedy designed to mitigate one type of harm may inadvertently create another type of harm as an unintended consequence. For example, a conduct remedy limiting price increases may result in the unintended reduction in quality of care.

Conduct remedies designed to prevent price increases have several serious deficiencies. First, they are typically temporary. After the conduct remedy expires, the less competitive market structure remains, but any constraint imposed by the remedy will be eliminated, and prices are likely to increase as a result. [196] Second, designing and enforcing price restrictions is a complicated and highly resource-intensive endeavor, in part because such restrictions would need to constrain prices for all current and future services provided by the merged entity during the relevant timeframe, and account for different (or changes in) reimbursement methodologies. [197] In the healthcare industry, in particular, where prices, quality, and costs are difficult to measure, these kinds of regulatory mechanisms often do not achieve their intended purpose, no matter how well-intentioned. [198]

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

[195] *See* Commonwealth v. Partners Healthcare Sys., No. SUCV2014–02033–BLS2, at 42 (Sup. Ct. of Mass. Jan. 30, 2015), http://www mass.gov/ago/docs/press/2015/partners-memo-of-decision-and-order.pdf ("A conduct remedy, which typically involves regulation of specific conduct over a limited period of time, is more difficult to craft and easier to circumvent. It also does not directly address the problem, which is a loss of competition: indeed, it permits consolidation and then attempts to limit the consequences that flow from that by imposing certain restrictions on the defendant's behavior. . . . [C]onduct remedies 'seek to thwart the natural incentives of the merged entity to behave as a single firm' and thus require constant and costly monitoring.").

[196] *See id.* at 3 (stating that the temporary conduct remedies would be "like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is taken off.").

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

[198] *See* Letter from 21 Health Care Economists to The Honorable Janet L. Sanders in the Matter of Commonwealth of Massachusetts v. Partners Healthcare Sys. (July 21, 2014) [hereinafter Partners Economist Letter]; Gregory S. Vistnes, *An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health* 11 (Feb. 10, 2011), http://www mountainx.com/files/copareport.pdf ("Economists have long recognized the difficulties of regulating monopolists and how regulation, no matter how

Even assuming that price restrictions could effectively replicate pricing that would prevail were the Parties to continue to compete, the proposed merger would still likely cause a reduction in business incentives to improve or maintain quality. Economic theory and empirical evidence indicate that adverse quality effects of mergers are particularly likely in markets where prices are regulated. [199] For example, studies of the United Kingdom healthcare market, where rate regulation has long been the norm, demonstrate that highly concentrated provider markets have worse patient health outcomes than competitive provider markets. [200]

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

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

The federal antitrust agencies have long contended that conduct remedies are inadequate for addressing competitive harms that result from horizontal mergers. Instead, the agencies strongly prefer "structural remedies," which seek to restore pre-merger competitive conditions through an injunction preventing consummation of a merger or a divestiture of assets. [201] Courts

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carefully crafted and implemented, can inadvertently create undesirable incentive problems."); Cory S. Capps, *Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health System* 32 (May 2, 2011) ("Economists generally agree that, with rare exceptions, competition produces better outcomes than regulation."); Comment from Amerigroup Corp. to the Tenn. Dep't of Health 4 (Sept. 21, 2015), https://www.tn.gov/assets/entities/health/attachments/Amerigroup-COPA_Written_Comments.pdf ("regardless of the obligations and restrictions placed on recipients of a COPA, regulations are never an effective substitute for competition").

[199] *See, e.g.*, Gaynor, Ho & Town, *supra* note 64.

[200] *See, e.g.*, Gaynor, Moreno-Serra & Propper, *supra* note 161.

[201] *See* DOJ Merger Remedies Manual, *supra* note 190; FTC Merger Remedies Study, *supra* note 190; Feinstein, *supra* note 191. *See also* Fed. Trade Comm'n, Analysis of Proposed Agreement Containing Consent Order to Aid Public Comment: In the Matter of Phoebe Putney Health System, Inc., et al., Docket No. 9348, at 1 (Aug. 22, 2013), https://www ftc.gov/sites/default/files/documents/cases/2013/08/130822phoebeputneyanal.pdf ("The Commission

generally agree with this position. [202] In 2015, for example, a Massachusetts court rejected a consent agreement that would have allowed multiple hospital systems to merge, provided they agreed to certain conduct remedies. The court found that the proposed conduct remedies – which included price caps, component contracting, a prohibition on joint contracting, and physician and network growth restrictions – would have done little to restore the lost competition or to address the anticompetitive harms. [203] Furthermore, the court expressed serious concerns about its ability to enforce the conduct remedies, which would have required substantial technical expertise and resources to resolve complicated issues relating to healthcare pricing during a time in which healthcare contracting practices were changing enormously. [204] While every geographic area has unique aspects, these challenges would almost certainly arise in the Syracuse area.

In summary, rate regulation and other conduct remedies do not replicate lost competition resulting from mergers, they are challenging and costly to implement, and they require constant supervision to ensure compliance. Adding to this complexity, hospitals subject to rate regulation and other conduct remedies often have strong financial incentives to circumvent the required regulatory commitments. [205] All of these factors would strain the state's ability to determine whether the public policy goals of the COPA are being met and to hold the combined hospital system accountable.

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has declined to seek price cap or other nonstructural relief, as such remedies are typically insufficient to replicate pre-merger competition, often involve monitoring costs, are unlikely to address significant harms from lost quality competition, and may even dampen incentives to maintain and improve healthcare quality.").

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

[203] *See Partners Healthcare Sys.*, *supra* note 195, at 2. Indeed, several prominent health economists urged the Massachusetts court not to accept the consent agreement, arguing that it would not offset the consumer harm likely to result from the acquisitions. Responding to arguments offered by Partners that the mergers would yield economic and operational efficiencies, as well as quality improvements, that would help to slow the growth rate of healthcare expenditures and benefit consumers, the economists stated that "systematic evidence from hundreds of hospital mergers around the nation provides little empirical support for these assertions." Partners Economist Letter, *supra* note 198, at 2.

[204] *See Partners Healthcare Sys.*, *supra* note 195, at 19 (stating that the methodology for regulating prices "remains a mystery" to the court, and expressing concerns that any monitor would be able to handle the complex task of administering the price caps) ("Even with some expertise in the field, the monitor will have to take into account complex contractual arrangements between Partners and the major payers, each of which have their own unique features and tradeoffs. The prices at issue are not for a homogenous good or a single product but for a complex set of services which can be bundled and redefined from one year to the next.").

[205] *See id.* at 42 ("A conduct remedy, which typically involves regulation of specific conduct over a limited period of time, is more difficult to craft and easier to circumvent. It also does not directly address the problem, which is a loss of competition: indeed, it permits consolidation and then attempts to limit the consequences that flow from that by imposing certain restrictions on the defendant's behavior. . . . [C]onduct remedies 'seek to thwart the natural incentives of the merged entity to behave as a single firm' and thus require constant and costly monitoring."); *id.* at 32 ("Particularly where the product or transaction is complex and enforcement of the remedies is over a long period of time, there are many opportunities for the entity, in pursuit of its own self-interest, to 'crowd' the border of stated rules and create ways to evade them.").

VIII. Conclusion

Existing competition between SUNY Upstate and Crouse benefits patients, employers, and hospital employees in the Syracuse area by constraining prices for inpatient, outpatient, and physician services, which ultimately helps control out-of-pocket healthcare expenses. This competition also has spurred these hospitals to offer a wide breadth of services and to strive to be high-quality providers of those services in order to attract physician referrals and patient admissions.

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

In summary, FTC staff respectfully encourages the NY DOH to consider the following factors and questions when reviewing the COPA Application submitted by SUNY Upstate and Crouse:

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

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

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

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

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

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

In our assessment, there is insufficient evidence that the potential benefits of the COPA outweigh the potential disadvantages of the elimination of competition between SUNY Upstate and Crouse.

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

Please direct all questions regarding this submission to Gustav Chiarello, Attorney, Mergers IV Division, Bureau of Competition, 202-326-2633, gchiarello@ftc.gov; and Stephanie Wilkinson, Attorney Advisor, Office of Policy Planning, 202-326-2084, swilkinson@ftc.gov.

FTC Public Comment
Attachment A

FTC Policy Perspectives on Certificates of Public Advantage

Staff Policy Paper

August 15, 2022

FEDERAL TRADE COMMISSION

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

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

Introduction

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

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

What is a COPA and why do hospitals seek them?

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

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

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

Why should state lawmakers be concerned about hospital consolidation?

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

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

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

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

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

Competition results in better outcomes than consolidation subject to COPAs

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

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

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

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

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

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

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

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

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

Hospital arguments in favor of consolidation subject to COPAs are flawed

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

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

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

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

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

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

FTC efforts to prevent harmful hospital consolidation are undermined by COPAs

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

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

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

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

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

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

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

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

Mission Health System (North Carolina)

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

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

Benefis Health System (Montana)

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

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

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

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

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

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

Palmetto Health System (South Carolina)

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

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

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

MaineHealth (Maine)

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

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

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

Recent COPAs and Developments

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

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

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

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

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

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

Hendrick Health System and Shannon Health System (Texas)

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

Conclusion

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

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

Endnote References

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

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

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

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

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

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

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

and Acquisitions, 382 NEW ENG. J. MED. 51 (Jan. 2, 2020), https://www.nejm.org/doi/pdf/10.1056/NEJMsa1901383?articleTools=true. For surveys of the research literature, *see, e.g.*, Martin Gaynor & Robert Town, THE IMPACT OF HOSPITAL CONSOLIDATION – UPDATE (Robert Wood Johnson Found., The Synthesis Project, Policy Brief No. 9, 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; Martin Gaynor, Kate Ho & Robert Town, *The Industrial Organization of Health-Care Markets*, 53 J. ECON. LITERATURE 235 (2015), https://www.researchgate.net/publication/278676719_The_Industrial_Organization_of_Health-Care_Markets.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[40] *Id.* at 41.

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

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

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

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

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

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

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

[48] *Id.* at 21.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Federal Trade Commission

Key COPA Facts

FTC.gov/COPA

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

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

- **Mission Health COPA (NC):** Substantial increases in commercial inpatient prices during early COPA years (at least 20%), during later COPA years (average 25%), and after COPA was repealed (at least 38%). Demonstrates price regulations during COPA were ineffective, as well as the risk of eventually having an unregulated monopolist.
- **Benefis Health COPA (MT):** Substantial increases in commercial inpatient prices after COPA was repealed (at least 20%). Demonstrates the risk of eventually having an unregulated monopolist.

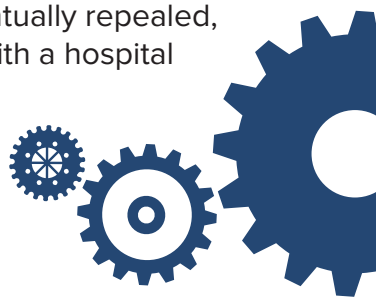
Studies show that several hospital mergers subject to COPAs have resulted in higher prices and reduced quality of care, despite regulatory commitments designed to mitigate these anticompetitive effects.

- **MaineHealth COPA (ME):** Substantial increases in commercial inpatient prices at unregulated hospital during COPA (at least 38%), as well as after COPA expired at both hospitals – for a total price increase of at least 50% during the COPA and post-COPA period. Demonstrates the risk of selectively regulating hospitals within a larger system, as well as the risk of eventually having an unregulated monopolist. Measurable decline in quality at the acquired hospital after the COPA expired.

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

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

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



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

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

FTC Public Comment
Attachment B

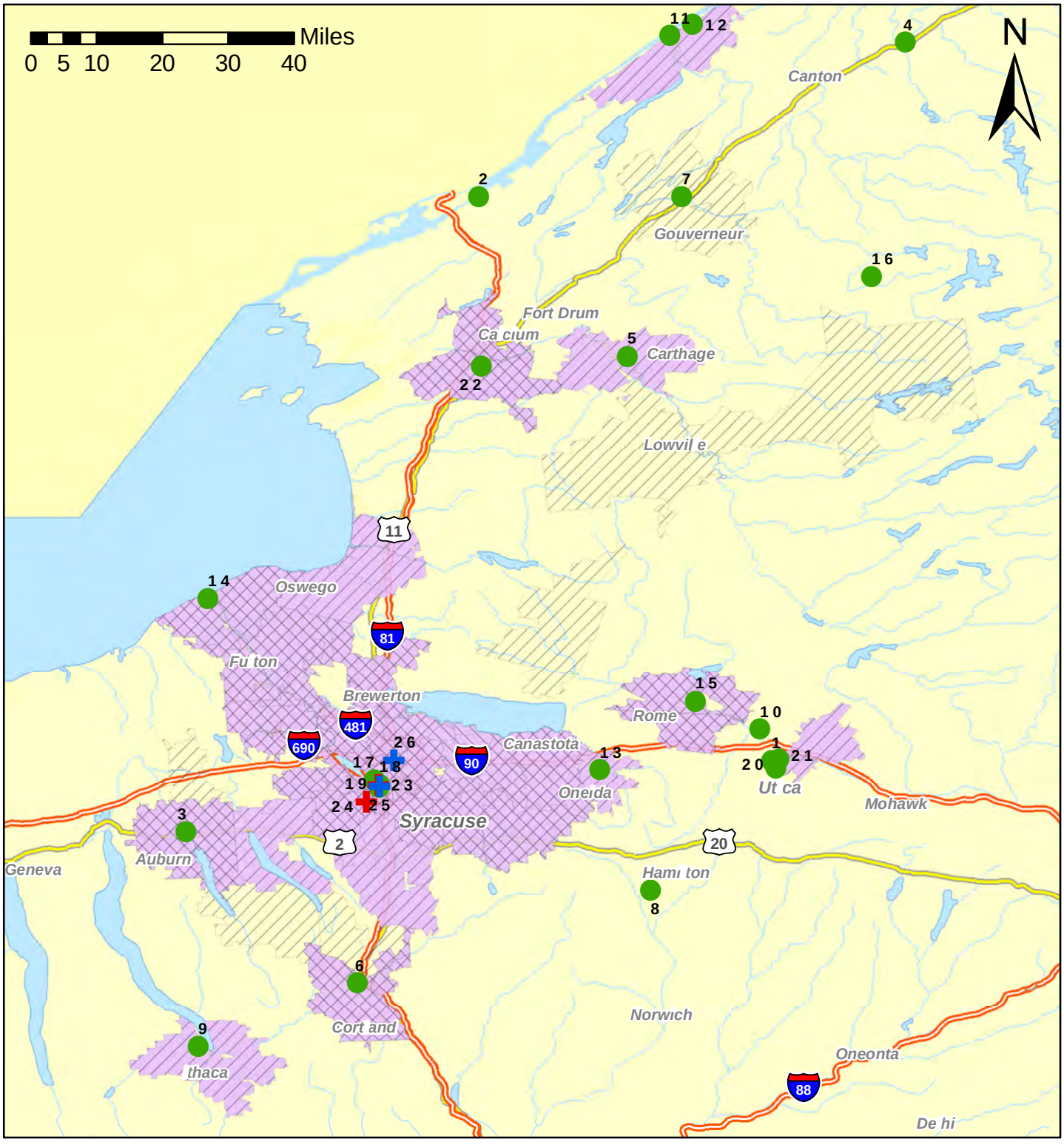
Table B1: Market Shares and HHIs in Prior Healthcare Merger Cases [206]

Case	Combined Share	HHI Increase	Post-Merger HHI	Outcome
University Health (11th Cir. 1991)	43%	630	3,200	Enjoined
ProMedica Health System (6th Cir. 2014)	58%	1,078	4,391	Enjoined
OSF Healthcare (N.D. Ill. 2012)	59%	1,767	5,179	Enjoined
Rockford Memorial (7th Cir. 1990)	68%	2,322	5,111	Enjoined
Advocate Health Care Network (7th Cir. 2016)	60%	1,782	3,943	Enjoined
Penn State Hershey Medical Center (3rd Cir. 2016)	76%	2,582	5,984	Enjoined
Hackensack Meridian Health (3d. Cir. 2022)	47%	841	2,835	Enjoined
SUNY Upstate/Crouse (Commercial Inpatient Services in Onondaga County)	**67%**	**2,197**	**5,556**	**TBD**

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

FTC Public Comment
Attachment C

SUNY Upstate and Crouse Individual and Combined Primary Service Areas



Legend

- Upstate
- Crouse
- 3rd Party
- Upstate PSA
- Crouse PSA
- Combined PSA

Number	Hospital Name	Number	Hospital Name
1	Faxton St. Luke's Healthcare	14	Oswego Hospital
2	River Hospital	15	Rome Memorial Hospital
3	Auburn Community Hospital	16	Clifton-Fine Hospital
4	Canton-Potsdam Hospital	17	St. Joseph's Hospital Health Center
5	Carthage Area Hospital	18	Richard H. Hutchings Psychiatric Center
6	Guthrie Cortland Regional Medical Center	19	Syracuse Veterans Affairs Medical Center
7	Gouverneur Hospital	20	St. Elizabeth Medical Center
8	Community Memorial Hospital	21	Mohawk Valley Psychiatric Center
9	Cayuga Medical Center at Ithaca	22	Samaritan Medical Center
10	Central New York Psychiatric Center	23	Upstate University Hospital
11	Claxton-Hepburn Medical Center	24	SUNY Upstate Community Hospital
12	St. Lawrence Psychiatric Center	25	Crouse Health
13	Oneida Healthcare	26	Crouse Commonwealth Place