Bureau of Competition
Bureau of Economics
Office of Policy Planning

UNITED STATES OF AMERICA
Federal Trade Commission
WASHINGTON, D.C. 20580

September 11, 2020

VIA ELECTRONIC MAIL

Texas Health and Human Services Commission
c/o Phil Wilson, Executive Commissioner
Brown-Heatly Building
4900 North Lamar Blvd.
Austin, TX 76711-3247
Public Comment Inbox: healthfacilitylicensing@hhsc.state.tx.us

Re: Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System

Dear Executive Commissioner Wilson:

On behalf of the staffs of the FTC's Bureau of Competition, Bureau of Economics, and Office of Policy Planning, and pursuant to Texas Health and Safety Code § 314A.001 *et seq.*, we are providing the attached public comment that presents our views on the respective Applications for Certificate of Public Advantage submitted by Hendrick Health System and Shannon Health System. We can provide copies of any documents referenced in this comment upon request.

Please direct questions concerning this submission to Melissa Hill, Deputy Assistant Director of the Mergers IV Division, Bureau of Competition, 202-326-2673, mchill@ftc.gov; and Stephanie Wilkinson, Attorney Advisor, Office of Policy Planning, 202-326-2084, swilkinson@ftc.gov.

Respectfully submitted,

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cc: W. Kenneth Paxton, Jr., Attorney General of the State of Texas

Federal Trade Commission Staff Submission to Texas Health and Human Services Commission Regarding the Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System

Pursuant to Texas Health and Safety Code § 314A.001 *et seq*.
and rules implemented thereunder at §567.1 *et seq*.

September 11, 2020

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Table of Contents

I. Executive Summary 1

II. The FTC's Interest and Experience 6

III. The FTC Evaluates Healthcare Mergers Similarly to the Approach Outlined in the Texas COPA Act 7

IV. The Hendrick COPA Is Likely to Result in Significant Disadvantages Due to a Reduction in Competition Between Hendrick and Abilene Regional 9

A. Diversion Ratio Analysis Confirms That Hendrick and Abilene Regional are Closest Competitors 12

B. High Market Shares and Concentration Levels in the Hendrick Service Areas Confirm that the Hendrick COPA Is Likely to Result in Significant Disadvantages 14

C. Descriptive Analysis of Geographic and Service Overlaps Confirms that Hendrick and Abilene are Closest Competitors and Face Little Competition from Other Hospitals 18

V. Statutory Factor Analysis: Benefits of the Hendrick COPA Are Unlikely to Outweigh the Disadvantages Resulting from a Reduction in Competition 19

A. Hendrick Merger Would Likely Have a Substantial Adverse Impact on the Quality and Price of Hospital and Health Care Services for Citizens of Texas 20

1. Consolidation of Clinical Services Is Uncertain and Could Reduce Patient Access 22

2. Hendrick Has Not Shown Why the Hospitals Cannot Pursue Clinical Standardization Without the COPA 23

3. Hendrick Has Not Shown That the COPA is Necessary for Population Health Improvement of the Region 24

4. Hendrick Has Not Shown Why the Implementation of Uniform EMR System is Necessary to Improve Quality of Care 25

B. Hendrick Merger Would Likely Reduce Public Access to Acute Care Hospital Services in Midwest Texas 27

C. Claims of Cost Efficiencies for Services, Resources, and Equipment are Unsubtantiated, Not Merger-Specific, and Insufficient to Overcome the Likely Competitive Harm 28

D. Hendrick Merger Would Make It More Difficult for Health Care Payers to Negotiate Payment and Service Arrangements with the Combined Hospital Entity, Likely Resulting in Higher Prices for Employers and Patients 31

E. Hendrick Merger Would Likely Substantially Reduce Competition for Physician Services and Ancillary Healthcare Services 35

F. Hendrick Merger Would Likely Depress Wage Growth for Registered Nurses 36

VI. Entry Would Not Be Timely, Likely, or Sufficient to Overcome the Likelihood of Substantial Harm to Competition 38

VII. Proposed Rate Review and Possibility of Additional Terms and Conditions Are Unlikely to Mitigate the Harm Resulting From Loss of Competition 39

A. Rate Review Will Be Difficult to Administer and May Not Address Consumer Harms 42

B. Accountability and Enforcement Mechanisms for Quality Benefits Appear to Be Lacking 44

C. Commitment Regarding Physician Contracting Will Not Mitigate Merger Harms 44

VIII. Possibility of Voluntary Termination is Highly Concerning and Corrective Action Plan and Revocation of COPA Are Unlikely to Be Effective Remedies 45

IX. Practical Concerns Associated with Certificates of Public Advantage in Other States.... 47

X. Conclusion 55

Attachment A: Shannon Health System COPA Application 57

Attachment B: Market Shares and HHIs in Prior Cases 66

I. Executive Summary

The staffs of the Federal Trade Commission's ("FTC") Bureau of Competition, Bureau of Economics, and Office of Policy Planning (collectively, "FTC staff")[1] respectfully submit this public comment regarding the certificate of public advantage ("COPA") application submitted by Hendrick Health System ("Hendrick") to the Texas Health and Human Services Commission ("HHSC")[2] pursuant to Section 314A.001 *et seq.* of the Texas Health and Safety Code.[3] We appreciate the opportunity to present our views on the proposed acquisition by Hendrick of Abilene Regional Medical Center ("Abilene Regional") and Brownwood Regional Medical Center ("Brownwood Regional") (the "Hendrick merger" or "Hendrick COPA") in connection with HHSC's review of the Hendrick COPA Application. In Attachment A, we also present economic analyses of the proposed acquisition by Shannon Health System, Inc. ("Shannon") of San Angelo Community Medical Center ("SACMC") (the "Shannon merger" or "Shannon COPA") in connection with HHSC's review of that COPA application.[4]

FTC staff submits this comment to express our concern that the proposed Hendrick merger presents substantial risk of serious competitive and consumer harm in the form of higher healthcare costs, lower quality, reduced innovation, and reduced access to care. Evidence shows that this harm is unlikely to be outweighed by any potential benefits of the merger, and it is doubtful that the statutory rate review to be conducted by HHSC would effectively mitigate all of the potential anticompetitive harms to consumers. FTC staff is primarily concerned with Hendrick's acquisition of Abilene Regional, and we will focus our comment on this transaction. Although Hendrick's acquisition of Brownwood Regional does not raise the same concerns, it likely exacerbates the overall competitive harms. Accordingly, we will include some economic analysis of the Hendrick-Brownwood Regional transaction later in the comment.

FTC staff recognizes the challenges confronting many states regarding unmet needs in healthcare, particularly in rural areas with vulnerable patient populations, inadequate access to providers, and struggling local economies. We also understand that healthcare providers face regulatory and financial pressure to better coordinate the delivery of healthcare services, and that these pressures may be heightened during the COVID-19 pandemic. The FTC's mission is 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 Hendrick Health System to Texas Health and Human Services Commission (Apr. 29, 2020) [hereinafter Hendrick COPA Application].
[3] Texas Health and Safety Code § 314A.001 *et seq.*, Merger Agreements Among Certain Hospitals [hereinafter Texas COPA Act]. *See also* Texas Health and Human Services Commission Emergency Rules Implementing Texas Health and Safety Code, Chapter 314A, § 567.1 *et seq.*, Certificate of Public Advantage (Jun. 2, 2020), https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/facilities-regulation/memos/copa-emergency-rules.pdf [hereinafter Texas COPA Rules].
[4] Application for Certificate of Public Advantage Submitted by Shannon Health System, Inc. to Texas Health and Human Services Commission (Apr. 23, 2020) [hereinafter Shannon COPA Application]. The Shannon COPA Application often includes nearly identical claims as the Hendrick COPA Application. Accordingly, much of the information we present regarding the Hendrick COPA Application is relevant to the Shannon COPA Application.

preserve competition that will benefit consumers and enhance innovation in healthcare markets. The antitrust laws, which the FTC enforces, are consistent with the "triple aim" of healthcare reform to improve quality, enhance patient experience and access to care, and reduce costs.[5] Competition is at the core of the American economy, particularly in the healthcare sector.[6] Vigorous competition among healthcare providers in an open marketplace provides consumers with the benefits of lower prices, higher quality goods and services, greater access to goods and services, and innovation.[7]

We understand that the Texas state legislature passed the Texas COPA Act with the intention of allowing hospital mergers that "may benefit the public by maintaining or improving the quality, efficiency, and accessibility of health care services offered to the public" and therefore address the "unique challenges in providing health care services in rural areas."[8] However, supplanting antitrust laws with a regulatory scheme that allows for provider consolidation in highly concentrated markets likely undermines these laudable goals. We also have doubts as to whether the primary service areas for these hospitals, as defined by the parties, are appropriately considered "rural," and whether these communities cannot support hospital competition.

Counsel for Hendrick asserts that "the COVID-19 pandemic has radically altered the economic and public health environment throughout Texas" and that "[n]ow more than ever, it is imperative that Texas hospitals come together to coordinate care and preserve access where it is

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[5] *See, e.g.*, Edith Ramirez, *Antitrust Enforcement in Health Care – Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245, 2247 (2014), http://www.nejm.org/doi/full/10.1056/NEJMp1408009 ("The FTC supports the key aims of health care reform, and we recognize that collaborative and innovative arrangements among providers can reduce costs, improve quality, and benefit consumers. But these goals are best achieved when there is healthy competition in provider markets fostering the sort of dynamic, high-quality, and innovative health care that practitioners seek and patients deserve."); Deborah L. Feinstein, Director, Bureau of Competition, FTC, Remarks at the Fifth National Accountable Care Organization Summit: Antitrust Enforcement in Health Care: *Proscription, not Prescription* 16 (Jun. 19, 2014), https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf ("We continue to hear claims that antitrust principles are at odds with the mandates of the Affordable Care Act. I believe these arguments misunderstand the focus and intent of federal antitrust enforcement. . . . In the final analysis, our actions make clear the important role of antitrust in health care policy. Ultimately, we believe that the imperatives of developing lower cost, higher quality health care can coexist with continued enforcement of the antitrust laws.").

[6] *See, e.g.*, Standard Oil Co. v. Fed Trade Comm'n, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition."); N.C. State Bd. of Dental Examiners v. Fed. Trade Comm'n, 135 S. Ct. 1101, 1109 (2015) ("Federal antitrust law is a central safeguard for the Nation's free market structures. In this regard, it is 'as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms.'").

[7] *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.").

[8] Texas COPA Act § 314A.03(a)(1)-(2).

needed most."[9] 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.[10] However, evidence suggests that hospital consolidation may reduce quality and access for healthcare services. Competition has proven to be a more reliable and effective mechanism for controlling healthcare costs while preserving quality of care, including in rural areas facing economic challenges. For these reasons, both the current and former administrations and several leading academics have raised concerns about COPAs and have cautioned states not to rely on them in the absence of evidence that COPAs produce better results than market-based competition.[11]

FTC staff's concerns detailed in this submission are based on our assessment of the proposed merger, applying the analytical framework described in the *Horizontal Merger Guidelines* ("*Merger Guidelines*") that antitrust agencies, state courts, and federal courts use to evaluate mergers.[12] We have evaluated both the potential harm to consumers from the loss of competition as well as the potential benefits, including clinical quality benefits and cost savings, that Hendrick claims it will be able to achieve through the proposed merger. Under Texas law, HHSC must weigh these same factors when reviewing COPA applications. Thus, our analysis is closely aligned with the analysis that HHSC will undertake. For ease of reference, we present our analysis using the specific factors contained in the Texas COPA Act.

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[9] Cover Letter to Hendrick COPA Application, from Kenneth Field to Texas Health and Human Services Executive Commissioner Phil Wilson (Apr. 29, 2020).

[10] 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).

[11] *See. e.g.,* Report by 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 59 (Dec. 2018, issued in response to Executive Order 13813 signed by Donald Trump on Oct. 17, 2017), https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf ("States should discontinue the use of COPAs to shield anti-competitive provider collaborations and mergers from antitrust scrutiny in the absence of any clear evidence that these regulatory schemes produce better results than market-based competition."); Joseph Simons, Prepared Statement of the Federal Trade Commission Before the United States Senate Committee on the Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights, *Oversight of the Enforcement of the Antitrust Laws* 11 (Sept. 17, 2019), https://www.judiciary.senate.gov/imo/media/doc/Simons%20Testimony.pdf ("The Commission has been concerned about the impact of COPAs on consumers, and has undertaken a broad effort to gather additional evidence on their effects."); Keynote Address of FTC Chairwoman Edith Ramirez, Antitrust in Healthcare Conference 6-7 (May 12, 2016), https://www.ftc.gov/system/files/documents/public_statements/950143/160519antitrusthealthcarekeynote.pdf ("In my view, these legislative efforts to immunize [healthcare provider] combinations from the antitrust laws are misguided and risk harming consumers."); 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 (describing the impact of hospital consolidation on price and quality of healthcare services and suggesting that states "discontinue the use of COPAs").

[12] 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*].

Competition between Hendrick and Abilene Regional benefits area employers and residents. It enables health insurers to negotiate lower hospital reimbursement rates (*i.e.*, prices) on behalf of their 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 improves healthcare quality, availability of services and new healthcare technologies, and other non-price factors, 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. The proposed Hendrick merger would eliminate that competition to the detriment of the residents of Midwest Texas.[13] Many consumers, health insurers, healthcare providers, and community stakeholders have expressed similar concerns.[14]

As described in greater detail in Section IV, FTC staff's quantitative economic analyses confirm that Hendrick competes closely with Abilene Regional, and that the merger will result in extraordinarily high market shares. To measure the degree of lost competition likely to result from the proposed merger, we calculated diversion ratios, which estimate the proportion of Hendrick patients that view Abilene Regional as their next-best choice, and vice-versa. The diversion ratios show a high degree of substitutability – i.e., extremely close competition – between Hendrick and Abilene Regional; more than 50% of each hospital's patients view the other merging party as their next best choice. Diversion ratios of this magnitude indicate that Hendrick and Abilene Regional are close substitutes and competitors, and that the merger would likely lead to significant price increases, as well as reduced incentives to maintain or improve quality.

Additionally, we calculated market shares, which typically are informative when evaluating the likely competitive impact of a proposed hospital merger. High market shares and concentration among healthcare providers often indicate that merging hospital systems will be able to raise prices. FTC staff estimates that the combined Hendrick-Abilene Regional-Brownwood Regional hospital system would have a share greater than 85% of inpatient hospital services in the geographic area that it plans to serve.[15] The proposed merger would increase market concentration to a level that far exceeds the threshold for a legal presumption of significant anticompetitive effects. The combined market shares and increases in concentration would also exceed those of past hospital mergers that the FTC challenged and federal courts found anticompetitive.[16]

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[13] Although FTC staff does not believe that "Midwest Texas" constitutes a relevant geographic market for antitrust purposes, for consistency with the Hendrick COPA Application, we use the term "Midwest Texas" to describe the general geographic area affected by the proposed Hendrick merger.

[14] *See, e.g.*, Letters from Physicians and Employees of Abilene Regional Medical Center to Mack Harrison at HHSC, dated Jun. 22, 2020 and Jul. 1, 2020.

[15] *See* Table 1: Shares and Concentration in Hendrick SSA. These are estimated shares for Hendrick's Secondary Service Area ("SSA"), as defined by Hendrick in its COPA application. *See* Hendrick COPA Application at 5-6. Estimated shares in Hendrick's Primary Service Area ("PSA") are even higher. FTC staff does not believe that either the PSA or SSA necessarily constitute a relevant geographic market for antitrust purposes.

[16] *See* Market Shares and HHIs in Prior Healthcare Merger Cases (Attachment B).

Although there is evidence that the proposed Hendrick merger would likely lead to higher prices and reduced quality for healthcare services, Hendrick asserts that the merger would also result in clinical quality benefits and cost savings, and is necessary to ensure continued access to healthcare facilities and services throughout the region. We urge HHSC to carefully evaluate these claimed quality benefits and cost savings. Most studies have shown that competition among health systems – not consolidation – results in the greatest price constraints and quality benefits for consumers.[17] FTC staff has assessed Hendrick's claims, with a particular focus on potential clinical quality efficiencies. Importantly, Hendrick has not provided sufficient information to substantiate many of these claims, nor has it demonstrated that the claimed benefits and cost savings would offset the merger's substantial harm to competition. Moreover, the proposed Hendrick merger does not appear necessary to achieve many of these claimed benefits, which could be realized either independently or through another collaboration or merger that would not be as harmful to competition as the proposed merger.

HHSC may also wish to consider the likelihood that the proposed Hendrick merger will depress wage growth for registered nurses due to increased employer consolidation. To the extent that the COPA must offer public advantages in order to be approved, the impact of the merger on worker pay and community access to healthcare services may be relevant to HHSC's review.[18]

Hendrick claims that the merger is unlikely to result in "any meaningful competitive harm" because of active supervision by the state, namely that the rate review to be conducted by HHSC should mitigate the potential adverse effects on prices.[19] However, regulatory rate review regimes can prove difficult to implement, monitor, and enforce and are unlikely to replicate the benefits of competition. Such regimes could result in higher prices than might otherwise occur in a competitive market. Also, the merged hospitals would have strong financial incentives to circumvent the regulatory process, which could further undermine the effectiveness of the proposed rate review in mitigating the likely competitive harm of the proposed merger. Notably, the HHSC rate review process would do nothing to mitigate the potential adverse effects on

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[17] *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.

[18] *See* Section V.F for further discussion of wage effects.

[19] Hendrick COPA Application at 1, 23-24, 36, and 40.

quality and access. For these reasons, this type of "conduct remedy" is generally disfavored by antitrust agencies and courts.[20]

Finally, if Hendrick is allowed to acquire Abilene Regional, there should be no expectation that a subsequent antitrust enforcement action could effectively unwind the merger if Hendrick voluntarily terminates the COPA, HHSC revokes the COPA, or the state revises or repeals the underlying COPA statute. Experience shows that unwinding consummated healthcare provider mergers and successfully restoring the lost competition is extremely difficult, and often impossible. If any of these scenarios were to occur, the regulatory oversight intended to mitigate the anticompetitive effects of the merger could be eliminated entirely, leaving the combined system free to exercise its significant market power with neither regulatory oversight nor a credible threat of antitrust enforcement. COPAs implemented in other states illustrate some of these practical challenges with regulating a hospital monopoly in perpetuity.[21]

If the Hendrick COPA is approved, the harm resulting from the reduction in competition is likely to far outweigh any potential benefits. In our view, the evidence put forward by Hendrick in its COPA application falls short of the standard it must meet pursuant to the Texas COPA Act. Consequently, we urge HHSC not to approve the Hendrick COPA.

II. The FTC's Interest and Experience

The FTC is an independent, bipartisan agency with a unique dual mission of promoting competition and protecting consumers. 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. 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.[22] Pursuant to its statutory mandate, the FTC seeks to identify mergers and acquisitions, business practices, laws, and regulations that may impede competition without providing countervailing benefits to consumers.

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

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[20] 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). *See* Section VII for further discussion of regulatory rate review and other conduct remedies.
[21] *See* Section IX for further discussion of COPAs in other states.
[22] *See* Clayton Act, 15 U.S.C. § 18; Federal Trade Commission Act, 15 U.S.C. § 45.
[23] *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 (2020), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview_health_care_final_updated_07272020.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; *Examining Health Care Competition*, FED. TRADE COMM'N (Mar. 20-21, 2014), https://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition; *Examining Health Care Competition*, FED. TRADE COMM'N &

consumers 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, including those in rural areas, to determine whether they are, on balance, likely to benefit or harm consumers.[24]

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 and harm consumers, without countervailing benefits sufficient to outweigh the potential harms.[25] In 2017, the FTC announced a policy project to assess the impact of COPAs on prices, quality, access, and innovation for health care 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] Some findings from this work are described in more detail in Section IX. In particular, we have learned that COPAs can be difficult to monitor and regulate over a long period, and are not always successful in mitigating price and quality harms resulting from a loss in competition. Furthermore, when COPA oversight is removed, the risk of price and quality harms increases significantly.

III. The FTC Evaluates Healthcare Mergers Similarly to the Approach Outlined in the Texas COPA Act

The FTC's mission to protect competition and consumers in healthcare markets is similar to HHSC's mandate to help improve "the health, safety, and well-being of Texans."[28] When reviewing a proposed hospital merger, FTC staff devotes significant resources to understand the

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U.S. DEP'T OF JUSTICE (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.

[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.

[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/copa [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].

[28] Texas Health and Human Services, *About HHS – Vision & Mission*, https://hhs.texas.gov/about-hhs/vision-mission (last accessed Aug. 25, 2020).

transaction's likely efficiencies and benefits (*e.g.*, lower costs and improved quality), as well as its likely competitive harm (*e.g.*, higher prices, reduced quality, and less access to care). Many hospital mergers reviewed by the FTC do not raise competitive concerns and are allowed to proceed without any challenge.

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."[29]

This approach is similar to the statutorily-prescribed process by which HHSC must review COPA applications. The Texas COPA Act directs HHSC to review applications for a COPA between merging hospitals and to issue a COPA if HHSC "determines under the ***totality of the circumstances*** that: (A) the proposed merger would likely benefit the public by maintaining or improving the quality, efficiency, and accessibility of health care services offered to the public; and (B) ***the likely benefits . . . outweigh any disadvantages attributable to a reduction in competition that may result from the proposed merger***."[30] If the COPA is granted, HHSC would be responsible for actively supervising the hospital "to ensure that the immunized conduct of a merged entity furthers the purposes of [the Texas COPA Act]."[31] Notably, the factors that HHSC must consider, as discussed in greater detail below, are similar to those that FTC staff considers when reviewing hospital mergers.

Some hospital mergers, including those that raise competitive concerns, may yield meaningful clinical quality improvements and cost savings that might not be possible without the merger. Taking this into account, FTC staff's analysis of a proposed merger includes a thorough assessment of the potential benefits and efficiencies, as well as the disadvantages and harms resulting from a reduction in competition. Those benefits are then weighed against the likely adverse effects. The FTC declines to challenge transactions that might raise competitive concerns when there is compelling evidence that the likely benefits of the transaction would be of sufficient magnitude to offset the potential harm from lost competition.[32]

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[29] *Merger Guidelines* § 1.
[30] Texas COPA Act § 314A.056(a)(1) (emphasis added). *See also* Texas COPA Rules § 567.26.
[31] Texas COPA Act § 314A.101. *See also* Texas COPA Rules § 567.51.
[32] *See, e.g.*, FTC COPA Workshop Transcript: Session 2 (Afternoon), Christopher Garmon remarks at 37 (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/session2_transcript_copa.pdf [hereinafter FTC COPA Workshop Transcript: Session 2] (describing how COPAs are unnecessary because the FTC considers the financial condition and occupancy rates of hospitals and whether an area can support hospital competition, and how cognizable quality efficiencies have justified mergers that initially appeared to raise concerns).

FTC staff has conducted a preliminary investigation of the proposed Hendrick merger. As is customary in our investigations of hospital mergers, a team of attorneys and economists interviewed market participants, including health insurers and physician practices. We performed economic analyses using hospital discharge data and a labor market analysis. We considered the potential clinical quality benefits and cost savings that Hendrick claims it will be able to achieve through the proposed merger. Although the FTC is typically prohibited from disclosing confidential information obtained during an investigation, we are nonetheless able to provide an assessment of the proposed merger based on public sources. Our assessment is also supported by the non-public data and information that we have reviewed.

IV. The Hendrick COPA Is Likely to Result in Significant Disadvantages Due to a Reduction in Competition Between Hendrick and Abilene Regional

Today, Hendrick competes vigorously with Abilene Regional to be included in health plan networks and to attract patients. The proposed Hendrick merger would eliminate this competition and would likely lead to increased prices and reduced quality and availability of healthcare services in Midwest Texas. In this section, we describe the evidence and economic analyses supporting our conclusion that Hendrick and Abilene Regional are extremely close competitors, and that the post-merger market structure indicates a high likelihood of significant harm to consumers resulting from the elimination of competition between the systems. We include this foundation because it is relevant to assessing the statutory factors listed in the Texas COPA Act.

The FTC and healthcare economists use the following framework for analyzing competition in hospital markets. Hospital systems generally compete in two interrelated stages: first, they compete for inclusion in a health insurer's network; and, second, they compete to attract patients and physician referrals to their respective systems. In the first stage, health insurers – on behalf of their customers (employer and individual) – 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 employers who purchase health insurance for their employees, consumers who receive health insurance as an employee benefit, and consumers who purchase their own health insurance. In the second stage, competition between hospitals to attract patients typically leads to increased quality and availability of healthcare services. Thus, hospital systems compete on both price and quality, and mergers between close rivals eliminate that beneficial competition. Therefore, 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 consumers) and non-price effects such as reduced quality and availability of services.[33] 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.

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[33] *Merger Guidelines* §§ 1, 6.

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.[34] 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."[35] Notably, this empirical finding is true regardless of whether the merging hospitals have for-profit or not-for-profit status.[36] In other words, non-profit hospitals have the propensity to exercise market power and raise prices, similar to for-profit hospitals.[37] Thus, as most courts generally recognize, the non-profit status of merging hospitals does not mitigate the potential for anticompetitive harm.[38]

Hendrick routinely competes with Abilene Regional on price, quality, innovation, and patient experience for inclusion in health insurer networks and to attract patients to their respective hospital system for inpatient, outpatient, and physician services. These hospitals offer similar facility locations, service offerings, and quality of care. 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.[39] Indeed, Hendrick and Abilene

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[34] *See, e.g.*, Cooper, Craig, Gaynor & Reenen, *supra* note 17; Beaulieu, Dafny, Landon, Dalton, Kuye & McWilliams, *supra* note 17; GAYNOR & TOWN, *supra* note 17; Gaynor, Ho & Town, *supra* note 17.

[35] GAYNOR & TOWN, *supra* note 17, at 2.

[36] *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 17.

[37] *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.").

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

[39] *See* Hendrick COPA Application at 6, Figure 1.1.

Regional are only 11 miles apart. Consistent with our economic analyses, empirical research indicates that mergers among hospitals in close proximity are likely to result in particularly significant price increases.[40] 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 consumers. The proposed Hendrick merger also would reduce the combined system's incentives to maintain or improve the quality or availability of healthcare services.

In its COPA application, Hendrick emphasizes the challenges that rural hospitals face in providing healthcare services in Midwest Texas.[41] However, competition is no less important for addressing the challenges in rural and economically-stressed communities than it is in urban and more prosperous ones. Competition between Hendrick and Abilene Regional has long benefitted area patients and employers in the form of lower prices and enhanced quality and availability of healthcare services. While the parties' COPA application identifies various challenges facing rural hospitals, it is not clear that these challenges affect Hendrick or Abilene Regional.[42] Hendrick offers no evidence that this region cannot support competition between the parties, or that such competition inhibits their ability to serve the region effectively. Furthermore, Hendrick offers no evidence that these hospitals are not financially sound or do not have the resources to continue operating independently.[43]

Hendrick claims that the proposed merger would "increase services available to rural communities in Texas by creating substantial cost savings and other efficiencies, fostering the creation of jobs in our local communities, and most importantly, improving health care access and outcomes for rural populations disproportionately composed of poor and elderly citizens." Hendrick further claims that "there is no appreciable danger of any meaningful competitive harm from the transaction."[44] We disagree with these characterizations of the proposed merger. As we discuss in more detail below, the cost savings and efficiencies claimed by Hendrick are speculative and unsubstantiated. Indeed, studies show that mergers often do not achieve

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[40] *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.").

[41] *See* Hendrick COPA Application at 13 ("Many rural hospitals face unfavorable patient reimbursement trends, substantial capital needs relating to their physical plant and ongoing clinical operations, . . . and difficulty recruiting health care providers to serve their patients.").

[42] *See* Hendrick COPA Application at 9 (acknowledging that Abilene is a metropolitan area in Midwest Texas and "serves as a health care hub for people living within the region"). Although the Hendrick COPA Application generally describes the challenges facing rural hospitals, it does not include any specific evidence tying this problem to the Abilene area.

[43] This determination is based on our review of the public and non-public versions of the Hendrick COPA Application. *See also* Letters from Physicians and Employees of Abilene Regional Medical Center to Mack Harrison at HHSC, dated Jun. 22, 2020 and Jul. 1, 2020 (describing Abilene Regional as profitable).

[44] Hendrick COPA Application at 1.

projected cost savings and efficiencies.[45] Furthermore, many of the cost savings projected by Hendrick would be the direct result of facility consolidation and job reductions, 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 Hendrick claims, there is *substantial* danger of competitive harm from the transaction that is unlikely to be outweighed by any potential benefits, and the statutory rate review to be conducted by HHSC would be unlikely to mitigate this harm.

FTC staff's economic analyses of the proposed Hendrick merger are described in the following subsections. Subsection A presents the diversion ratio analysis using patient discharge data from the Texas Health Care Information Collection Center for Health Statistics ("THCIC") to assess the competitive effects of the proposed merger. Subsection B presents market share and concentration analysis using patient discharge data from the American Hospital Association ("AHA"). Subsection C presents a descriptive analysis of geographic and service overlaps using the THCIC data.

A. Diversion Ratio Analysis Confirms That Hendrick and Abilene Regional are Closest Competitors

To directly measure the degree of competition between the merging hospitals, FTC staff performed a diversion ratio analysis.[46] This analysis calculates what would happen if, hypothetically, one of the merging 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 must now use a hospital outside of that system. If a significant fraction of those "diverted" patients would choose a hospital in the other merging system, then that system can be said to be a close competitor to the first system. This fraction of diverted patients is known as the diversion ratio, and it is a standard economic metric used to measure closeness of competition in hospital merger cases.[47] The diversion ratio is a highly useful measure of the

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[45] *See infra* note 102.

[46] To calculate diversion ratios, we estimate a patient choice model using THCIC state hospital discharge data for commercially insured patients covering the one-year period from the second quarter of 2015 through the first quarter of 2016. *See* Texas Dep't of State Health Services (HSDS), Texas Health Care Information Collection Center for Health Statistics (THCIC) Inpatient Data (2Q 2015 – 1Q 2016). Although this is not the most recent data available from THCIC, it is still highly informative for evaluating the likely competitive effects of the proposed Hendrick merger. The general acute care ("GAC") hospital market in Hendrick's SSA appears to have changed very little between 2015 and 2017. According to 2017 AHA data, the only entry or exit of GAC hospitals located in the Hendrick SSA was the exit of the 12-bed Stamford Memorial Hospital. *See* AHA Data Products, https://www.aha.org/data-insights/aha-data-products (representing information provided by nearly 6,300 hospitals and more than 400 health care systems). 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.

[47] *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

degree of patient overlap between Hendrick and Abilene Regional in terms of the geographic locations of their patients (as determined by the 5-digit ZIP code of the patient), the health conditions of their patients (as determined by the DRG codes used for the patient), and other patient characteristics such as gender and age. Importantly, all hospitals in the state of Texas are included in FTC staff's diversion ratio analysis as possible alternatives for patients.[48]

FTC staff's diversion ratio analysis clearly confirms that Hendrick and Abilene Regional are each other's closest competitors for inpatient services. FTC staff calculates that if Hendrick were no longer an option for area residents, 57.8% of the patients who currently use Hendrick would seek care at Abilene Regional. Conversely, if Abilene Regional were no longer an option for area residents, 52.5% of the patients who currently use Abilene Regional would seek care at Hendrick. These estimated diversion ratios are extremely high and indicate that Hendrick and Abilene Regional are closest substitutes from the perspective of patients and payers.[49] These high diversion ratios are not surprising, given that Hendrick and Abilene Regional serve patients from a similar geographic area with similar health conditions, and there are very few nearby third-party hospitals. These diversion ratios strongly indicate that a merger between Hendrick and Abilene Regional would substantially lessen competition and likely lead to significant price increases, as well as reduced incentives to maintain or improve quality.[50]

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indicating a greater likelihood of such effects."). Unilateral price effects refers to the ability of a merged firm to raise prices on its own, without colluding with other competitors.

[48] It should be noted, however, that some small hospitals are statutorily exempt from reporting data to the THCIC. Hence, our analyses that utilize the THCIC data cannot account for these hospitals. Of the general acute care hospitals located in the 24-county Hendrick SSA, the following nine are absent from the THCIC data: Ballinger Memorial Hospital, Comanche County Medical Center, Fisher County Hospital District, Throckmorton County Memorial Hospital, Haskell Memorial Hospital, Knox County Hospital, North Runnels Hospital, Stonewall Memorial Hospital, and Throckmorton County Memorial Hospital. These hospitals have a small bed capacity; according to 2017 AHA data, the range in bed capacity for these hospitals is 12-23, with a mean of 16.9. These hospitals also likely account for a very small number of non-Medicare/Medicaid patients who resided within the Hendrick SSA during the time period of our analyses, which is the second quarter of 2015 through the first quarter of 2016. According to AHA data for 2015 and 2016, these nine hospitals admitted a total of 386 (in 2015) and 272 (in 2016) patients not covered by Medicare or Medicaid. According to the THCIC data from the second quarter of 2015 through the first quarter of 2016, there were 9,565 commercial patients residing within the Hendrick SSA. Hence, even if all of the non-Medicare/Medicaid patients treated by the nine exempt hospitals resided within the Hendrick SSA, which is highly unlikely especially given that some of these hospitals are located near the boundary of the SSA, they would account for less than 4% of the commercial patients residing within the Hendrick SSA. For this reason, the omission of commercial patients treated by the nine exempt hospitals in the THCIC data likely has only a trivial effect on our results.

[49] These diversion ratios exceed those in recent hospital merger cases where courts found the proposed mergers to be anticompetitive. *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%).

[50] In addition, FTC staff calculates that if Brownwood Regional were no longer an option for area residents, 13.1% of the patients who currently use Brownwood Regional would seek care at Hendrick. Diversion ratios of this magnitude, while not nearly as troubling as the diversion ratios between Hendrick and Abiline Regional, do indicate some patient overlap between Brownwood Regional and Hendrick. For this reason, the acquisition of Brownwood

B. High Market Shares and Concentration Levels in the Hendrick Service Areas Confirm that the Hendrick 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 consumer harm because the merged hospital system will be able to raise prices without offering sufficient quality improvements to justify the higher price.[51] 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 high market shares in Midwest Texas and lead to a highly concentrated provider market, resulting in substantial harm to consumers due to lost competition.

Courts and antitrust agencies use a standard measure of market concentration, the Herfindahl-Hirschman Index ("HHI"), to gauge a merger's effect on concentration in the area.[52] 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.[53]

This concentration analysis is most appropriate when applied to a properly defined relevant antitrust market. According to the *Merger Guidelines*, a market is a "relevant antitrust market" if a hypothetical monopolist of all of the suppliers located in that market could impose a

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Regional would likely exacerbate the substantial reduction in competition for inpatient services resulting from the merger between Hendrick and Abilene Regional.

[51] *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.").

[52] 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.

[53] *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.").

small, but significant, price increase.[54] While the Hendrick COPA Application does not define a relevant antitrust market for the proposed merger, Hendrick does put forward its Primary Service Area ("PSA") and Secondary Service Area ("SSA") as potentially relevant geographic service areas. The PSA of Hendrick is the smallest set of counties that comprises 75% of Hendrick's patients, while the SSA of Hendrick is the smallest set of counties that comprises 90% of Hendrick's patients.[55] FTC staff used the 24-county SSA of Hendrick as a potential relevant geographic market and utilized AHA discharge data for patients not covered by Medicare or Medicaid for the 2017 calendar year to calculate market shares and concentration.[56] Consistent with the *Merger Guidelines*, FTC staff calculated shares for the hospitals located within this area that account for all commercial patients admitted to these hospitals, regardless of where these patients live.

Table 1 contains the results of our concentration analysis in the 24-county SSA of Hendrick. The post-merger HHI is 7,266 and the increase in HHI is 3,391. These concentration numbers approach monopoly levels and far exceed the thresholds that would create a presumption of illegality under the *Merger Guidelines* and the relevant case law.[57] The combined Hendrick-Abilene Regional-Brownwood Regional hospital system would have a share of 85.1% of inpatient hospital services in the Hendrick SSA. The combined share and HHI calculations exceed the levels in past hospital mergers that courts have found to be anticompetitive and blocked.[58] As shown in Table 1, no other hospital system's share would come close to that of the merged hospital entity.

FTC staff has assessed concentration using the Hendrick SSA to be consistent with the information submitted in the Hendrick COPA Application. However, we do not believe that the Hendrick SSA necessarily represents a "relevant geographic market" under the *Merger Guidelines* or antitrust case law. This area is almost certainly broader than a market properly defined for antitrust purposes, meaning the shares listed in Table 1 are conservative and likely to understate the competitive impact. For example, the four hospitals located within Hendrick's PSA would almost certainly pass the Hypothetical Monopolist Test described in the *Merger Guidelines*. Hence, the Hendrick PSA is likely a more appropriate antitrust market than the Hendrick SSA. But adjusting the area in which to assess market shares does not change the conclusion that the merger results in a high combined share.

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

[55] *See* Hendrick COPA Application at 5-6. There are three counties in the Hendrick PSA: Callahan, Jones, and Taylor. There are 24 counties in the Hendrick SSA: Knox, Kent, Stonewall, Haskell, Throckmorton, Scurry, Fisher, Jones, Shackelford, Stephens, Mitchell, Nolan, Taylor, Callahan, Eastland, Runnels, Coleman, Brown, Comanche, Hamilton, Mills, McCulloch, San Saba, and Lampasas Counties.

[56] *See* AHA Data Products, https://www.aha.org/data-insights/aha-data-products (representing information provided by nearly 6,300 hospitals and more than 400 health care systems).

[57] *See supra* note 53.

[58] *See* Market Shares and HHIs in Prior Healthcare Merger Cases (Attachment B).

Table 1: Shares and Concentration in Hendrick SSA (24-County Area)
(Based on 2017 AHA Data, Non-Public Discharges)

Hospital	Pre-Merger Share	Post-Merger Share
Hendrick	53.3%	85.1%
Abilene Regional	25.2%	
Brownwood Regional	6.6%	
Cogdell Memorial Hospital	2.4%	2.4%
Hamilton General Hospital	2.0%	2.0%
Comanche County Medical Center	1.6%	1.6%
Eastland Memorial Hospital	1.1%	1.1%
Mitchell County Hospital	1.1%	1.1%
Stephens Memorial Hospital	1.0%	1.0%
Rolling Plains Memorial Hospital	1.0%	1.0%
Haskell Memorial Hospital	0.9%	0.9%
Coleman County Medical Center	0.8%	0.8%
Heart of Texas Memorial Hospital	0.8%	0.8%
Rollins Brook Community Hospital	0.6%	0.6%
Fisher County Hospital District	0.6%	0.6%
Throckmorton County Memorial Hospital	0.3%	0.3%
Anson General Hospital	0.3%	0.3%
Hamlin Memorial Hospital	0.2%	0.2%
Stonewall Memorial Hospital	0.2%	0.2%
Knox County Hospital	0.1%	0.1%
Ballinger Memorial Hospital	0.0%	0.0%
North Runnels Hospital	0.0%	0.0%
HHI	**3,875**	**7,266**
	Change in HHI = 3,391	

Table 2 shows the parties' combined share in each of the 24 counties included in the Hendrick SSA. The first column shows the share of Hendrick's commercial patients that reside in that county, and the second column adds each share by county to show the accumulated share of Hendrick's commercial patients. The second column indicates that the 24 counties in the Hendrick SSA account for nearly 97% of Hendrick's commercial patients, and the first ten counties in the shaded portion of Table 2 account for 90% of Hendrick's commercial patients. The final column shows the combined post-merger share of Hendrick, Abilene Regional, and Brownwood Regional, and indicates that the combined hospital system would have a dominant share in many of these counties.

Table 2: Inpatient Shares by County in Hendrick SSA (24-County Area)
(Based on 2Q 2015 – 1Q 2016 THCIC Data, Commercial Discharges)

	Share of Hendrick's Commercial Patients		Combined Share of Hendrick, Abilene Regional, and Brownwood Regional
County	**Share By County**	**Cumulative Share**	
Taylor	63.8%	63.8%	81.5%
Callahan	6.1%	69.9%	82.0%
Jones	5.1%	75.0%	73.6%
Nolan	3.9%	78.9%	40.2%
Eastland	3.0%	81.9%	38.0%
Stephens	2.6%	84.5%	43.0%
Brown	2.5%	87.0%	69.2%
Haskell	1.8%	88.8%	59.7%
Fisher	1.0%	89.8%	47.2%
Shackelford	1.0%	90.8%	75.8%
Coleman	1.0%	91.8%	36.2%
Knox	0.9%	92.7%	44.2%
Scurry	0.8%	93.5%	7.5%
Runnels	0.8%	94.3%	20.8%
Mitchell	0.7%	95.0%	25.2%
Comanche	0.6%	95.6%	24.9%
Stonewall	0.4%	96.0%	57.6%
Kent	0.2%	96.2%	22.8%
Throckmorton	0.2%	96.4%	21.2%
McCulloch	0.1%	96.5%	8.4%
San Saba	0.1%	96.6%	14.5%
Hamilton	0.0%	96.6%	0.9%
Mills	0.0%	96.6%	17.9%
Lampasas	0.0%	96.6%	0.0%

C. Descriptive Analysis of Geographic and Service Overlaps Confirms that Hendrick and Abilene are Closest Competitors and Face Little Competition from Other Hospitals

In addition to the diversion ratio and concentration analyses, FTC staff also performed a descriptive analysis of the inpatient discharge data from THCIC covering the one-year period from the second quarter of 2015 through the first quarter of 2016. To evaluate the geographic overlap of Hendrick and Abilene Regional, FTC staff analyzed which hospitals are chosen by patients who reside in the PSA and SSA of Hendrick.[59] In contrast to the *Merger Guidelines* concentration analysis in the previous section, this analysis considers the hospital choices of all commercial patients who reside in the PSA or SSA of Hendrick, irrespective of which hospital in the state of Texas treats the patient.[60] As with the diversion ratio analysis, all hospitals in the state of Texas are included in the PSA and SSA patient choice analyses.

Table 3 contains information regarding hospital choices of patients within the Hendrick PSA, which consists of Callahan, Jones, and Taylor counties. The table shows that Hendrick and Abilene Regional combined provided services to 80.9% of the commercial patients residing in these three counties, indicating that the merged entity would face little competition from other hospitals for patients residing in the Hendrick PSA. Similar analysis for patients residing in the Hendrick SSA indicates that, even in this much broader area, Hendrick, Abilene Regional, and Brownwood Regional combined provided services to 51.8% of the commercial patients residing in these 24 counties, indicating that the merged entity would be by far the dominant provider of hospital services patients in the Hendrick SSA. These descriptive analyses are consistent with the diversion ratio analysis, which indicates that Hendrick and Abilene Regional are each other's closest competitors for inpatient services.

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[59] FTC staff has calculated hospital choices of patients residing within the PSA and SSA, as defined by Hendrick, to be consistent with the information submitted in the Hendrick COPA Application. As noted above, we do not believe that either the PSA or SSA of Hendrick necessarily represents a "relevant geographic market" under the *Merger Guidelines* or antitrust case law.

[60] This analysis is distinct from the *Merger Guidelines* market shares and concentration analysis described in the preceding section, in that this considers the hospital choices of all patients living in a given geographic area (the PSA or SSA of Hendrick), no matter where the hospitals are located. The *Merger Guidelines* analysis of shares and concentrations levels, as described in the preceding section, considers shares of hospitals located within a given geographic area, regardless of where those patients reside. This distinction is explained in the *Merger Guidelines* discussion of geographic markets based on the locations of suppliers versus customers, in Sections 4.2.1-4.2.2. For clarity, the analysis in this section is not a market share and concentration analysis using an appropriate geographic market as was provided in the prior section, but rather provides a rough assessment of the most likely substitutes for Hendrick and the extent to which Hendrick is dominant in its own service area. For example, if Hendrick provides services to a very large share of patients residing in its own PSA, it would likely be a dominant provider for local patients. Other hospitals providing services to large shares of patients residing in the PSA are much more likely to be close substitutes for Hendrick than hospitals with small shares in the PSA. While providing some of the same intuition as a diversion ratio analysis, a PSA share analysis is a less-refined tool in that it does not account for some of the patient and hospital characteristics that may be important in assessing substitution.

Table 3: Hospital Choices of Patients Residing in Hendrick PSA (3-County Area)
(Based on 2Q 2015 – 1Q 2016 THCIC Data, Commercial Discharges)

Hospital	Share
Hendrick	47.7%
Abilene Regional	33.2%
Cook Children's Medical Center	2.2%
Baylor University Medical Center	1.5%
All Other Texas Hospitals (less than 1% share each)	15.4%

In addition to analyzing the geographic overlap between Hendrick and Abilene Regional, FTC staff also analyzed the overlap between Hendrick and Abilene Regional in the health conditions of the patients they treat. Using the THCIC data from the second quarter of 2015 through the first quarter of 2016, FTC staff defined the set of DRG codes that are common to both hospitals. Any DRG code that appears in the data for both hospitals for at least three inpatient events is included in the overlap set, which consists of 191 unique DRG codes. The overlap set accounts for 80.5% of all patients treated at Hendrick and 92.5% of all patients treated at Abilene Regional. This result shows that, in addition to the extensive geographic overlap between Hendrick and Abilene Regional shown in the PSA and SSA analyses, Hendrick and Abilene Regional also overlap extensively in the health conditions of the patients they treat.

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

V. Statutory Factor Analysis: Benefits of the Hendrick COPA Are Unlikely to Outweigh the Disadvantages Resulting from a Reduction in Competition

In conjunction with our standard analysis under the *Merger Guidelines*, FTC staff evaluated the proposed merger applying the statutory factors that HHSC must consider when reviewing the Hendrick COPA application under the Texas COPA Act. Based on our analysis under this framework, we conclude that the claimed benefits of the COPA are unlikely to outweigh the significant disadvantages that would result from a reduction in competition between Hendrick and Abilene Regional.

Under Texas law, HHSC must consider whether the proposed COPA is likely to generate sufficient public benefits to offset the likely harm to consumers.[61] This is similar to the analysis that courts and antitrust agencies perform when assessing the competitive impact of mergers.[62]

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[61] *See* Texas COPA Act § 314A.056(a).
[62] *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).

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 transaction.

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."[63] 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 merging parties, and because efficiencies may not be realized.[64] 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.[65] Experience has shown that "[e]fficiencies almost never justify a merger to monopoly or near-monopoly."[66]

A. Hendrick Merger Would Likely Have a Substantial Adverse Impact on the Quality and Price of Hospital and Health Care Services for Citizens of Texas

COPA FACTOR 1: *The quality and price of hospital and health care services provided to citizens of this state*[67]

ASSESSMENT: As described above, our analysis indicates that Hendrick and Abilene are each other's closest competitor and that the geographic service areas of Hendrick are highly concentrated. As a result, the proposed merger would give Hendrick tremendous bargaining leverage with insurers to negotiate significantly higher reimbursement rates, because insurers

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[63] *Merger Guidelines* § 10.

[64] 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)).

[65] *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).

[66] *Merger Guidelines* § 10.

[67] Texas COPA Act § 314A.056(b)(1).

would no longer be able to play two competitors off of each other during negotiations.[68] 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.[69] Thus, the proposed Hendrick merger would have a substantial adverse impact on patients with respect to the price of healthcare services. As described in Section VII, the statutory rate review conducted by HHSC would be unlikely to mitigate this harm.

The elimination of competition between Hendrick and Abiliene Regional would also significantly diminish the hospitals' incentives to maintain or improve current levels of quality, patient experience, and access to services and innovative technology, because Hendrick 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 proposed merger is likely to 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 its COPA application, Hendrick argues that the merger generally would lead to improved quality of care and enhanced clinical coordination throughout the merged entity.[70] 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' 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.

Based on FTC staff's deep experience in evaluating these types of quality justifications, we observe that many of the claims Hendrick makes about the likely quality benefits from the merger are unsubstantiated or the benefits appear modest in scope. Furthermore, many of the claimed quality enhancements could be achieved through less restrictive alternatives – 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.

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[68] *See infra* Section V.D, for further discussion of this dynamic.
[69] *See supra* Section IV.
[70] Hendrick COPA Application at 24-25, 37, 37, and 40.

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

Hendrick proposes that consolidating certain clinical services at Hendrick or Abilene Regional will benefit patients, though it does not identify conclusively which specific services it intends to consolidate. This proposed consolidation of clinical services likely would require considerable effort, money, and time. Hendrick has not provided sufficiently detailed information in its COPA application, so it remains unclear whether the merged entity could successfully consolidate clinical services in such a way as to improve patient outcomes, or when the merging hospitals might expect to realize any purported quality benefits. Moreover, although not acknowledged in the COPA application, 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.

Hendrick suggests that a post-merger consolidation of clinical services would increase the volume of procedures performed within a single hospital system, leading to improved quality outcomes because the higher volumes would allow hospital staff to better develop their skills.[71] 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.[72] Any quality benefits from Hendrick's proposed clinical consolidation would, therefore, be confined to those services for which there is a demonstrated volume/outcome relationship. Consolidations such as 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.

Hendrick has not identified the specific service lines it is likely to consolidate, so it is not possible to substantiate whether these services would be likely to demonstrate a beneficial volume/outcome relationship. Moreover, even for such procedures, 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

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[71] Hendrick COPA Application at 20 ("Combining the resources of Hendrick, Brownwood Regional, and Abilene Regional will allow for the coordination of key service lines that some of the facilities offer separately (such as newborns and deliveries), leading to increased volumes, which will improve quality of these services. Moreover, the transaction will likely allow the development of new services within the community, such as quaternary services, which none of the entities have the volume to provide separately. Additionally, the combination will allow for the creation of new centers of excellence, which will increase the volumes, and as a result, quality of these services.").

[72] *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.

from the consolidation.[73] 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.[74]

2. Hendrick Has Not Shown Why the Hospitals Cannot Pursue Clinical Standardization Without the COPA

Hendrick claims the merger "would allow the parties to maintain the high level of quality at Hendrick while strengthening the quality of care at Abilene Regional and Brownwood Regional" through the dissemination of best practices, protocols, and programs, including quality improvement and assurance programs. Hendrick claims that "clinical integration – between facilities and providers will likely lead to a reduction of medical errors and cost savings."[75] 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 information from market participants, Hendrick and Abilene Regional both have good quality levels. Thus, as an initial matter, this potential source of quality improvement appears to be limited. Yet beyond these general statements, Hendrick does not identify any specific areas targeted for quality improvement or detailed plans for achieving improvements.

Having said that, if Hendrick and Abilene Regional 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

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[73] *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.

[74] *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.").

[75] Hendrick COPA Application at 18.

ways that they can collaborate without running afoul of the antitrust laws.[76] Generally, most of the benefits from the merger could be achieved through alternatives that are less restrictive to competition and achieve comparable benefits or a more favorable balance of benefits over disadvantages.[77]

3. Hendrick Has Not Shown That the COPA is Necessary for Population Health Improvement of the Region

In its COPA application, Hendrick claims that the proposed merger would create a larger combined patient base, and that this would enhance population health efforts.[78] Hendrick intends to "incorporate and utilize Abilene Regional's and Brownwood Regional's resources to assist in tackling [population health] challenges. A coordinated and more robust approach will likely have greater reach and overall services across the service area, eliminate unnecessary and duplicative costs, and free up resources of the combined entities to invest in new services and technologies."[79] Given the limited information regarding the specifics of Hendrick's plans to improve population health in the region as a result of the proposed merger, however, these aspirational claims cannot be fully assessed or credited.

While Hendrick generally describes the benefits of population health management and how such initiatives can help to address significant health challenges and alleviate access issues in rural communities, it does not offer a comprehensive plan for achieving this. Hendrick already independently invests in population health initiatives and states its intention to expand these initiatives to Abilene Regional and Brownwood Regional.[80] It is unclear, however, why the proposed merger is necessary for any of these population health management initiatives. Indeed, it appears that Abilene Regional may already engage in population health initiatives.[81] The

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[76] *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.

[77] 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.

[78] Hendrick COPA Application at 20.

[79] Hendrick COPA Application at 23.

[80] Hendrick COPA Application at 22. Hendrick plans to expand the following intiatives it has developed to Abilene Regional and Brownwood Regional: physician recruiting strategies, Discharge Navigation Program for emergency department patients, one-call scheduling system, and Lyft transportation program. Hendrick is still developing programs "to assess and assist individuals with chronic diseases and to provide financial assistance and education about managing chronic disease and seeking preventative care," and intends to implement these programs at Abilene Regional and Brownwood Regional. Hendrick also participaties in the City of Abilene's Behavioral Health Advisory Team, and will try to replicate this initiative in the Brownwood community.

[81] *See, e.g.*, Abilene Regional Medical Center News, *Managing Type 2 Diabetes During Holidays*, https://www.abileneregional.com/news-room/managing-type-2-diabetes-during-holidays-15351; Abilene Regional

relevant question is whether Hendrick, Abiliene Regional, and Brownwood Regional would be more likely to participate in such initiatives, or participate more effectively, with this merger than they would without it. Hendrick presents 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 a merger to near-monopoly. 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 Hendrick to achieve these goals post-merger.

4. Hendrick Has Not Shown Why the Implementation of Uniform EMR System is Necessary to Improve Quality of Care

Hendrick intends to implement an integrated, uniform electronic medical records ("EMR") system across all of the merged facilities, claiming this "would lead to more efficient care and ease of use" and "facilitate better patient care and coordination of treatments and decrease unnecessary duplication of health care services" and "foster improved population health initiatives by allowing for more robust data analytics."[82] Hendrick claims that "[t]his benefit cannot be realized without the transaction, as implementation of a common IT platform requires sharing of proprietry information and commitment of significant resources by multiple systems, which would be infeasible for independent health systems to pursue." Currently, Hendrick has a fully integrated EMR at all sites of care (AllScripts), while Abilene Regional and Brownwood Regional use different records systems depending on the site of care (MedHost for inpatient, EDIS for emergency, and Athena for outpatient). Hendrick asserts that "[h]aving a single records system promoting seamless communication among various providers would lead to more efficient care and ease of use."[83]

For several reasons, Hendrick's claims regarding a uniform EMR system may be overstated. First, Hendrick, Abilene Regional, and Brownwood Regional 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. Each hospital already has an effective means of sharing information with each other, even with their separate EMR systems, further limiting the benefits of a common system. Moreover, it is possible that federal legislation regarding EMR interoperability may reduce or obviate the need for a common EMR platform between the parties.[84]

Medical Center News, *American Heart Month: Free Health Screenings*, https://www.abileneregional.com/news-room/american-heart-month-free-health-screenings-14418.

[82] Hendrick COPA Application at 19.

[83] *Id.*

[84] *See* Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Our understanding is that MACRA requires widespread exchange of health information through interoperable certified EMR technology among healthcare providers. Absent the merger, the parties may already be required to achieve EMR interoperability. Thus, current MACRA provisions would seem to undermine Hendrick's argument that a merger is necessary to achieve a common EMR platform, so that the hospitals can exchange health information. *See also* Centers for Medicare and Medicaid Services, Promoting Interoperability Programs, https://www.cms.gov/Regulations-and-

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,[85] and the conversion process can delay access to critical patient information. All told, the time, difficulties, and expense of converting to a common EMR system may outweigh the potential benefit.

Third, a Health Information Exchange (HIE) already exists in Texas, which enables secure access to patient information across the continuum of care, thereby improving patient health outcomes.[86] Hendrick already participates in this HIE, and presumably Abilene Regional and Brownwood Regional have the option of utilizing the HIE to access a significant amount of clinical patient information. Hendrick has not adequately explained the incremental benefit of the information accessible on a combined EMR system versus that available on the existing HIE.

In summary, the proposed merger eliminates substantial competition between Hendrick and Abilene Regional, and will likely lead to significantly higher prices and a reduced incentive to maintain or improve quality and access to care. 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.[87] To the contrary, the literature demonstrates that the net effect of mergers of competing hospitals on quality is often negative, and increased competition is associated with better quality.[88] Thus, the available evidence provides no reason to presume that any given hospital merger is likely to improve quality or reduce costs by enough to offset a price increase.

Guidance/Legislation/EHRIncentivePrograms/index?redirect=/EHRIncentivePrograms, and Certified EHR Technology, https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification (last accessed Aug. 25, 2020).

[85] *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.

[86] Hendrick COPA Application at 28.

[87] *See* Romano & Balan, *supra* note 72; Gaynor, Ho & Town, *supra* note 17; GAYNOR & TOWN, *supra* note 17; Beaulieu, Dafny, Landon, Dalton, Kuye & McWilliams, *supra* note 17, 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 wth worsening patient experiences."); Marah Noel Short & Vivian Ho, *Weighing the Effecs 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.").

[88] *See* Gaynor, Ho & Town, *supra* note 17, at 249 ("[T]he evidence indicates that increases in competition improve hospital quality."); GAYNOR & TOWN, *supra* note 17, at 3 ("While it is not possible to draw direct conclusions about the United States based on evidence from the United Kingdom, these studies add to the growing evidence base that competition leads to enhanced quality under administered prices.").

Notably, 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 will harm 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.[89]

B. Hendrick Merger Would Likely Reduce Public Access to Acute Care Hospital Services in Midwest Texas

COPA FACTOR 2: *The preservation of sufficient hospitals within a geographic area to ensure public access to acute care*[90]

ASSESSMENT: Hendrick cites concerns about low reimbursement rates and future reductions in reimbursement that may occur as a result of declining admissions and healthcare reform efforts,[91] and asserts that "[f]unding population health, access to care, enhanced health services, and other commitments would be difficult without the efficiencies and savings created by the merger."[92] We urge HHSC to consider whether any challenges that Hendrick, Abilene Regional, and Brownwood Regional face in response to the changing delivery and payment landscape can be addressed in less restrictive ways than the proposed merger, without substantially reducing competition in this region. Hendrick has not presented evidence that these hospitals lack the financial resources to continue operating independently and to maintain quality and access to healthcare services.

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[89] 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.

[90] Texas COPA Act § 314A.056(b)(2).

[91] Hendrick COPA Application at 13-14.

[92] Hendrick COPA Application at 31. Hendrick further states "[i]t is only through the proposed transaction that the parties have the incentive and ability to coordinate care in a way that improves efficiency and increases the quality of care provided to patients in the Midwest Texas region." *Id.* at 27.

Notably, Hendrick has made no firm commitments to keep open or maintain current service levels at hospitals and other facilities. Indeed, Hendrick would likely need to consolidate facilities to achieve projected cost savings and efficiencies, which would likely lead to a reduction in access to healthcare services. Without offering specific details, Hendrick has identified some general service areas in which it expects to consolidate volume at one hospital or the other following the merger, thereby reducing patient access to care. These service ares include obstetrics, neonatal services, and cardiology.[93]

Hendrick also suggests that it is capacity constrained, partly due to volume growth over the last five years.[94] In particular, Hendrick estimates that it needs 100 additional beds to meet demand for hospital services in Midwest Texas.[95] Hendrick claims this will allow it to "be able to alleviate capacity constraints, enhance patient quality, and expand access."[96] Hendrick has not demonstrated this claim sufficiently. To be clear, Hendrick's claim does not mean that bed capacity in Midwest Texas will actually increase under the merger. In fact, rather than constructing new facilities as Hendrick had initially considered prior to proposing the merger, Hendrick now plans to use the available capacity at Abilene Regional and Brownwood Regional to alleviate its capacity constraints.[97] Thus, the merger will likely lead to a reduction in capacity in Midwest Texas.

Furthermore, Hendrick can already refer patients to Abilene Regional if Hendrick is capacity constrained at any given time. As previously discussed, there is significant overlap between Hendrick and Abilene Regional in terms of the health conditions of the patients they treat.[98] Therefore, absent the merger, Abilene Regional is already a good alternative for potential transfers from Hendrick for the vast majority of patients treated at Hendrick. At best, Hendrick's claim is limited to the extent that it can leverage "its higher acuity service offerings and physician coverage capabilities at Abilene Regional."[99] However, Hendrick does not quantify the impact of this claim, nor does it assess the likely number of patients who would be transferred from Hendrick to Abilene Regional post-merger who could not be transferred pre-merger.

C. Claims of Cost Efficiencies for Services, Resources, and Equipment are Unsubtantiated, Not Merger-Specific, and Insufficient to Overcome the Likely Competitive Harm

COPA FACTOR 3: *The cost efficiency of services, resources, and equipment provided or used by the hospitals that are a party to the merger agreement*[100]

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[93] Hendrick COPA Application at 20, 35.
[94] Hendrick COPA Application at 9-10.
[95] Hendrick COPA Application at 27.
[96] Hendrick COPA Application at 16.
[97] Hendrick COPA Application at 27.
[98] *See supra* Section IV.C.
[99] Hendrick COPA Application at 10.
[100] Texas COPA Act § 314A.056(b)(3).

ASSESSMENT: Hendrick claims 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.[101] For the reasons below, the purported gains in cost-savings may be overstated and may not outweigh the substantial loss in competition. Furthermore, experience and evidence demonstrates that hospital mergers often do not result in significant efficiencies, despite company projections that they will.[102]

FTC staff recognize that mergers have the potential to achieve cost savings by eliminating duplicative corporate and administrative staff or through purchasing synergies, and we consider this as part of our analysis. Here, however, Hendrick has not provided sufficient detail to evaluate the credibility and magnitude of its claims. For example, Hendrick has not identified the specific steps necessary to achieve these savings, the expenditures involved, and a sufficient breakdown of the estimated annual cost savings for each category of claimed efficiencies in its COPA application. Without this information, the likelihood and magnitude of the cost-savings claims cannot be verified, which is necessary for HHSC to determine whether the claimed efficiencies would offset the significant disadvantages of the proposed Hendrick merger. Furthermore, even assuming Hendrick could achieve some of these cost savings, it is unclear how much would be passed through to heathcare consumers in the form of lower prices.

In addition, many of the claimed savings are the type that are likely achievable without the merger. Hendrick has 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. Hendrick pledges to use cost savings derived from the merger to invest in quality and healthcare initiatives, including population health management initiatives. However, it is unclear what portion of the savings is truly incremental compared to the current or future investments that Hendrick, Abilene

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[101] *See* Hendrick COPA Application at 31-36. The public version of the Hendrick COPA Application does not include the specific amounts and breakdown of the cost savings and efficiencies, so we are unable to address them in greater detail.

[102] *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."); Noah Smith, *Mergers Raise Prices, Not Efficiency*, BloombergView (Oct. 24, 2016), https://www.bloomberg.com/view/articles/2016-10-24/mergers-raise-prices-not-efficiency (summarizing the Blonigen & Pierce study); 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.").

Regional, and Brownwood Regional would have made independently, absent the merger. Hendrick and Abilene Regional already make significant investments in quality and healthcare initiatives,[103] and likely would continue to do so without the merger.

Hendrick claims "[t]he efficiencies and cost savings created by this transaction will fund population health, access to care, enhanced health services, and other community-oriented commitments."[104] There do not appear to be any enforceable commitments, however, to achieve cost savings or efficiencies, or to use these savings to fund quality and access improvements. Even if Hendrick were able to reduce its 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. Indeed, Hendrick acknowledges that some jobs, facilities, and services will have to be eliminated or consolidated in order to achieve their projected cost savings.[105] Notably, much of the efficiencies section of the Hendrick COPA Application is redacted so the public has no way of knowing what Hendrick plans to consolidate or eliminate to achieve cost savings. Any detrimental impact that this consolidation would have on the quality of patient care should receive appropriate consideration.

Hendrick then claims that "[b]y aligning Hendrick, Abilene Regional and Brownwood Regional's efforts in key service lines and other areas, the combined system will drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services."[106] Presumably, these hospitals have made careful medical and business judgments about how to utilize precious tax-exempt resources to best serve the community's needs, and have not made unnecessary expenditures. Indeed, Hendrick has not identified the specific expenditures that it believes to have been unnecessary or duplicative. 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.[107] Competition between hospitals often leads to investments that improve patient

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[103] *See, e.g.*, Abilene Regional Medical Center, *Managing Type 2 Diabetes During Holidays* (Nov. 27, 2019), https://www.abileneregional.com/news-room/managing-type-2-diabetes-during-holidays-15351; Abilene Regional Medical Center, *American Heart Month: Free Health Screenings* (Feb. 2 2019), https://www.abileneregional.com/news-room/american-heart-month-free-health-screenings-14418; Hendrick Health System, *Hendrick Continues to Earn Top Grades for Focus on Patient Safety* (May 1. 2020), https://www.hendrickhealth.org/main/news/hendrick-continues-to-earn-top-grades-for-focus-on-240.aspx; Hendrick Health System, *Hendrick Health System Nationally Recognized for Advanced Patient Record Environment* (Aug. 19, 2020), https://www.hendrickhealth.org/main/news/hendrick-health-system-nationally-recognized-for-a-204.aspx.
[104] Hendrick COPA Application at 35.
[105] *See* Hendrick COPA Application at 31-36.
[106] Hendrick COPA Application at 35.
[107] *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.

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.[108] For example, although new equipment can be costly, the quality benefits associated with technology advances may justify these expenditures.[109] Investments in facilities, technology, and equipment can result in shorter wait times, more convenient service options for physicians and patients, and the continued availability of services when a piece of equipment fails, all of which are far from wasteful, but quite beneficial. In contrast, to the extent that the combined system's future plans include the consolidation of clinical services, including reduced facility and equipment investments, this could result in reduced patient choice and access to healthcare services.

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

COPA FACTOR 4: *The ability of health care payors to negotiate payment and service arrangements with hospitals proposed to be merged under the agreement*[110]

ASSESSMENT: The Texas COPA Act requires HHSC 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

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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).

[108] 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, 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 certificate of need ("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.").

[109] *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.").

[110] Texas COPA Act § 314A.056(b)(4).

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.[111] 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.[112] Because the FTC is concerned about the impact that healthcare mergers will have on consumers, we take seriously the impact that a hospital merger will have on the ability of insurers to negotiate competitive prices and other contractual terms on consumers' behalf.

Currently, prices for inpatient, outpatient, and physician services provided by Hendrick and Abilene Regional 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

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[111] *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.

[112] *See, e.g.*, Gaynor, Ho & Town, *supra* note 17, 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 17, 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[.]"); 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); Jay Bhattacharya & M. Kate Bundorf, *The Incidence of the Healthcare Costs of Obesity*, 28 J. HEALTH ECON. 649 (2009), http://www.sciencedirect.com/science/article/pii/S0167629609000113 (finding that increased health insurance costs can be passed to employees in the form of lower wages); 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, *The Effect of Rising Health Insurance Costs on Compensation and Employment*, (Mar. 25, 2013) (unpublished manuscript), http://docplayer.net/1978184-The-effect-of-rising-health-insurance-costs-on-compensation-and-employment.html (finding that as health insurance costs increase, employers that offer health insurance reduce total employee compensation).

because, after the merger, insurers now have more to lose from failing to reach agreement with the merged system.

Today, Hendrick and Abilene Regional each *already* has 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 an alternative. That is, an insurer could still offer a fairly attractive network if it included only one of these hospital systems, especially because that more limited network would likely be offered at a discount.[113] Indeed, this has happened before in Midwest Texas. For example, in 2014, Blue Cross Blue Shield of Texas dropped Hendrick from its network[114] and relied on Abilene Regional to meet its patient members' healthcare needs after Hendrick demanded higher prices than the insurer was willing to pay and Blue Cross Blue Shield of Texas could not reach an agreement with Hendrick during contract negotiations.[115]

The proposed merger would give the combined hospital system even greater bargaining leverage over insurers and eliminate the ability of insurers to leverage competition between the hospitals. Failure to reach an agreement with the merged hospital system would now mean the loss of *both* hospital systems from the insurer's network, making that network *very* unattractive to consumers. It would be virtually impossible for an insurer to assemble a viable local provider network without contracting with the merged hospital system. This would give the merged hospital system the ability to extract substantially higher reimbursement rates from health insurers during contract negotiations. Competition from other hospitals would not prevent this harm, as the other hospitals are either too far away from most of the patients who currently use Hendrick and Abilene Regional, or their service offerings are too limited to constitute an

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[113] 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.

[114] Hendrick Health System, *Hendrick Health System No Longer In-Network for Blue Cross Blue Shield Members* (Jul. 1, 2014), https://www.hendrickhealth.org/main/news/hendrick-health-system-no-longer-innetwork-for-blu-49.aspx.

[115] *See* Letters from Physicians and Employees of Abilene Regional Medical Center to Mack Harrison at HHSC, dated Jun. 22, 2020 and Jul. 1, 2020; KTAB/KRBC/Telemundo Abilene, *Blue Cross Blue Shield Reaches Agreement with Hendrick Health System* (Jan. 29, 2016), https://www.bigcountryhomepage.com/news/blue-cross-blue-shield-reaches-agreement-with-hendrick-health-system/ ("Hendrick's decision to leave the network came after eleven months of failed negotiations. A representative from BCBSTX claims Hendrick was asking for a 40 percent rate increase, but a Hendrick spokesperson said it's normal for hospitals to request an increase as the cost of health care rises. . . . Hendrick estimated around 10,000 households were affected when they dropped out of the BCBSTX network. BCBSTX reported significantly higher numbers, saying 75,000 members in the Big Country, including 35,000 in Taylor County, were affected."); Abilene Reporter News, *Blue Cross Blue Shield and Hendrick Medical Center Settle Contract Dispute* (May 23, 2018), https://www.reporternews.com/story/news/2018/05/23/blue-cross-and-hendrick-settle-contract-dispute/637095002/ ("Hendrick was temporarily dropped from Blue Cross Blue Shield's network June 30, 2014, because the two parties could not agree on reimbursement rates. . . . Hendrick returned as an in-network provider for BCBS March 1, 2016.").

attractive provider network. Thus, the proposed merger would greatly enhance the hospitals' bargaining power, which would lead to substantially higher prices for consumers.[116]

Hendrick points to the rate review provision in the Texas COPA Act as sufficient to mitigate the impact of any anticompetitive increase in bargaining leverage for the merged entity. But as we discuss in greater detail in Section VII, a regulatory rate review regime is not a replacement for the benefits of competition and prices still could be expected to increase. Hendrick also asserts the merger would facilitate the adoption of value-based arrangements with health insurers, because the rate review conducted by HHSC would restrict the combined hospital system's ability to raise prices and therefore incentivizes the combined hospital system to consider value-based payment models rather than fee-for-service models.[117] However, it is unclear exactly how the merger would affect Hendrick's incentives to enter into value-based payment models. It is possible that the COPA, by increasing Hendrick's bargaining leverage, could diminish Hendrick's 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, Hendrick 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 Hendrick. 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.[118] On a related note, recent literature suggests that health systems with increased scale are not more likely to engage in or be more successful at value-based contracting.[119]

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[116] The above analysis assumes that the merged hospital system will bargain with insurers on an all-or-nothing basis (*i.e.*, contract with all hospitals in the system or none). If instead each hospital continued to negotiate separately, the merger would still lead to a price increase, though the mechanism would be slightly different.

[117] Hendrick COPA Application at 24 (stating that the HHSC rate review "restricts the parties from gaining revenue by simply raising prices," so "it is likely the parties will be forced to move away from fee-for-service models to value-based models.").

[118] *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 17, 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.").

[119] *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),

Furthermore, as Hendrick acknowledges, the shift to value-based initiatives is already occurring among many hospital systems and insurers nationwide, and is mandated by CMS in some circumstances.[120] In keeping with this trend, Hendrick and Abilene Regional likely would continue to transition to value-based initiatives independently. To the extent these hospitals have already transitioned to value-based initiatives and would have continued to engage in value-based initiatives independently, this cannot be considered a merger-specific benefit.[121]

In summary, the proposed Hendrick merger is likely to increase the prices of healthcare services for residents in Midwest Texas. As discussed in Section VII, the rate review conducted by HHSC would be unlikely to mitigate this harm.

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

COPA FACTOR 5: *The extent of any reduction in competition among physicians, allied health professionals, other health care providers, or other persons providing goods or services to, or in competition with, hospitals*[122]

ASSESSMENT: The framework to evaluate mergers that combine outpatient providers and physician services 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.

Hendrick and Abilene Regional are close competitors for outpatient and physician services. The systems operate competing outpatient centers that serve Midwest Texas, and each system employs physicians in the area across numerous specialties. The systems compete for

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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).

[120] *See* Hendrick COPA Application at 20. *See also* 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. 26, 2020); 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).

[121] *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).

[122] Texas COPA Act § 314A.056(b)(5).

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 employers and area residents. As discussed in Section VII, the rate review conducted by HHSC would be unlikely to mitigate this harm.

F. Hendrick Merger Would Likely Depress Wage Growth for Registered Nurses

"OTHER" COPA FACTOR 6: *Any other factor the applicant deems relevant to HHSC's determination under Texas Health and Safety Code §314A.056*[123]

ASSESSMENT: HHSC is allowed to consider any other relevant factors in its review of a COPA Application. HHSC must evaluate whether proposed COPAs are in the best interest of the public, namely that they confer public advantage. The impact of hospital consolidation on labor markets has garnered particular attention during recent merger reviews and is highly relevant to HHSC's analysis, as this can affect worker pay and community access to healthcare services.[124] A recent study found that mergers generating large increases in employer concentration have meaningful and statistically signficiant effects on employee wages.[125] At the FTC COPA Workshop, one participant suggested that this type of wage depression might increase the risk of economic inequality in local communities where hospitals are leading employers, and therefore worsen population health.[126]

FTC staff analyzed the likely competitive effects of the proposed Hendrick merger in the labor market for registered nurses. FTC staff defined a potentially relevant geographic market for calculating labor concentration as the commuting zone for nursing labor, as developed by the

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[123] *See* Texas COPA Rules §567.26(C)(vi); Texas COPA Act § 314A.056(b) (describing list of factors to consider when evaluating COPA applications as "nonexclusive").

[124] *See* FTC COPA Workshop Transcript: Session 2, *supra* note 32, Elena Prager remarks at 29 (describing how labor market effects are a relevant consideration for states who are evaluating COPAs, and may care about constituent pay and community access, among other policy goals; for states that have a broad public interest mandate and want to take these issues into account, there is sufficient evidence of "substantial and detectable effect on worker pay").

[125] *See* Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, Washington Center for Equitable Growth Working Paper (2019), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3391889 [hereinafter Prager & Schmitt Study]; David Arnold, *Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes*, Working Paper (2020), https://darnold199.github.io/jmp.pdf. *See also* Elena Prager Presentation at FTC COPA Workshop, *Effects of Hospital Mergers on Employee Pay* (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/slides-copa-jun_19.pdf at 109 (describing the study and methodology).

[126] *See* FTC COPA Workshop Transcript: Session 2, *supra* note 32, at 30-31 (panel discussion of Prager & Schmitt Study).

U.S. Department of Agriculture.[127] For the proposed Hendrick merger, this commuting zone consists of the following six counties: Callahan, Fisher, Jones, Nolan, Taylor, and Shackelford. Hendrick and Abilene Regional are both located in this commuting zone. FTC staff applied 2017 AHA data to calculate market shares of registered nurses working at all general acute care hospitals in this commuting zone. FTC staff used these market shares to calculate pre- and post-merger HHIs for the proposed Hendrick merger.

FTC staff found that the labor market for registered nurses is highly concentrated before the proposed merger, and that the merger would increase concentration to an extraordinarily high level. Table 4 shows that Hendrick and Abilene Regional have a combined share in the commuting zone of 72.5%. The post-merger HHI is 8,598 and the increase in HHI is 3,149. The post-merger HHIs and changes in HHIs create a strong inference that the proposed Hendrick merger would cause harm to registered nurses. For context, these increases in HHI are well above the 75th percentile among hospital mergers included in the Prager and Schmitt study, which found that hospital mergers in the top quartile of increases in HHI resulted in an economically significant lower growth in wages for nurses. The 75th percentile of the increase in HHI calculated by Prager and Schmitt is 1,115. The increase in HHI in the proposed Hendrick merger is 3,149, which is far greater than 1,115. This indicates that the reduction in competition caused by the proposed Hendrick merger in the labor market for registered nurses is likely to be extraordinarily high.

Table 4: Registered Nurse Shares in Hendrick Commuting Zone
(Based on 2017 AHA Data)

Hospital	Pre-Merger Share	Post-Merger Share
Hendrick	70.1%	92.6%
Abilene Regional	22.4%	
Rolling Plains Memorial Hospital	4.9%	4.9%
Fisher County Hospital District	1.0%	1.0%
Anson General Hospital	0.8%	0.8%
Hamlin Memorial Hospital	0.8%	0.8%
HHI	**5,449**	**8,598**
	Change in HHI = 3,149	

[127] 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.

In summary, assessing the Hendrick merger under the Texas COPA Act factors, we conclude that it is likely to result in serious disadvantages resulting from the loss of competition, while any benefits are likely to be modest and largely achievable by other means that are less restrictive to competition. In the following sections, we assess whether entry by a new competitor or the statutory rate review and other potential COPA commitments could mitigate the significant disadvantages of the COPA.

VI. Entry Would Not Be Timely, Likely, or Sufficient to Overcome the Likelihood of Substantial Harm to Competition

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 Hendrick merger.[128] Although this is not a factor under the Texas COPA Act or regulations, FTC staff acknowledges that such entry – if it would be timely, likely, and sufficient – could offset or reduce concerns from the elimination of competition between Hendrick, Abilene Regional, and Brownwood Regional.

The evidence shows, however, that new entry would not be timely, likely, or sufficient to offset the competitive harm of the proposed Hendrick merger. Construction and operation of new acute care hospitals involve significant capital investment and take many years from the initial planning stage to opening. Moreover, because the merger combines three hospital systems, entry by a single hospital – or even a few hospitals – would not be sufficient to replicate the current scope and strength of competition between Hendrick, Abilene Regional, and Brownwood Regional. Of course, the time, cost, and challenges of building multiple new hospitals would be significantly greater than building a single hospital.

In short, it is unlikely that any firm could overcome the entry barriers necessary to build a new acute care hospital in the area, much less a new hospital system, in the foreseeable future. Unsurprisingly, FTC staff's investigation revealed no such plans for new entry by acute care hospitals.

Notably, Hendrick claims the combined hospital systems would "continue to face the threat of significant competition from other potential providers that can challenge the hospitals simply by arriving at their doorstep."[129] This seems to contradict Hendrick's claims that rural hospitals in Midwest Texas face imminent risk of closure and cannot continue to operate independently. Based on Hendrick's assertion that only the proposed merger will allow these established hospitals to navigate the financial, regulatory, and operational challenges of providing care in Midwest Texas, it seems unlikely that a potential new entrant could survive these challenges and provide any meaningful competition to Hendrick post-merger.

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[128] *Merger Guidelines* § 9.

[129] Hendrick COPA Application at 38. Furthermore, Hendrick describes how "[m]any health systems in Texas are currently undergoing significant facility and service expansions," albeit these examples fall outside of the Midwest Texas region. *Id.* at 38-39.

VII. Proposed Rate Review and Possibility of Additional Terms and Conditions Are Unlikely to Mitigate the Harm Resulting From Loss of Competition

Hendrick asserts that the rate review conducted by HHSC would limit its ability to exercise market power and increase prices, and would therefore shield consumers from the anticompetitive effects of the merger.[130] However, rate review is not an adequate substitute for actual competition and is unlikely to be successful in protecting consumers from higher prices and reduced quality. HHSC has discretion to impose additional terms and conditions on recipients of COPAs, although we do not know whether this will happen or what possible terms might entail.[131] 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.[132]

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.[133] 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.[134] Second, designing and enforcing price

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[130] Hendrick COPA Application at 1, 23-24, 36, and 40.

[131] Other states have imposed various types of terms and conditions on recipients of COPAs, including rate regulation, mechanisms for sharing cost savings and efficiencies with local residents, public reporting of quality metrics, and commitments regarding certain contractual provisions between the hospitals and commercial health insurers.

[132] 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.

[133] *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.").

[134] *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.").

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.[135] 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.[136]

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 the 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.[137] 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.[138]

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 Hendrick 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

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[135] 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.

[136] *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 [hereinafter Vistnes COPA Analysis] ("Economists have long recognized the difficulties of regulating monopolists and how regulation, no matter how carefully crafted and implemented, can inadvertently create undesirable incentive problems."); Cory S. Capps, *Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health System* 32 (May 2, 2011) [hereinafter Capps COPA Analysis] ("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").

[137] *See, e.g.*, Gaynor, Ho & Town, *supra* note 17.

[138] *See, e.g.*, Gaynor, Moreno-Serra & Propper, *supra* note 107.

is difficult to envision how a supervisor of the COPA would be able to effectively force Hendrick 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.[139] Courts generally agree with this position.[140] 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.[141] 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.[142] While every geographic area has unique aspects, these challenges would apply equally in Midwest Texas.

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[139] *See* ANTITRUST DIV., U.S. DEP'T OF JUSTICE, MERGER REMEDIES MANUAL (2020), https://www.justice.gov/atr/page/file/1312416/download; FED. TRADE COMM'N, THE FTC'S MERGER REMEDIES 2006-2012: A REPORT OF THE BUREAUS OF COMPETITION AND ECONOMICS (2017), https://www.ftc.gov/system/files/documents/reports/ftcs-merger-remedies-2006-2012-report-bureaus-competition-economics/p143100_ftc_merger_remedies_2006-2012.pdf; Feinstein, supra note 5. *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 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.").

[140] *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.").

[141] *See Partners Healthcare Sys.*, *supra* note 133, 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 136, at 2.

[142] *See Partners Healthcare Sys.*, *supra* note 133, 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.").

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.[143] 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 Hendrick accountable.

A. Rate Review Will Be Difficult to Administer and May Not Address Consumer Harms

HHSC appears to have wide discretion for administering the parameters of the statutory rate review process and the guidelines for when HHSC must reject or approve proposed rates appear vague. As such, it remains unclear whether the rate review would restrict Hendrick's ability to raise prices post-merger, and Hendrick would still have discretion to renegotiate prices after the COPA has been approved. All of this leaves open the potential for the rate review process to be manipulated, especially because Hendrick would control the underlying data.[144] It is difficult, if not impossible, to foresee all of the ways that the rate review process could fall short of its intended purpose, be circumvented, or result in unintended consequences.

Several specific, practical issues arise from the rate review process, including:

- Benchmark Metrics: It appears that HHSC would use the producer price index for hospital services published by the Bureau of Labor Statistics of the U.S. Department of Labor or a comparable price index chosen by HHSC if this producer price index is abolished. The use of a price index such as the producer price index for hospital services as a benchmark is intended to allow prices to increase commensurate with costs, where the benchmark serves as a proxy for costs. However, such benchmarks do not take into account differences in cost structures, case mix, or service offerings between the merging hospitals and the other hospitals that make up the benchmark. Thus, the producer price

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[143] *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.").

[144] This concern has been raised in other cases involving price commitments proposed by hospitals. *See Partners Healthcare Sys.*, *supra* note 133, at 2 ("Significantly, the monitor must rely on [the hospital system] for the critical information to make these calculations – so that the fox is literally guarding the proverbial chicken coop."). *See also supra* note 142; RANDALL R. BOVBJERG & ROBERT A. BERENSON, URBAN INSTITUTE, CERTIFICATES OF PUBLIC ADVANTAGE: CAN THEY ADDRESS PROVIDER MARKET POWER? 22 (2015), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf, [hereinafter URBAN INSTITUTE COPA REPORT] (describing the challenges of obtaining "objective information not controlled by the supplier of data" and how "[c]ontrol over data could allow a regulatee to cherry pick its public documentation and possibly even metrics of oversight").

index for hospitals could overstate cost changes in the Abilene area if, for example, costs in this area were to grow slower than the national or regional average. Under such a scenario, relying on the hospital producer price index as a benchmark may allow Hendrick's prices to rise by more than its costs, thus allowing Hendrick to excerice its increased market power.

- Justifications for Rate Increases May Be Difficult to Verify: It appears that Hendrick may propose rate increases that exceed the producer price index as long as such a proposal is accompanied by a justification for the rate proposal. The Texas COPA Rules do not specify the standard of evidence required to support such a rate proposal nor is it clear how HHSC will evaluate the proposal. It may be very difficult for HHSC to verify the claims in such justifications, especially given that, as noted above, Hendrick will control the most relevant underlying data.

- Comparisons to Competitive Rates May Not Be Practical: The Texas COPA Rules state that HHSC may approve a proposed rate increase if HHSC determines that the proposed rate increase does not inappropriately exceed competitive rates for comparable services in the hospital's market area. One likely problem with this framework is determining what the "competitive rate" is in the hospital's market area. As discussed in Section IV above, Hendrick would become the dominant hospital system in its SSA, making evaluating a "competitive price" in this area particularly problematic.

- Rate Review May Not Apply to Evolving Delivery and Payment Models: The proposed rate review attempts to limit Hendrick's ability to raise prices under existing fixed-rate contracts. But this may not prevent price increases if Hendrick's future contracts with payers are structured as value-based contracts or risk-based contracts. As delivery and payment models for healthcare services continue to evolve, we question how the proposed rate review would be applicable to new value-based contracting models, which do not rely on fee-for-service reimbursement rates.[145] The terms of these value-based contracts are negotiated, however, so Hendrick could exercise its enhanced bargaining leverage to demand significantly higher prices. Competitive environments naturally allow for healthcare providers to adjust their output and quality in response to changes in reimbursement structures. Regulatory environments, such as what is being proposed by this COPA, do not allow for such adjustments.

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

B. Accountability and Enforcement Mechanisms for Quality Benefits Appear to Be Lacking

Hendrick makes many claims about potential quality improvements that may result from the proposed merger. However, there do not appear to be any meaningful mechanisms proposed for evaluating the quality benefits of the COPA. Any discussion of monitoring the impact of the COPA on quality is vague, and consists of little more than the filing of an annual report to HHSC in which the parties will attest to any progress they are making towards quality improvments.

Measuring healthcare quality can be quite difficult and Hendrick's COPA Application does not include objective, quantitative quality of care benchmarks by which the claimed benefits can be evaluated, much less weighed against the disadvantages likely to result from the COPA. Moreover, it is unclear whether HHSC has any mechanism for addressing potential problems or shortcomings with the information submitted in the annual report. It is unclear how the HHSC could objectively determine whether the hospital attestations regarding quality benefits are accurate, and thus whether Hendrick is complying with the requirements of the COPA. Critically, the COPA appears to contain no meaningful enforcement mechanism if Hendrick fails to achieve its promises regarding quality improvements, other than revoking the COPA. HHSC is allowed to investigate the hospital's activities and require a corrective action plan, but it is unclear what happens if these mechanisms prove inadequate for resolving a problem with the COPA.

C. Commitment Regarding Physician Contracting Will Not Mitigate Merger Harms

In its COPA application, Hendrick appears to commit not to engage in exclusive contracting for independent physician services.[146] The antitrust agencies have noted that, depending on the circumstances, some types of these contracting practices can be anticompetitive when imposed by a dominant hospital system, in which case such commitments might be helpful.[147] However, these practices would not be the primary source of projected harm from the proposed merger – lost competition would be the source of the harm. Thus, prohibiting these practices would not solve the problem. In a market where competition among the most

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[146] *See* Hendrick COPA Application at 40 ("The independent physicians in the community will maintain the ability to refer patients to any health care facility. As has always been the case, none will be required to refer to Hendrick, Abilene Regional, or Brownwood Regional.").

[147] *See, e.g.*, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, *supra* note 76, at 67029-30, Section IV.B.1.b. (identifying several contracting practices that may raise competitive concerns if imposed by a provider with high market shares or other possible indicia of market power, including: "[p]reventing or discouraging private payers from directing or incentivizing patients to choose certain providers . . . through 'anti-steering,' 'anti-tiering,' 'guaranteed inclusion,' 'most-favored-nation,' or similar contractual clauses or provisions"; "[t]ying sales (either explicitly or implicitly through pricing policies) of [some of the provider's] services to the private payer's purchase of other services from [other] providers"; "contracting on an exclusive basis"; and "[r]estricting a private payer's ability to make available to its health plan enrollees cost, quality, efficiency, and performance information to aid enrollees in evaluating and selecting providers in the health plan").

significant healthcare providers has already been eliminated, prohibiting such practices would not be meaningful.[148]

VIII. Possibility of Voluntary Termination is Highly Concerning and Corrective Action Plan and Revocation of COPA Are Unlikely to Be Effective Remedies

Under the Texas COPA Act and Rules, Hendrick can voluntarily terminate its COPA by giving HHSC 30 days notice at any time after the COPA is approved.[149] This means that once all of the hospital assets are combined, Hendrick 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 Texas COPA Act and Rules require a corrective action plan to address any deficiencies in the hospital's activities if HHSC determines that the activity does not benefit the public or no longer meets the standard prescribed by the Act – namely that the activity benefits the public by maintaining or improving the quality, efficiency, and accessibility of health care services, and these benefits outweigh any disadvantages attributable to a reduction in competition resulting from the merger.[150] However, there are no specific guidelines provided in the Act or the Rules about what would be required in a corrective plan, or how it would be implemented or enforced. Furthermore, the Texas COPA Act allows HHSC 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, the issuance of the COPA was obtained as a result of material misreprentation, the hospital fails to pay any required fee, or the benefits of the merger no longer outweigh the disadvantages attributable to a reduction in competition resulting from the merger.[151] Unfortunately, there is no certainty that these provisions would protect the public if the COPA does not fulfill its promised benefits.

It would be unrealistic to expect that terminating a COPA following a merger's consummation would return the hospital systems to their pre-merger status and, therefore, fully restore the lost competition. According to Hendrick, this transaction would involve a significant degree of integration. For example, the combined entity would be likely to: 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

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[148] For example, payers may attempt to control costs by steering patients to high-quality, low-cost providers or making price and quality information more transparent to patients. However, such strategies are unlikely to be successful in markets that lack sufficient competition among providers. Thus, if a COPA results in substantial provider consolidation, imposing prohibitions on contractual provisions that would undermine these strategies would be meaningless.

[149] Texas COPA Act § 314.058; Texas COPA Rules § 567.33.

[150] Texas COPA Act § 314A.104; Texas COPA Rules § 567.54.

[151] Texas COPA Act § 314A.151.

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.[152]

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.[153] 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.[154] Similarly, if the Hendrick COPA is approved, and Hendrick is allowed to merge its operations with Abilene Regional and Brownwood Regional, the remedies available if the merger does not yield its promised benefits would be severely limited.

The corrective plan and revocation provisions do not guarantee a structural remedy or a restoration of pre-consolidation market competition, nor do they guarantee an adequate timeline for restoring pre-consolidation market competition. Based on recent FTC experience, it can take

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[152] Recent FTC and DOJ statements have indicated that the agencies are willing to seek post-consummation structural relief in appropriate circumstances. *See* DOJ Merger Remedies Manual, *supra* note 139, at 19 ("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, 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."); FTC Merger Remedies Study, *supra* note 139, at 12, 18-19 (describing the significant challenges in crafting a remedy for a consummated merger when assets have been combined). However, experience demonstrates that this type of relief would be highly unlikely for consummated hospital mergers where significant integration has occurred over several years. *See infra* note 154.

[153] *See* Feinstein, *supra* note 5.

[154] *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/2008/04/080428commopiniononremedy.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).

a year or more to finalize divestitures, even when there has not been significant facility, clinical, and other integration between the parties.[155]

IX. Practical Concerns Associated with Certificates of Public Advantage in Other States

Although many states have enacted COPA legislation since the 1990s, very few hospital mergers have been approved pursuant to such legislation. We are aware of eight states that purported to grant antitrust immunity to merging hospitals under a COPA regulatory scheme: North Carolina, South Carolina, Montana, Maine, Minnesota, and most recently, West Virginia, Tennessee, and Virginia.[156] Of these states, North Carolina, Montana, and Minnesota have repealed the underlying legislation so that hospitals in these states are no longer allowed to obtain COPAs. The practical effect of these legislative changes, however, was that the merged healthcare systems that had already received COPAs were allowed to exercise their monopoly market power unconstrained by state regulatory oversight or antitrust enforcement.

FTC staff has evaluated several of these COPAs, and we are aware of recent empirical research on the price and quality effects of some of the older COPAs.[157] While the results of these studies vary in terms of price and quality effects, one study of several COPAs concluded that "the removal of COPA regulation can lead to higher prices and reduced quality due to unconstrained provider market power. Furthermore, poorly-designed COPAs that do not regulate all of the hospitals of the merged system can allow the merged system to exercise market power at the unregulated hospitals."[158] We have learned anecdotally that COPAs can be difficult to implement and monitor. Over time, regulatory fatigue and staff turnover at the agencies responsible for COPA oversight can lead to less vigorous supervision. Futhermore, the hospitals subject to COPAs often lobby for the repeal of the COPA oversight or for the relaxation of COPA conditions, citing the costs and difficulties of compliance. We provide the following study results and information to HHSC in case it is useful in evaluating the proposed COPA application.

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[155] *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).

[156] 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); and Ballad Health System (Tennessee and Virginia, 2018).

[157] *See* Christopher Garmon & Kishan Bhatt, *Certificates of Public Advantage and Hospital Mergers: Evidence from Maine, Montana and South Carolina* (Jun. 2020), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3634577 [hereinafter Garmon & Bhatt COPA Paper]; 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 [hereinafter Tran & Schwarz COPA Presentation].

[158] Garmon & Bhatt COPA Paper at 7.

A. Mission Health System

In December 1995, Memorial Mission Hospital and St. Joseph's Hospital, the only two general acute care hospitals in Asheville, North Carolina, entered into a cooperative agreement under the state's COPA statute for certain collaborative activities. In 1998, the two hospitals merged their assets 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 entity, renamed Mission Health System ("Mission Health"), operated under these terms for nearly 20 years. In 2015, the North Carolina legislature repealed the state's COPA statute as a result of lobbying efforts by Mission Health, and the Mission Health COPA was terminated as of September 2016 – leaving no meaningful competitive or regulatory constraint on Mission Health's monopoly market power. In February 2019, Mission Health was acquired by HCA Healthcare.

At the FTC COPA Workshop, empirical research was presented on the price effects of the Mission Health COPA for inpatient hospital services from 1996 to 2008. The study showed that Mission Health increased its prices by at least 20% more than the control hospitals during the COPA period, suggesting that despite the margin and cost regulations, state COPA oversight did not prevent Mission Health from raising prices.[159] Prior to this empirical research, health policy experts and economists evaluated certain aspects of the Mission Health COPA, but were unable to reach conclusions about whether the COPA successfully constrained prices, reduced healthcare costs, or improved quality.[160]

In addition to this empirical research, workshop participants shared practical experiences with the Mission Health COPA. Kip Sturgis, from the North Carolina Attorney General's office, was responsible for overseeing the Mission Health COPA for nearly 20 years. Mr. Sturgis explained that in hindsight, he would have implemented more quality metrics and financial incentives for the hospital to control costs.[161] He does not recommend that states use COPAs due to the potential for regulatory evasion during the COPA period, and the ability of hospitals to

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[159] *See* Tran & Schwarz COPA Presentation.

[160] *See* URBAN INSTITUTE COPA REPORT at 16-17, 22 (noting the limited public information available to assess the impact of the COPA on prices, costs, or quality, and the seemingly limited access that consultants had to data that might have allowed for an independent empirical analysis of the COPA's effects); *id.* at 16 ("This case study found no definitive evidence about whether the COPA's state oversight has successfully replaced the former competition that was lost by permitting the collaboration and combination of the only two general hospitals in the population center of WNC."); Vistnes COPA Analysis at 6-8, 11 n.14 (describing the scope of the analysis and acknowledging an inability to determine whether the merger actually resulted in a substantial increase in market power or whether Mission Health acted on incentives to evade regulations intended to curtail its market power); Capps COPA Analysis at 14 (stating that "under the current regulatory framework, MHS has the ability to charge high prices . . . in direct contradiction to the clear intent of the COPA" but acknowledging an inability to assess whether MHS has in fact done so). *But see* Thomas McCarthy, *Economist's Report on the Mission Health Certificate of Public Advantage* (2011) (reporting that prices and costs at Mission Health were comparable to the control group).

[161] FTC COPA Workshop Transcript: Session 1 (Morning), Kip Sturgis remarks at 33 (Jun. 18, 2020), https://www.ftc.gov/system/files/documents/public_events/1508753/session1_transcript_copa.pdf [hereinafter FTC COPA Workshop Transcript: Session 1].

eventually be freed of COPA oversight, which leaves the community with an unregulated monopoly.[162] He described how immediately following the repeal of the COPA, Mission Health had a contracting dispute with the state's largest payer, Blue Cross Blue Shield of North Carolina ("BCBS-NC"), apparently because Mission Health demanded higher reimbursement rates than BCBS-NC was willing to pay.[163] Cory Capps, a healthcare economist who was hired to evaluate the Mission Health COPA in 2011, shared his perspectives at the workshop. He discussed the difficulty of designing a regulatory scheme that prevents evasion *and* is flexible enough to allow for industry changes over the full duration of the COPA.[164]

B. Benefis Health System

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 regulatory scheme that imposed conduct remedies intended to mitigate the competitive disadvantages of the merger.[165] For ten years, Benefis Health System ("Benefis Health") was subject to revenue caps, conditions relating to the quality of hospital care, and other cost-saving efficiency commitments agreed to as conditions of COPA approval. In 2007, at Benefis Health's urging, the Montana state legislature passed a bill that effectively terminated the COPA agreement, despite the objections of the Montana Attorney General. As a result, Benefis Health has been able to freely exercise its monopoly market power with no regulatory or antitrust oversight since 2009, when the legislation took effect. Since that time, there have been concerns regarding significant price increases by Benefis Health.[166]

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[162] *Id.* at 43. Kip Sturgis and Mark Callister explained that when overseeing a COPA, it is hard to anticipate everything that can happen in a market over time and the ways regulations can be evaded, and that this concern is "inherent in a regulatory scheme that displaces competition." *Id.* at 44-45.

[163] *Id.* at 46. Kip Sturgis explained that BCBS-NC responded by putting Mission Health out-of-network for a brief time, which was very disruptive for the community.

[164] FTC COPA Workshop Transcript: Session 1, *supra* note 161, Cory Capps remarks at 34-35 ("So there's an inherent trade-off between rigidity and efficacy of price regulation and flexibility and adaptability. And I think that is one example at least of why regulation is challenging and why we generally rely on competition to drive good outcomes for the efficient operation of firms and outcomes for consumers.").

[165] FTC staff investigated the merger and determined that the transaction raised "significant antitrust concerns," but closed its investigation in light of the COPA. Letter from Robert Leibenluft, Federal Trade Commission, to Joe Sims, Jones, Day, Reavis & Pogue (Jun. 28, 1996), https://www.ftc.gov/sites/default/files/documents/closing_letters/columbus-hospital/montana-deaconess-medical-center/960628columbushospitalletter.pdf.

[166] *See* Jimmy Tobias, *Costly Care: Great Falls Hospital Merger Holds Lessons For Missoula*, MISSOULA INDEP.: INDY BLOG (Mar. 26, 2014), http://missoulanews.bigskypress.com/IndyBlog/archives/2014/03/26/great-falls-hospital-merger-holds-lessons-for-missoula (citing the Benefis Health COPA as an example of the potential problems associated with hospital mergers that create substantial market power, including complaints of significant prices increases – up to 38% over three years for some health plans – after the COPA was rescinded; also reporting that the annual Montana attorney general reports on non-profit state hospitals "show prices rapidly rising at Benefis" from 2008 to 2010, including average prices at Benefis for esophagitis treatments increasing from $6,564 to $9,230, for simple pneumonia procedures increasing from $7,722 to $13,076, and for vaginal births increasing from $3,475 to $4,832).

At the FTC COPA Workshop, empirical research was presented on the price effects of the Benefis Health COPA for inpatient hospital services from 1995 to 2015. The study showed that Benefis's prices closely tracked the prices of the control hospitals in duopoly markets in Montana and the Upper Midwest 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 these control hospitals, but that the COPA removal led to higher prices consistent with the exercise of market power by an unconstrained hospital monopoly.[167]

In addition to this empirical research, worshop participants shared practical experiences with the Benefis Health COPA. Benefis CEO, John Goodnow, stated that he believes the COPA effectively controlled prices and did not see the kind of post-COPA price increases found in the Garmon study.[168] He did not think COPAs adequately address the rising costs of healthcare,[169] and described the potential disincentives that revenue and cost caps can create for hospitals to reduce costs.[170] Mark Callister, who was hired by the Montanta 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.[171]

Finally, Kendall Cotton, a policy advisor for the Montana Insurance Commissioner, explained that his office recently proposed legislation to repeal Montana's COPA statute as part of an effort to enhance competition in provider and insurance markets.[172] His office viewed COPAs as a "regulatory incentive for consolidation"[173] at a time when the research has clearly shown "that

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[167] *See* Garmon & Bhatt COPA Study at 6-7; Christopher Garmon Presentation at FTC COPA Workshop, *The Benefis Health Certificate of Public Advantage: Estimates of Commercial Price Effects* (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/slides-copa-jun_19.pdf at 6.
[168] FTC COPA Workshop Transcript: Session 1, *supra* note 161, John Goodnow remarks at 40 ("So I think COPAs are effective maybe, depending on how they're set up, but probably only during their duration.").
[169] *Id.* at 40.
[170] *Id.* at 43-44.
[171] FTC COPA Workshop Transcript: Session 1, *supra* note 161, Mark Callister remarks at 38. Mark Callister informed us that the Benefis Health COPA was opposed by medical professionals and citizens of Great Falls, but was supported by the payers. *Id.* at 37.
[172] FTC COPA Workshop Transcript: Session 1, *supra* note 161, Kendall Cotton remarks at 40 ("We believe that a more competitive marketplace for providers and health care facilities leads to stronger insurer networks, leads to lower premiums, and lower costs for consumers in the end.").
[173] *Id.* at 41 ("From our perspective, merging hospitals would only likely apply for this COPA because they worry that their merger is going to run afoul of federal antitrust scrutiny or loss, and they're seeking a public interest exemption. . . . With the later 10-year sunset that was put in place on the COPA statute, we saw this perverse incentive for mergers become even worse, in our perspective. Now not only could mergers who were worried about federal antitrust scrutiny escape it under a COPA, but they could also continue to act as a monopolistic power after its expiration.").

hospital consolidation leads to poor outcomes for both quality and costs."[174] He claimed that since the time that 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."[175]

C. Palmetto Health System

In May 1997, Baptist Healthcare System and Richland Memorial Hospital, two general acute care hospitals in Columbia, South Carolina entered into an agreement where they contributed their assets to a new entity – Palmetto Health System ("Palmetto Health") – that would operate the combined assets. 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 of these conditions were changed or eliminated in November 2003. Palmetto Health reports annually to DHEC, and asserts that it is operating in accordance with the revised terms of the COPA. In November 2017, Palmetto Health merged with Greenville Health System to create the largest health system in South Carolina, which is now known as Prisma Health System.[176]

At the FTC COPA Workshop, empirical research was presented on the price effects of the Palmetto Health COPA for inpatient hospital services from 1997 to 2008. The study showed that prices increased at Palmetto Health during the first decade of the COPA, but that the increase was not statistically different from price changes at the control 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.[177] 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 (now owned by LifePoint Health) and Lexington Medical Center.[178] Indeed, in its COPA application submitted to DHEC, Palmetto Health

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[174] *Id.* at 40.
[175] *Id.* at 41 ("They exert significant market power. In addition to that, we saw that the year directly after the COPA reporting periods expired, Benefis executives received multimillion dollar bonuses in the compensation." Benefis CEO, John Goodnow, refuted this claim and Kendall Cotton responded, "But that is complexly backed up in the data, where it shows that monopolies and uncompetitive markets have a greater disparity between executive pay and other hospital employees, and so we're seeing that play out with Benefis. So with that being said, we decide in the best interests of Montana consumers to repeal this incentive for hospital consolidation entirely.").
[176] The Palmetto Health hospitals still operate under the COPA that was originally approved in 1997.
[177] *See* Garmon & Bhatt COPA Paper at 36; Kishan Bhatt Presentation at FTC COPA Workshop, *Palmetto Health COPA: Evidence on Price Effects* (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/slides-copa-jun_19.pdf at 18 [hereinafter Bhatt Presentation].
[178] At the time of the COPA application, four general acute care hospitals served the Columbia Core-Based Statistical Area in addition to Baptist Healthcare and Richaland Memorial: Providence Health in Columbia (now owned by LifePoint), Lexington Medical Center in West Columbia, Kershaw Health in Camden (now owned by LifePoint), and Fairfield Memorial Hospital in Winnsboro (closed in 2018). *See* Garmon & Bhatt Study at 11-12

highlighted this competition as a constraint on its ability to exercise post-merger market power.[179] Alternatively, it may be that the study was unable to isolate the effect of the merger from other factors that may have affected prices at Palmetto Health and the control hospitals during that time period.

D. MaineHealth

In March 2009, MaineHealth acquired Southern Maine Medical Center ("SMMC") pursuant to 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 entity has a dominant share of patient discharges in the SMMC service area. The terms of the COPA required MaineHealth to limit SMMC's operating profit margin and reduce expenses, as well as expand access and maintain quality. In accordance with the state COPA statute, the MaineHealth COPA expired after six years in May 2015.

Counsel for MaineHealth submitted a public comment to the FTC, for consideration during the FTC COPA Workshop, claiming that the COPA successfully met the state's policy objectives regarding quality of healthcare services; consumer geographic proximity and access to care; cost efficiency of healthcare services; and health resource utilization.[180] Since then, empirical research has been conducted on the price and quality effects of the MaineHealth COPA from 2003 to 2018 that indicates otherwise.[181] The study shows the following results:

> SMMC's price was slightly below the average price at other Maine hospitals during the period of COPA enforcement, but increased by at least 40 percent relative to other Maine

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("Baptist and Richland together represented 55 percent of the bed capacity in the Columbia CBSA and treated 66 percent of the commercially insured inpatients."). *See also* Bhatt Presentation at 20 (describing the local hospitals that competed within a 10-mile area in Columbia at the time of the COPA application, including Richland Memorial, Baptist Healthcare, Providence Health, and Lexington Medical Center).

[179] Earlier this year, Prisma announced plans to acquire certain assets from LifePoint, including Providence Health in Columbia (includes both Providence Health and Providence Health Northeast general acute care hospitals) and Kershaw Health in Camden. In February 2020, at Prisma's request, DHEC approved a modification to the COPA to add the LifePoint assets and updated the COPA Agreement Conditions. *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. According to Garmon and Bhatt: "Nowhere in the new conditions are explicit restrictions on price except for the submission of financial reports and the proviso that the DHEC 'may amend these conditions to include, but not be limited to, the lowering of prices should unexpected events lead to abnormally high margins from operations.' The new conditions also do not explicitly address quality of care, except for the requirement to maintain existing services. If consummated, the acquisition would leave only one remaining independent hospital in the Columbia area, Lexington Medical Center, which currently has roughly 23 percent of the staffed hospital beds in the Columbia CBSA." Garmon & Bhatt COPA Paper at 14.

[180] MaineHealth Submission to the FTC (Jun. 17, 2019), https://www.regulations.gov/document?D=FTC-2019-0016-0068.

[181] Garmon & Bhatt COPA Paper at 29.

> hospitals after the COPA expired. The price at MMC and SMMC overall increased at least 27 percent during the COPA period and 45 percent after the COPA expired relative to other Maine Hospitals. We find mixed quality results during the Maine COPA, but a marked deterioration in patient outcomes at SMMC after COPA enforcement ends.[182]

These results suggest that there were price increases during the COPA period at MaineHealth hospitals that remained unregulated by the COPA, as well as price increases after the COPA expired. In addition, and perhaps more importantly, there was a decline in quality after the COPA expired.

E. Ballad Health System and Cabell Huntington Hospital COPAs[183]

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 ("Ballad Health") pursuant to COPA approvals from both the Virginia and Tennessee Departments of Health.[184] 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. However, the Tennessee Department of Health and Tennessee Attorney General's Office has temporarily suspended several of the COPA conditions due to the COVID-19 pandemic.[185]

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

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[182] Garmon & Bhatt COPA Paper at 6. The authors note that rapid consolidation of healthcare facilities was occurring in Maine during this time period. Thus, when interpreting the study results it is possible that "the large price increase and worsening of patient outcomes that occurred at SMMC after the COPA expired may be due to unconstrained market power from numerous MaineHealth acquisitions, not just the acquisition of SMMC." *Id.* at 18.
[183] In October 2019, the FTC issued orders to five health insurance companies and two health systems to provide information that will allow the agency to study the effects of the Ballad Health and Cabell Huntington COPAs on prices, quality, access, and innovation of healthcare services, as well as the impact of hospital consolidation on employee wages. The Commission is authorized to issue Orders to File a Special Report by Section 6(b) of the FTC Act, 16 U.S.C. § 46(b). The FTC intends to collect information over the next several years that will help FTC staff to conduct retrospective analyses of the Ballad Health and Cabell COPAs. *See* 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.
[184] FTC staff investigated the proposed merger of Mountain States and Wellmont for more than two years. After determining that the merger raised significant antitrust concerns, FTC staff submitted extensive 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.
[185] *See* Tennessee Dep't. of Health, COPA Announcements, https://www.tn.gov/health/health-program-areas/health-planning/certificate-of-public-advantage/redir-copa/copa-announcements.html (last accessed Aug. 31, 2020); 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. 31, 2020).

Virginia Health Care Authority ("Authority").[186] The conditions of the COPA 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.[187]

At the FTC COPA Workshop, Janet Kleinfelter from the Tennessee Attorney General's office and Joseph Hilbert from the Virginia Department of Health described the lengthy review process by the states to approve the COPAs and active supervision, as well as the terms and conditions imposed on Ballad Health.[188] Richard Cowart, legal counsel for Ballad Health, defended the goals of the COPA and the hospital system's performance implementing the COPA in order to improve population health.[189] Scott Fowler, President and CEO of Holston Medical Group, and John Syer of Anthem raised concerns about the implementation and early performance of the COPA, 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.[190] Daniel Pohlgeers, a former member of the Tennessee COPA Local Advisory Council, described the significant public concern with the implementation of the COPA, namely the trauma center and NICU closures, as well as staffing shortages.[191] Finally, law professor Erin Fuse Brown

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[186] 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.

[187] In 2016-17, after the COPA was approved, the West Virginia legislature made significant changes to the Authority, including the elimination of the salaried board of directors (including those who approved the COPA), 50 percent reduction in funding, and significant staffing reductions (including those who evaluated the COPA). In addition, the autonomy of the Authority was eliminated, and it was placed under the direction of the West Virginia Department of Health and Human Resources. *See* West Virginia Health Care Authority, *About HCA*, https://hca.wv.gov/About/Pages/default.aspx (last accessed August 21, 2020). The Authority is responsible for the continued oversight of the Cabell COPA.

[188] FTC COPA Workshop Transcript: Session 2, *supra* note 32, Janet Kleinfelter and Joseph Hilbert remarks at 3-6.

[189] FTC COPA Workshop Transcript: Session 2, *supra* note 32, 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.

[190] Workshop Transcript: Session 2, *supra* note 32, Scott Fowler and John Syer remarks at 11-16. Scott Fowler cited "a lot of confusion in an effort to coordinate, between a business and the government, rapid changes on the ground which impact patients." *Id.* at 13 "At this point, it appears that the risks outweigh the benefits of the COPA. And we'll have to see if some of these things can be addressed." *Id.* at 14. John Syer stated that in addition to his concerns regarding contract negotiations and value-based contracting, he is concerned about outpatient services being moved back to the more expensive hospital setting. *Id.* at 16.

[191] FTC COPA Workshop Transcript: Session 2, *supra* note 32, Daniel Pohlgeers remarks at 16-17. *See also* numerous submissions to the FTC from concerned citizens,

described her work on COPAs, emphasizing that COPAs are incredibly resource-intensive – combining rate regulation with quality, access, and population health regulation. Unless new competition enters the market, she warned that states must remain vigilent and oversee COPAs in perpetuity.[192]

In summary, the COPA regimes implemented in other states illustrate the challenges with regulating a hospital monopoly in perpetuity. If Hendrick were to voluntarily terminate the COPA, HHSC were to revoke the COPA, or the Texas state legislature were to repeal or revise the Texas COPA Act, the regulatory oversight intended to mitigate the anticompetitive effects of the merger could be eliminated, allowing Hendrick to exercise unchecked market power. Recent studies and information presented at the FTC COPA Workshop suggest that COPAs can be difficult to monitor and regulate over a long period, and are not always successful in mitigating price and quality harms resulting from a loss in competition. Furthermore, when COPA oversight is removed, the risk of price and quality harms increases significantly.

X. Conclusion

Existing competition between Hendrick and Abilene Regional benefits employers and consumers in Midwest Texas 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 Hendrick a dominant share of the market, which would allow Hendrick to exercise significant market power. This would likely result in higher prices and reduced quality for healthcare services in Midwest Texas. Hendrick has not provided sufficient information regarding claimed cost savings, efficiencies, and quality improvements to allow us to fully assess these claims. 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 regulatory rate review would fully mitigate the likely price effects of this merger, and it could exacerbate reductions in the quality of care or access to care for

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https://www.regulations.gov/docketBrowser?rpp=25&so=DESC&sb=commentDueDate&po=0&dct=PS&D=FTC-2019-0016.

[192] FTC COPA Workshop Transcript: Session 2, *supra* note 32, Erin Fuse Brown remarks at 18-20. *See also* 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 Certifcate 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/.

consumers in Midwest Texas. Furthermore, Hendrick has not offered any enforceable commitments to maintain or improve quality and access.

In summary, FTC staff respectfully encourages HHSC to consider the following factors and questions when reviewing the COPA application submitted by Hendrick:

1. Will the proposed merger substantially reduce competition, allowing Hendrick to negotiate higher prices for healthcare services, and reducing its 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. Has Hendrick substantiated its 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 the proposed rate review and any other commitments effectively mitigate the competitive harms of the mergers, 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 HHSC to discipline Hendrick if it fails to meet the COPA requirements, and can a corrective action plan realistically be achieved?

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

In our assessment, the likely benefits of the COPA do not outweigh the likely disadvantages of the elimination of competition between Hendrick and Abilene Regional.

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

Please direct all questions regarding this submission to Melissa Hill, Deputy Assistant Director of the Mergers IV Division, Bureau of Competition, 202-326-2673, mchill@ftc.gov; and Stephanie A. Wilkinson, Attorney Advisor, Office of Policy Planning, 202-326-2084, swilkinson@ftc.gov.

FTC Public Comment
Attachment A

SHANNON HEALTH SYSTEM COPA APPLICATION

In this Attachment A, FTC staff presents its assessment of the COPA application submitted by Shannon Health System, Inc. ("Shannon")[193] to the Texas Health and Human Services Commission ("HHSC") pursuant to Section 314A.001 *et seq.* of the Texas Health and Safety Code. This application involves the proposed acquisition by Shannon of San Angelo Community Medical Center ("SACMC") (the "Shannon merger" or "Shannon COPA").

FTC staff performed economic analyses and a labor market analysis of the proposed Shannon merger, and we have included this information in case it is helpful to HHSC as it reviews the Shannon COPA Application. Many of the claims in the Shannon COPA Application are nearly identical to the claims in the Hendrick COPA Application. Furthermore, it appears that Shannon and SACMC offer similar facility locations and service offerings, with significant overlap in Tom Green County.[194] Accordingly, much of the information we already provided regarding the statutory factor analysis, regulatory rate review, and other potential commitments for the Hendrick COPA Application are relevant for evaluating the Shannon COPA Application.

Although our comment has focused primarily on the Hendrick COPA Application, we do not intend to diminish potential concerns about the Shannon COPA Application. Indeed, our economic analyses of the proposed Shannon merger indicate that it is likely to raise substantial concerns that HHSC may wish to consider as it evaluates the Shannon COPA.[195]

A. Diversion Ratio Analysis Confirms that Shannon and SACMC are Closest Competitors

Similar to FTC staff's analysis of the proposed Hendrick merger, FTC staff measured the degree of competition between Shannon and SACMC by performing a diversion ratio analysis, using THCIC inpatient discharge data covering the one-year period from the second quarter of 2015 through the first quarter of 2016.[196] In this matter, the analysis confirms that Shannon and SACMC are extremely close competitors in the market for inpatient services. FTC staff calculates that if Shannon were no longer an option for area residents, 58.8% of the patients who currently use Shannon would seek care at SACMC. Conversely, if SACMC were no longer an option for area residents, 70.5% of the patients who currently use SACMC would seek care at Shannon. As with the proposed Hendrick merger, these estimated diversion ratios are extremely high and indicate that Shannon and SACMC are close substitutes from the perspective of patients

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[193] Application for Certificate of Public Advantage Submitted by Shannon Health System, Inc. to Texas Health and Human Services Commission (Apr. 23, 2020) [hereinafter Shannon COPA Application].

[194] *See* Shannon COPA Application at 3-5.

[195] *See generally* Joe Hyde, *When Shannon Health Becomes San Angelo's Only Hospital*, San Angelo Live (Aug. 27, 2020), https://sanangelolive.com/news/health/2020-08-27/when-shannon-health-becomes-san-angelos-only-hospital (describing potential harms of the Shannon COPA to consumers and independent physicians).

[196] As is the case in the Hendrick COPA, the THCIC data from 2Q 2015 – 1Q 2016 are highly informative for evaluating the likely competitive effects of the proposed Shannon merger, despite not being the most recent data. The GAC hospital market in Shannon's SSA appears to have changed very little between 2015 and 2017. According to AHA data, there were no entry or exit events between 2015 and 2017.

and payers. The explanation for these high diversion ratios is the same as in the Hendrick COPA. Shannon and SACMC serve patients from a similar geographic area with similar health conditions, and there are very few nearby third-party hospitals. These diversion ratios strongly indicate that a merger between Shannon and SACMC would substantially lessen competition and lead to significant price increases, as well as reduced incentives to maintain or improve quality.

B. High Market Shares and Concentration Levels in the Shannon Service Areas Confirm that the Shannon COPA Is Likely to Result in Significant Disadvantages

Like the Hendrick COPA Application, the Shannon COPA Application does not define a relevant antitrust market for the proposed merger. However, Shannon does propose a Primary Service Area ("PSA") and Secondary Service Area ("SSA") as potentially relevant geographic service areas.[197] Similar to our approach in analyzing the proposed Hendrick merger, FTC staff calculated shares and concentration in the Shannon SSA to evaluate the likely competitive effects of the proposed Shannon merger. As is the case with the Hendrick COPA, we do not believe the Shannon SSA necessarily constitutes a relevant geographic market for antitrust purposes. Using 2017 AHA data, FTC staff calculated shares and HHI measures based on the hospitals located within the Shannon SSA for all patients admitted to these hospitals, regardless of where these patients live.

Table A1 contains the results of our concentration analysis in the 25-county SSA proposed by Shannon. The post-merger HHI is 4,171 and the increase in HHI is 1,467. These concentration numbers approach monopoly levels and far exceed those that would create a presumption of illegality under the *Merger Guidelines* and the relevant case law.[198] The combined Shannon-SACMC hospital system would have a share of 62.3% of inpatient hospital services in the Shannon SSA. The combined share and HHI calculations also exceed the levels in past hospital mergers that courts have found to be anticompetitive and blocked.[199] Table A1 shows that no other hospital system's share would come close to that of the merged hospital entity.

FTC staff has assessed concentration using Shannon's proposed SSA to be consistent with the information submitted in the Shannon COPA Application. However, we do not believe that the Shannon SSA necessarily represents a "relevant geographic market" under the *Merger Guidelines* or antitrust case law. This area is almost certainly broader than a market properly defined for antitrust purposes, meaning the shares listed in Table A1 are conservative and likely to understate the competitive impact. But, as in the Hendrick COPA, adjusting the area in which

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[197] *See* Shannon COPA Application at 4. Shannon claims there are 17 counties its PSA: Howard, Mitchell, Sterling, Coke, Runnels, Coleman, Brown, Reagan, Irion, Tom Green, Concho, McCulloch, Crockett, Schleicher, Menard, Sutton, and Kimble. Shannon adds the following eight counties to its proposed SSA: Nolan, Mason, Mills, San Saba, Upton, Pecos, Terrell, and Val Verde. As explained in the next section, FTC staff believes the PSA and SSA proposed in the Shannon COPA Application are vastly overstated.

[198] *See supra* note 53.

[199] *See* Market Shares and HHIs in Prior Healthcare Merger Cases (Attachment B).

to assess market shares does not change the conclusion that the merger results in a high combined share.

Table A1: Shares and Concentration in Proposed Shannon SSA (25-County Area)
(Based on 2017 AHA Data, Non-Public Discharges)

Hospital	Pre-Merger Share	Post-Merger Share
Shannon	46.6%	62.3%
SACMC	15.7%	
Scenic Mountain Medical Center	10.6%	10.6%
Val Verde Regional Medical Center	9.8%	9.8%
Brownwood Regional Medical Center	8.1%	8.1%
Pecos County Memorial Hospital	2.0%	2.0%
Mitchell County Hospital	1.3%	1.3%
Iraan General Hospital	1.3%	1.3%
Rolling Plains Memorial Hospital	1.2%	1.2%
Coleman County Medical Center	1.0%	1.0%
Heart of Texas Memorial Hospital	0.9%	0.9%
Lillian M. Hudspeth Memorial Hospital	0.5%	0.5%
McCamey County Hospital District	0.3%	0.3%
Concho County Hospital	0.2%	0.2%
Rankin County Hospital District	0.1%	0.1%
Kimble Hospital	0.1%	0.1%
Schleicher County Medical Center	0.1%	0.1%
Reagan Memorial Hospital	0.1%	0.1%
Ballinger Memorial Hospital	0.0%	0.0%
North Runnels Hospital	0.0%	0.0%
HHI	**2,704**	**4,171**
	Change in HHI = 1,467	

Table A2 shows the parties' combined share in each of the 25 counties that Shannon includes in its proposed SSA. The first column shows the share of Shannon's commercial patients that come from that county, and the second column adds each share by county to show the accumulated share of Shannon's commercial patients. The second column indicates that the 25 counties in the claimed Shannon SSA account for more than 95% of Shannon's commercial patients, and the first twelve counties in the shaded portion of Table A2 account for 90% of Shannon's commercial patients. The final column shows the combined post-merger share of

Shannon and SAMC, and indicates that the combined hospital system would have a dominant share in many of these counties.

Table A2: Inpatient Shares by County in Proposed Shannon SSA (25-County Area) (Based on 2Q 2015 – 1Q 2016 THCIC Data, Commercial Discharges)

	Share of Shannon's Commercial Patients		Combined Share of Shannon and SACMC
County	Share By County	Cumulative Share	
Tom Green	70.2%	70.2%	86.6%
Runnels	3.4%	73.6%	61.1%
McCulloch	3.2%	76.9%	46.2%
Crockett	2.6%	79.5%	86.0%
Sutton	2.1%	81.6%	77.4%
Coke	1.9%	83.5%	87.6%
Reagan	1.7%	85.2%	78.6%
Schleicher	1.3%	86.5%	88.9%
Sterling	1.1 %	87.6%	77.1%
Concho	1.0%	88.7%	82.1%
Irion	1.0%	89.5%	85.3%
Coleman	0.8%	90.3%	9.4%
Howard	0.8%	91.0%	3.2%
Brown	0.8%	91.7%	4.6%
Nolan	0.7%	92.4%	4.7%
Pecos	0.7%	93.1%	4.4%
Menard	0.6%	93.6%	51.1%
Mitchell	0.5%	91.4%	6.4%
Val Verde	0.5%	94.5%	1.1%
Upton	0.4%	94.8%	13.6%
Kimble	0.4%	95.0%	6.7%
Mason	0.2%	95.2%	6.5%
San Saba	0.2%	95.4%	2.3%
Terrell	0.1%	95.5%	6.3%
Mills	0.0%	95.5%	0.0%

C. Descriptive Analysis of Geographic and Service Overlaps Confirms that Shannon and SACMC are Closest Competitors and Face Little Competition from Other Hospitals

In addition to the diversion ratio and concentration analyses, FTC performed a descriptive analysis of the inpatient discharge data from THCIC covering the one-year period from the second quarter of 2015 through the first quarter of 2016. To evaluate the geographic overlap of Shannon and SACMC, FTC staff analyzed which hospitals were chosen by the patients who reside in the PSA and SSA of Shannon. In contrast to the Merger Guidelines concentration analysis in the previous section, this analysis considers the hospital choices of all commercial patients who reside in the PSA or SSA of Hendrick, irrespective of which hospital in the state of Texas treats the patient. As with the diversion ratio analysis, all hospitals in the state of Texas are included in the PSA and SSA patient choice analyses.

One concern with the service area patient choice analyses of the proposed Shannon merger is that the PSA and SSA proposed by Shannon appear to be vastly overstated. As noted above, Shannon claims that its PSA consists of 17 counties and its SSA consists of 25 counties. However, as shown in Table A2, FTC staff's analysis of the THCIC data shows that just three counties account for 75% of Shannon's patients; Tom Green, McCulloch, and Runnels. Therefore, the appropriate definition of Shannon's PSA should include just these three counties. Similarly, the THCIC data shows that just twelve counties account for 90% of Shannon's patients: Tom Green, McCulloch, Runnels, Crockett, Sutton, Coke, Reagan, Schleicher, Sterling, Concho, Irion, and Coleman. Therefore, the appropriate definition of Shannon's PSA should include just these twelve counties.[200] Accordingly, FTC staff has calculated service area patient choice statistics using these revised PSA and SSA definitions.

Table A3 contains information regarding hospital choices of patients residing within the Shannon PSA, and shows that Shannon and SACMC combined provided services to 81.8% of the commercial patients residing in this area. Similar analysis for patients residing in the Shannon SSA indicates that, even in this much broader area, Shannon and SACMC combined provided services to 62.8% of the commercial patients residing in this area. Even more so than in the proposed Hendrick merger, the Shannon PSA and SSA patient choice statistics approach monopoly levels and indicate that Shannon and SACMC combined would face little competition. These descriptive analyses are consistent with the diversion ratio analysis, which indicates that Shannon and SACMC are each other's closest comeptitiors for inpatient services.

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[200] FTC staff have analyzed the appropriate PSA and SSA of Shannon using: (i) commercial patients only; and (ii) all patients. In each case, the same counties comprise the appropriate PSA and SSA of Shannon.

Table A3: Hospital Choices of Patients Residing in Revised Shannon PSA (3-County Area) (Based on 2Q 2015 – 1Q 2016 THCIC Data, Commercial Discharges)

Hospital	Share
Shannon	52.6%
SACMC	29.2%
UT MD Anderson Cancer Center	1.0%
Abilene Regional	1.0%
All Other Texas Hospitals (less than 1% share each)	15.5%

Despite the fact that the PSA and SSA proposed in the Shannon COPA Application appear to be overstated, the combined share of Shannon and SACMC in the PSA and SSA proposed by Shannon still raise significant concern. In the 17-county PSA proposed by Shannon, Shannon has a 32.4% share of commercial patients and SAMC has a 19.1% share, giving the parties a combined share of 51.5%. In the 25-county SSA proposed by Shannon, Shannon has a 23.3% share of commercial patients and SAMC has a 13.7% share, giving the parties a combined share of 37.0%. No other hospital has a share that exceeds 11% in either the 17- or 25-county area. These results show that combined Shannon and SACMC would be a dominant provider in the PSA and SSA, even using Shannon's overstated service area definitions.

Similar to FTC staff's analysis of the Hendrick COPA, FTC staff also analyzed the overlap between Shannon and SACMC in the health conditions of the patients they treat. Using the THCIC data from the second quarter of 2015 through the first quarter of 2016, FTC staff defined the set of DRG codes that are common to both hospitals. Any DRG code that appears in the data for both hospitals for at least three inpatient events is included in the overlap set, which consists of 191 unique DRG codes. The overlap set accounts for 74.3% of all patients treated at Shannon and 92.0% of all patients treated at SACMC. This result shows that, in addition to the extensive geographic overlap between Shannon and SACMC as shown in the PSA and SSA analyses, Shannon and SACMC also overlap extensively in the health conditions of the patients they treat.

D. Shannon Merger Would Likely Depress Wage Growth for Registered Nurses

FTC staff also analyzed the likely competitive effects of the proposed Shannon merger in the labor market for registered nurses. FTC staff defined a potentially relevant geographic market for calculating labor concentration as the commuting zone for nursing labor, as developed by the U.S. Department of Agriculture. For the proposed Shannon merger, this commuting zone consists of the following six counties: Coke, Concho, Irion, Runnels, Sterling, and Tom Green. Shannon and SACMC are both located in this commuting zone. FTC staff applied 2017 AHA data to calculate market shares of registered nurses among all general acute care hospitals in this commuting zone. FTC staff used these market shares to calculate pre- and post-merger HHIs for the proposed Shannon merger.

FTC staff found that the labor market for registered nurses is highly concentrated before the proposed merger, and that the merger would increase concentration to an extraordinarily high level. Table A4 shows that Shannon and SACMC have an extraordinarily high combined share in the commuting zone of 96.2%. The post-merger HHI is 9,260 and the increase in HHI is 4,470. The post-merger HHIs and changes in HHIs create a strong inference that the proposed Shannon merger would cause harm to registered nurses. For context, these increases in HHI are well above the 75th percentile among hospital mergers included in the Prager and Schmitt study, which found that hospital mergers in the top quartile of increases in HHI resulted in an economically significant lower growth in wages for nurses. The 75th percentile of the increase in HHI calculated by Prager and Schmitt is 1,115. The increase in HHI in the proposed Shannon merger is 4,470, which is far greater than 1,115. This indicates that the reduction in competition caused by the proposed Shannon merger in the labor market for registered nurses is likely to be extraordinarily high.

Table A4: Registered Nurse Shares in Shannon Commuting Zone (Based on 2017 AHA Data)

Hospital	Pre-Merger Share	Post-Merger Share
Shannon	57.0%	96.2%
SACMC	39.2%	
North Runnels Hospital	1.5%	1.5%
Ballinger Memorial Hospital	1.1%	1.1%
Concho County Hospital	1.1%	1.1%
HHI	**4,789**	**9,260**
	Change in HHI = 4,470	

FTC Public Comment
Attachment B

Table B1: Market Shares and HHIs in Prior Healthcare Merger Cases[201]

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
Hendrick/Abilene/Brownwood (Inpatient Services)	**85.1%**	**3,391**	**7,266**	**TBD**
Shannon/SACMC (Inpatient Services)	**62.3%**	**1,467**	**4,171**	**TBD**

[201] 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).