

**UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION**

COMMISSIONERS: **Joseph J. Simons, Chairman**
 Noah Joshua Phillips
 Rohit Chopra
 Rebecca Kelly Slaughter
 Christine S. Wilson

In the Matter of

**Thomas Jefferson University,
a corporation,**

and

**Albert Einstein Healthcare Network,
a corporation.**

Docket No. 9392

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act (“FTC Act”), and by the virtue of the authority vested in it by the FTC Act, the Federal Trade Commission (“Commission”), having reason to believe that Respondents Thomas Jefferson University (“Jefferson”) and Albert Einstein Healthcare Network (“Einstein”) have executed a system integration agreement in violation of Section 5 of the FTC Act, 15 U.S.C. § 45, which if consummated would violate Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18, and Section 5 of the FTC Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint pursuant to Section 5(b) of the FTC Act, 15 U.S.C. § 45(b), and Section 11(b) of the Clayton Act, 15 U.S.C. § 21(b), stating its charges as follows:

I.

NATURE OF THE CASE

1. Jefferson and Einstein are two of the leading providers of inpatient general acute care (“GAC”) hospital services and inpatient acute rehabilitation services in Philadelphia and Montgomery counties. Jefferson and Einstein entered a System Integration Agreement dated September 14, 2018 (“Integration Agreement”), whereby Jefferson will become the sole member of Einstein and the ultimate parent entity of Einstein (the “Transaction”). The proposed Transaction would combine the Jefferson and Einstein systems to create the largest hospital system in Philadelphia County and by far the largest hospital system in Montgomery County and in the greater Philadelphia region.

2. Einstein and Jefferson hospitals offer a broad range of medical and surgical diagnostic and treatment services that require an overnight hospital stay. Today, Respondents compete to sell these inpatient GAC hospital services to commercial insurers and to provide inpatient GAC hospital services to those insurers' members.

3. Einstein operates GAC hospitals that compete directly and significantly with Jefferson's GAC hospitals. Located in North Philadelphia, Einstein's flagship hospital, Einstein Medical Center Philadelphia ("EMCP"), significantly competes with Jefferson's Abington Hospital ("Abington"), located in eastern Montgomery County, and Jefferson Frankford Hospital, located in northeast Philadelphia. Einstein Medical Center Elkins Park ("EMCEP"), a GAC hospital inside a larger inpatient rehabilitation facility in eastern Montgomery County, likewise significantly competes with Jefferson's Abington Hospital and Jefferson Frankford Hospital. In Montgomery County, Einstein Medical Center Montgomery ("EMCM") significantly competes with both Jefferson's Abington Hospital and Jefferson's Abington-Lansdale Hospital ("Lansdale"). The relevant geographic markets to assess the competitive impact of the Transaction include GAC hospitals in the area around EMCP in North Philadelphia (the "Northern Philadelphia Area") and GAC hospitals in the area around EMCM in Montgomery County (the "Montgomery Area").

4. Jefferson and Einstein are close competitors for inpatient GAC hospital services. Einstein's internal documents identify Jefferson as the "market leader" for inpatient GAC hospital services in the greater Philadelphia region. Jefferson is "1st in the [Einstein] service area and ahead of [Einstein]." In negotiations with a commercial insurer, Einstein identified Jefferson's Abington and Lansdale GAC hospitals as "primary competitors for higher acuity/cost inpatient services." Likewise, Jefferson recognizes that Einstein "competes closely" with Jefferson and that Jefferson's GAC hospitals are "Einstein's major competitors in the Einstein [primary service area]."

5. Post-Transaction, Respondents would control at least 60% of the inpatient GAC hospital services market, as measured by commercially insured patient admissions in the Northern Philadelphia Area, with only one other hospital system providing inpatient GAC hospital services with any meaningful presence. Post-Transaction, Respondents also would become the market leader in the Montgomery Area, controlling at least 45% of the inpatient GAC hospital services market, as measured by commercially insured patient admissions, in the Montgomery Area.

6. Under the 2010 U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines ("Merger Guidelines"), a post-acquisition market concentration level above 2,500 points, as measured by the Herfindahl-Hirschman Index ("HHI"), and an increase in market concentration of more than 200 points renders an acquisition presumptively unlawful. Based on commercially insured patient admissions, the Transaction would significantly increase concentration in already highly concentrated markets for inpatient GAC hospital services, well beyond the thresholds set forth in the Merger Guidelines. Thus, under the Merger Guidelines, the Transaction is presumptively unlawful in the inpatient GAC hospital services product market in both the Northern Philadelphia Area and the Montgomery Area.

7. In addition to providing inpatient GAC hospital services, Respondents also operate nationally renowned inpatient rehabilitation facilities (“IRFs”) that compete against each other today. Einstein operates several IRFs under the name MossRehab (“Moss”) throughout the greater Philadelphia region, and Jefferson operates Magee Rehabilitation Hospital (“Magee”) in the Center City neighborhood of Philadelphia and two other IRFs in the greater Philadelphia region.

8. Einstein and Jefferson IRFs provide advanced post-acute rehabilitation care for patients treated at GAC hospitals for conditions such as stroke, traumatic brain injury, or spinal cord injury. IRFs provide such inpatient acute rehabilitation services to only those patients who can withstand and benefit from them. The relevant geographic market in which to analyze the effects of the Transaction for inpatient acute rehabilitation services is the area around Einstein’s Moss at Elkins Park (the “Philadelphia Area”). Together, Respondents operate six of the eight IRFs in the Philadelphia Area.

9. Both Einstein and Jefferson compete vigorously for rehabilitation patients. Magee “compete[s] head to head with [Moss] for everything.” Magee identifies Moss IRFs as its “Primary Competitor(s)” for post-acute “Services” and “Reputation/brand.” And from Einstein’s perspective, “Magee is a threat.”

10. The Transaction will substantially lessen competition in the market for inpatient acute rehabilitation services in the Philadelphia Area. Respondents are the largest providers of inpatient acute rehabilitation services in the Philadelphia Area. Post-Transaction, Respondents would control at least 70% of the inpatient acute rehabilitation services market by commercially insured patient admissions in the Philadelphia Area, with only one other IRF providing inpatient acute rehabilitation services with any meaningful presence.

11. In the Philadelphia Area, the Transaction would significantly increase market concentration in an already highly concentrated market for inpatient acute rehabilitation services such that the Transaction is presumptively unlawful under the Merger Guidelines.

12. Today, Jefferson and Einstein compete for inclusion in commercial insurers’ hospital networks. A commercial insurer would find it difficult to market a health plan to employers and their employees living or working in the Northern Philadelphia Area or the Montgomery Area that excluded all of the GAC hospitals owned by Einstein and Jefferson. Likewise, a commercial insurer would find it difficult to market a health plan to employers and their employees living or working in the Philadelphia Area that excluded all of the IRFs owned by Respondents.

13. Hence, by eliminating competition between Respondents, the Transaction is likely to increase Respondents’ bargaining leverage with commercial insurers and enhance Respondents’ ability to negotiate more favorable reimbursement terms, including reimbursement rates (i.e., prices). Faced with higher reimbursement rates and other less favorable terms, commercial insurers will have to pass on at least some of those higher healthcare costs to employers and their employees in the form of increased premiums, co-pays, deductibles, and other out-of-pocket expenses. “Self-insured” employers that pay the cost of their employees’

healthcare claims directly will bear the full and immediate burden of higher reimbursement rates and other less favorable terms.

14. Jefferson and Einstein have a history of upgrading medical facilities, improving patient access, and offering more competitive reimbursement rates and terms to commercial insurers because of competition from each other that will be lost if the Transaction goes forward.

15. The Transaction will substantially lessen competition and cause significant harm to consumers. If Respondents consummate the Transaction, healthcare costs will rise, and the incentive for Respondents to increase service offerings and improve the quality of healthcare will diminish.

16. Entry or expansion by other GAC hospitals or IRFs will not be likely, timely, or sufficient to offset the adverse competitive effects that likely will result from the Transaction. Potential entrants would need to devote significant time and resources to conduct studies, develop plans, acquire land or repurpose a facility, and construct and open a competitive GAC hospital or IRF. Respondents' reputations, size, and the breadth and depth of the inpatient GAC hospital services and inpatient acute rehabilitation services they provide make it unlikely that there will be entry on a sufficient scale to counteract or constrain post-Transaction price increases.

17. Respondents have not substantiated any verifiable, merger-specific efficiencies. Even if Respondents could identify some cognizable efficiencies resulting from the Transaction, any savings likely to be passed on to patients are far outweighed by the Transaction's potential harm and thus would not be sufficient to justify the Transaction.

II.

JURISDICTION

18. Respondents, and each of their relevant operating entities and subsidiaries are, and at all relevant times have been, engaged in commerce or in activities affecting "commerce" as defined in Section 4 of the FTC Act, 15 U.S.C. § 44, and Section 1 of the Clayton Act, 15 U.S.C. § 12.

19. The Transaction constitutes an acquisition subject to Section 7 of the Clayton Act, 15 U.S.C. § 18.

III.

BACKGROUND

A.

Respondents

20. Respondent Jefferson, a Pennsylvania not-for-profit corporation, operates an academic health system headquartered in Philadelphia that is the largest health system by hospital beds in the greater Philadelphia region. It is also the second-largest employer in Philadelphia, employing over 30,000 people, including approximately 6,100 physicians and practitioners and 7,400 nurses. For fiscal year 2019, Jefferson generated \$5.2 billion in revenues.

21. Jefferson operates 11 GAC hospitals in Pennsylvania and New Jersey and three IRFs in Pennsylvania. Across all of its inpatient facilities, Jefferson discharges approximately 130,000 inpatients a year. Jefferson also operates over 50 outpatient and urgent care locations in Pennsylvania and New Jersey.

22. Jefferson operates four GAC hospitals in the City of Philadelphia—Thomas Jefferson University Hospital (“TJUH”), Methodist Hospital, Jefferson Frankford Hospital (f/k/a Aria Frankford Hospital), and Jefferson Torresdale Hospital (f/k/a Aria Torresdale Hospital)—and two GAC hospitals in Montgomery County—Abington and Lansdale (together, f/k/a Abington Health).

23. Jefferson has acquired a number of hospital systems and IRFs in recent years. Since 2015, Jefferson has merged with Abington Health, Aria Health System, Kennedy Health, and Magee. By virtue of its merger with Aria Health System, Jefferson also has a partial ownership stake in Health Partners Plans, a not-for-profit health maintenance organization that offers managed government insurance, including Medicaid and Medicare plans, to members in Southeastern Pennsylvania. In December 2019, Jefferson signed definitive agreements to acquire Temple University’s Fox Chase Cancer Center, Temple’s Bone Marrow Transplant program, and Temple’s partial ownership interest in Health Partners Plans. Jefferson operates 12 colleges, schools, and institutes, including Sidney Kimmel Medical College, the fifth-largest medical school in the country.

24. After merging with Abington Health in 2015, Jefferson now owns and operates two hospitals in Montgomery County. Abington is a 665-bed regional referral center and teaching hospital located in Abington Township in eastern Montgomery County, near the border with Philadelphia County.¹ Lansdale is a 140-bed hospital in Lansdale, which is located in the northern part of central Montgomery County. Subsequent to its merger with Aria Health System in 2016, Jefferson gained control over three additional hospitals in the greater Philadelphia region, including Jefferson Frankford, a 115-bed hospital in northeast Philadelphia.

¹ This includes 23 hospital beds for inpatient acute rehabilitation services, as discussed *supra*.

25. Jefferson merged with Magee in 2018. Magee is located in the City of Philadelphia and is currently undergoing a renovation that will bring its hospital beds down from 96 to 82. Jefferson also operates two IRF units within larger GAC hospitals—one at TJUH named the Jefferson Acute Rehabilitation Unit and one at Abington named the Abington Acute Rehabilitation Unit. Both have 23 beds.

26. Respondent Einstein, a Pennsylvania not-for-profit corporation, operates an academic health system headquartered in North Philadelphia. Einstein operates three GAC hospitals—one in Philadelphia and two in Montgomery County—and five IRFs. Einstein also operates 15 outpatient centers. Einstein discharges over 30,000 inpatients a year and employs over 8,800 people, including over 500 physicians. Like Jefferson, Einstein has a partial ownership stake in Health Partners Plans. For fiscal year 2019, Einstein generated \$1.2 billion in revenues.

27. Einstein provides inpatient GAC hospital services at two main locations. EMCP, Einstein's largest GAC hospital with 485 licensed acute care beds, is located in North Philadelphia. EMCP is a tertiary care teaching hospital and a Level 1 Trauma Center. EMCP is the largest independent academic medical center in the greater Philadelphia region and trains more than 400 residents and fellows each year in graduate medical education programs. Einstein's second GAC hospital is EMCM, a 191-bed hospital in East Norriton in central Montgomery County. Einstein also owns and operates EMCEP, a 67-bed GAC hospital in eastern Montgomery County that is located inside the larger Moss at Elkins Park IRF.

28. Einstein's Moss provides inpatient acute rehabilitation services at five IRFs in the greater Philadelphia region. Moss at Elkins Park is a freestanding IRF with 130 licensed beds. Moss also owns and operates an IRF unit at EMCP with 19 beds. Moss currently operates three 12-bed IRF units at non-Einstein hospitals. Two are at Jefferson hospitals—Jefferson Frankford Hospital and Jefferson Bucks Hospital—and one is at Doylestown Hospital.

B.

The Transaction

29. After several years of discussions between Jefferson and Einstein, Respondents entered into the Integration Agreement on September 14, 2018, whereby Jefferson would become the sole member and ultimate parent entity of Einstein. The Respondents value the Transaction at \$599 million. The combined entity would operate 14 GAC hospitals, including 11 in Pennsylvania, and eight IRFs in Pennsylvania. The Transaction would make Jefferson—already the largest health system by hospital beds in the greater Philadelphia region—even larger, with over 1,000 more hospital beds than the next largest health system in the greater Philadelphia region.

IV.

THE RELEVANT SERVICE MARKETS

30. The Transaction threatens substantial harm to competition in two service markets: (i) inpatient GAC hospital services sold and provided to commercial insurers and their insured members; and (ii) inpatient acute rehabilitation services at IRFs sold and provided to commercial insurers and their insured members. For each service market, a hypothetical monopolist could profitably impose a small but significant and non-transitory increase in price (“SSNIP”). Because commercial insurers would accept a SSNIP rather than market a network that omitted inpatient GAC hospital services, and would accept a SSNIP rather than market a network that omitted inpatient acute rehabilitation services at IRFs, each of these service markets constitutes a relevant market for analyzing the Transaction.

A.

Inpatient GAC Hospital Services

31. Inpatient GAC hospital services sold and provided to commercial insurers and their insured members is a relevant service market for assessing the Transaction’s effects on competition. This service market encompasses a broad cluster of medical and surgical diagnostic and treatment services offered by both Einstein and Jefferson that require an overnight hospital stay. Inpatient GAC hospital services include, but are not limited to, many emergency services, internal medicine services, and surgical procedures offered by both Respondents under similar competitive conditions.

32. Although the Transaction’s likely effect on competition could be analyzed separately for each individual inpatient service, it is appropriate to evaluate the Transaction’s likely effects across this cluster of inpatient GAC hospital services because these services are offered to patients in the Northern Philadelphia Area and the Montgomery Area under similar competitive conditions. Thus, grouping the hundreds of individual inpatient GAC hospital services into a cluster for analytical convenience enables the efficient evaluation of competitive effects with no loss of analytic power.

33. Outpatient services are not included in the inpatient GAC hospital services market because commercial insurers and patients cannot substitute outpatient services in response to a price increase for inpatient GAC hospital services. Additionally, outpatient services are offered by a different set of competitors under different competitive conditions than inpatient GAC hospital services.

34. Finally, the inpatient GAC hospital services market does not include services related to psychiatric care, substance abuse, and rehabilitation services. These services also are offered by a different set of competitors under different competitive conditions than, and are not substitutes for, inpatient GAC hospital services.

B.

Inpatient Acute Rehabilitation Services

35. Inpatient acute rehabilitation services at IRFs sold and provided to commercial insurers and their insured members also is a relevant service market for assessing the Transaction's effects on competition. This service market encompasses a cluster of acute rehabilitation services provided under similar competitive conditions to patients that require an overnight stay and were previously treated at a GAC hospital (i.e., post-acute patients). Inpatient acute rehabilitation services include, at a minimum, intensive multi-disciplinary rehabilitation therapies at least three hours a day for five days per week, three face-to-face visits with a physician per week, and 24-hour nursing care, *inter alia*.

36. Although the Transaction's likely effect on competition could be analyzed separately for each inpatient acute rehabilitation service, it is appropriate to evaluate the Transaction's likely effects across this cluster of inpatient acute rehabilitation services because these services are offered to patients in the Philadelphia Area under similar competitive conditions.

37. IRFs, which operate under a hospital license, provide inpatient acute rehabilitation services. IRFs can exist either as units housed in larger hospitals providing inpatient GAC hospital services ("IRF units") or as standalone hospitals ("freestanding IRFs"). Freestanding IRFs may house departments providing other services as well. For instance, a freestanding IRF like Moss at Elkins Park can have a department—in this case, EMCEP—that offers inpatient GAC hospital services. To obtain certification for reimbursement as an IRF by the Centers for Medicare and Medicaid Services, 60% of all patient discharges (Medicare or other) must have as a primary diagnosis or comorbidity one of 13 specified conditions that typically require inpatient acute rehabilitation services.

38. Other post-acute care services like subacute rehabilitation services provided at skilled nursing facilities are not included in the market for inpatient acute rehabilitation services because commercial insurers and patients cannot substitute these services for inpatient acute rehabilitation services. Subacute rehabilitation services are offered by a different set of competitors under different competitive conditions than inpatient acute rehabilitation services. In fact, subacute rehabilitation services are often complementary to inpatient acute rehabilitation services.

V.

THE RELEVANT GEOGRAPHIC MARKETS

39. The relevant geographic markets in which to analyze the effects of the Transaction for inpatient GAC hospital services are the Northern Philadelphia Area and the Montgomery Area. For inpatient acute rehabilitation services, the relevant geographic market is the Philadelphia Area.

40. As with determining the appropriate service markets to analyze the Transaction, the appropriate geographic markets in which to analyze the Transaction are the areas where a hypothetical monopolist of the hospitals located in these areas could profitably impose a SSNIP on the relevant services. Because commercial insurers would accept a SSNIP rather than market insurance plans that exclude all hospitals providing inpatient GAC hospital services in the Northern Philadelphia Area, all hospitals providing inpatient GAC hospital services in the Montgomery Area, or all IRFs providing inpatient acute rehabilitation services in the Philadelphia Area, these are relevant geographic markets in which to analyze the Transaction.

A.

Inpatient GAC Hospital Services Geographic Markets

41. The Northern Philadelphia Area is approximately the area that includes the following GAC hospitals in Philadelphia—EMCP, Jefferson Frankford Hospital, Temple University Hospital, Temple’s Jeanes Hospital, Prime Healthcare’s Roxborough Memorial Hospital, and Tower Health’s Chestnut Hill Hospital—and in eastern Montgomery County—EMCEP (housed inside Moss at Elkins Park) and Jefferson’s Abington. The Northern Philadelphia Area also includes the following specialty hospitals in Philadelphia that provide select inpatient GAC hospital services—St. Christopher’s Hospital for Children, Temple’s Fox Chase Cancer Center, and Cancer Treatment Centers of America’s Philadelphia Comprehensive Care and Research Center. The Northern Philadelphia Area is the main area of competition between Einstein’s EMCP and EMCEP and the Jefferson hospitals with which they most directly compete—Abington and Jefferson Frankford.

42. The Montgomery Area is approximately the area that includes the following GAC hospitals in Montgomery County—EMCM, Jefferson’s Abington, Jefferson’s Lansdale, Main Line Health’s Bryn Mawr Hospital, and Prime Healthcare’s Suburban Community Hospital—and just outside Montgomery County—Main Line Health’s Paoli Hospital, Tower Health’s Chestnut Hill Hospital, Tower Health’s Phoenixville Hospital, and Prime Healthcare’s Roxborough Memorial Hospital. The Montgomery Area also includes a hospital in Montgomery County that provides specialty surgical services—Physicians Care Surgical Hospital. The Montgomery Area is the main area of competition between Einstein’s EMCM and the two Jefferson hospitals with which EMCM most directly competes—Abington and Lansdale. A hospital can be in more than one relevant geographic market if it competes, as Abington does, in more than one geographic area within which a hypothetical monopolist could profitably impose a SSNIP.

43. Patients who receive inpatient GAC hospital services in the Northern Philadelphia Area strongly prefer to obtain inpatient GAC hospital services close to where they live. It would be very difficult for a commercial insurer to market successfully a health plan provider network that excluded all hospitals located within the Northern Philadelphia Area. Hence, because a significant number of patients within this geographic market would not view hospitals outside of the market as practical alternatives, a hypothetical monopolist of all of the GAC hospitals within the Northern Philadelphia Area could profitably impose a SSNIP.

44. Likewise, patients who receive inpatient GAC hospital services in the Montgomery Area strongly prefer to obtain inpatient GAC hospital services close to where they live. It would be very difficult for a commercial insurer to market successfully a health plan provider network that excluded all hospitals located within the Montgomery Area. Hence, because a significant number of patients within this geographic market would not view hospitals outside of the market as practical alternatives, a hypothetical monopolist of all of the GAC hospitals within the Montgomery Area could profitably impose a SSNIP.

B.

Inpatient Acute Rehabilitation Services Geographic Market

45. The Philadelphia Area is approximately the area that includes the following IRFs in Philadelphia—Einstein’s Moss at EMCP, Einstein’s Moss at Jefferson Frankford Hospital, Jefferson’s Magee, Jefferson Acute Rehabilitation Unit at TJUH, the Penn Institute for Rehabilitation Medicine, and Trinity Health’s Nazareth Hospital Acute Rehabilitation Unit—and in eastern Montgomery County—Einstein’s Moss at Elkins Park and Jefferson’s Abington Acute Rehabilitation Unit. The Philadelphia Area is the main area of competition between Einstein’s Moss at Elkins Park, Moss at EMCP, and Moss at Frankford Hospital, and Jefferson’s Magee, Jefferson Acute Rehabilitation Unit at TJUH, and Abington Acute Rehabilitation Unit.

46. As with inpatient GAC hospital services, patients who receive inpatient acute rehabilitation services in the Philadelphia Area strongly prefer to obtain these services close to where they live. It would be very difficult for a commercial insurer to market successfully a health plan provider network that excluded all IRFs located within the Philadelphia Area. Hence, because a significant number of patients within the Philadelphia Area would not view IRFs outside of the area as practical alternatives, a hypothetical monopolist of all of the IRFs within the Philadelphia Area could profitably impose a SSNIP.

VI.

MARKET STRUCTURE AND THE TRANSACTION’S PRESUMPTIVE ILLEGALITY

47. Jefferson and Einstein are two of the largest providers, by commercially insured patient admissions, of inpatient GAC hospital services in the Northern Philadelphia Area and the Montgomery Area. Likewise, Jefferson and Einstein are the two largest providers, by commercially insured patient admissions, of inpatient acute rehabilitation services in the Philadelphia Area. The Transaction will significantly increase concentration in already highly concentrated markets for inpatient GAC hospital services and inpatient acute rehabilitation services in the relevant geographies. These levels of concentration render the Transaction presumptively unlawful under the Merger Guidelines.

48. Under the Merger Guidelines, a merger or acquisition is presumed likely to create or enhance market power—and is presumptively unlawful—when it increases the HHI by more than 200 points and results in a post-acquisition HHI above 2,500 points. Here, in each of the three relevant markets, the Transaction exceeds this concentration threshold.

49. Based on commercial inpatient GAC admissions of patients seeking care in the Northern Philadelphia Area, Respondents would control at least 60% of this market post-Transaction. The Transaction would increase the HHI by at least 1,200 points in the Northern Philadelphia Area, resulting in a post-Transaction HHI of at least 4,500, exceeding the threshold over which the Transaction is presumed likely to create or enhance market power—and is presumptively unlawful.

50. Based on commercial inpatient GAC admissions of patients seeking care in the Montgomery Area, Respondents would control at least 45% of this market post-Transaction. The Transaction would increase the HHI in the Montgomery Area by at least 700 points, resulting in a post-Transaction HHI of at least 3,500. These concentration measures make the Transaction presumptively unlawful.

51. Post-Transaction, Respondents also would control at least 70% of the market for inpatient acute rehabilitation services in the Philadelphia Area. The Transaction would increase the HHI in the Philadelphia Area by at least 2,500 points, resulting in a post-Transaction HHI of at least 5,900. These market concentration measures make the Transaction presumptively unlawful.

VII.

ANTICOMPETITIVE EFFECTS

A.

Competition Between Hospitals Benefits Consumers

52. Competition between hospitals (including IRFs) occurs in two distinct but related stages. First, hospitals compete for inclusion in commercial insurers' health plan provider networks. Second, in-network hospitals compete to attract patients, including commercial insurers' health plan members.

53. In the first stage of hospital competition, hospitals compete to be included in commercial insurers' health plan provider networks. To become an in-network provider, a hospital negotiates with a commercial insurer and, if mutually agreeable terms can be reached, enters into a contract. The financial terms under which a hospital is reimbursed for services rendered to a health plan's members are a central component of those negotiations, regardless of whether reimbursements are based on fee-for-service contracts, risk-based contracts, or other types of contracts.

54. In-network status benefits a hospital by giving it preferential access to the health plan's members. Health plan members typically pay far less to access in-network hospitals than those that are out-of-network. All else being equal, an in-network hospital will attract more patients from a particular health plan than an out-of-network one. This dynamic motivates hospitals to offer lower rates and other more favorable terms to commercial insurers to win inclusion in their networks.

55. From the insurers' perspective, having hospitals in-network is beneficial because it enables the insurer to create a health plan provider network in a particular geographic area that is attractive to current and prospective members, typically local employers and their employees.

56. A critical determinant of the relative bargaining positions of a hospital and a commercial insurer during contract negotiations is whether other, nearby comparable hospitals are available to the commercial insurer and its health plan members as alternatives in the event of a negotiating impasse. Alternative hospitals limit a hospital's bargaining leverage and constrain its ability to obtain more favorable reimbursement terms from commercial insurers. The more attractive alternative hospitals are to a commercial insurer's health plan members in a local area, the greater the constraint on a hospital's bargaining leverage. Where there are fewer meaningful alternatives, a hospital will have greater bargaining leverage to demand and obtain higher reimbursement rates and other more favorable reimbursement terms.

57. A merger between hospitals that are close substitutes in the eyes of commercial insurers and their health plan members tends to increase the merged entity's bargaining leverage. Such mergers lead to higher reimbursement rates by eliminating an available alternative for commercial insurers. This increase in leverage is greater when the merging hospitals are closer substitutes for (and competitors to) each other. This is true even where other factors, such as an insurer's leverage, may impact the pre-merger bargaining dynamic. Preexisting leverage for the insurer does not eliminate the concern about an increase in the post-merger bargaining leverage of the merged entity.

58. Changes in the reimbursement terms negotiated between a hospital and a commercial insurer, including increases in reimbursement rates, significantly impact the commercial insurer's health plan members. "Self-insured" employers rely on a commercial insurer for access to its health plan provider network and negotiated rates, but these employers pay the cost of their employees' healthcare claims directly and bear the full and immediate burden of any rate increase in the healthcare services used by their employees. Employees may bear some portion of the increased cost through increased premiums, co-pays, and deductibles. "Fully-insured" employers pay premiums to commercial insurers—and employees pay premiums, co-pays, and deductibles—in exchange for the commercial insurer assuming financial responsibility for paying hospital costs generated by the employees' use of hospital services. When hospital rates increase, commercial insurers generally pass on a significant portion of these increases to their fully insured customers in the form of higher premiums, co-pays, and deductibles.

59. In the second stage of hospital competition, hospitals compete to attract patients to their facilities. Because health plan members often face similar out-of-pocket costs for in-network hospitals, hospitals in the same network compete to attract patients on non-price features such as location, quality of care, access to services and technology, reputation, physicians and faculty members, amenities, convenience, and patient satisfaction. Hospitals compete on these non-price dimensions to attract all patients, regardless of whether they are covered by commercial insurance (including Medicare Advantage and Medicaid Managed Care), traditional Medicare and Medicaid, or are patients without commercial insurance. A merger of competing hospitals eliminates this non-price competition and reduces the merged entity's incentive to

improve and maintain service and quality. Providers also compete on price terms in this second stage of competition in circumstances when patients pay the full cost of the procedure out of pocket, regardless of whether they are commercially insured.

B.

The Transaction Would Eliminate Beneficial Head-to-Head Competition and Increase Bargaining Leverage

60. Jefferson and Einstein are close competitors for inpatient GAC hospital services. Einstein's internal documents focus on Jefferson as a "major," "primary," and "top" competitor for inpatient GAC hospital services and the "market leader" in its service area. Einstein's strategic planning team observed that "[c]ompetitors continue to pull volume from [EMCP's and EMCEP's] service area." In particular, Jefferson's Abington Health and Aria Health System experienced volume increases and held the second- and third-highest market shares in EMCP's and EMCEP's service area. Conversely, Einstein's growth at EMCM has "come at the expense of the competition," including Jefferson's Abington and Lansdale GAC hospitals. When asked what health systems Einstein aspires to compete with, Einstein's marketing team identified only one: "Jefferson Health is one of the top networks we aspire to compete with. They are better resourced and chosen over our services by potential patients." Similarly, Jefferson recognizes that Einstein is a significant competitor to Jefferson in the Northern Philadelphia and Montgomery Areas—internal Jefferson documents note that Einstein "competes closely" with Jefferson in EMCP's primary service area and that EMCM "competes with Abington Lansdale and Abington Hospital." Because Einstein and Jefferson offer close substitutes for inpatient GAC hospital services, the Transaction would eliminate significant head-to-head competition between Respondents post-merger.

61. Diversion analysis, a standard economic tool that uses data on where patients receive hospital services to determine the extent to which hospitals are substitutes, confirms that Einstein and Jefferson are close competitors for inpatient GAC hospital services. Diversion analysis shows that if Einstein hospitals were to become unavailable to patients for inpatient GAC hospital services, at least 30% of EMCP's patients, 35% of EMCEP's patients, and 17% of EMCM's patients, respectively, would seek care at a Jefferson hospital. Diversion analysis similarly shows that if Jefferson hospitals were unavailable to patients for inpatient GAC hospital services, at least 11% of Abington patients, 7% of Lansdale patients, and 7% of Jefferson Frankford patients, respectively, would seek care at an Einstein hospital. These diversion analyses lead to predictions of significant post-Transaction price increases.

62. Similarly, Jefferson and Einstein are close competitors for inpatient acute rehabilitation services. Both Moss and Magee executives testified that their IRFs "compete for the same patients." As described by a Magee marketing executive, Magee "compete[s] head to head with [Moss] for everything." In its strategic and financial plan, Magee identified Moss as its "Primary Competitor(s)" for post-acute "Services" and "Reputation/brand," citing Moss's "Rankings, marketing to consumers and physicians," as well as its "Centers of Excellence." Moss likewise views Magee as a competitive constraint. In an internal document, Einstein's Chief Marketing Officer stated succinctly, "Magee is a threat."

63. Diversion analysis indicates that if Einstein’s Moss at Elkins Park were to become unavailable to patients for inpatient acute rehabilitation services, at least 30% of Moss at Elkins Park’s patients would seek care at a Jefferson IRF. Likewise, if Jefferson’s Magee were to become unavailable to patients for inpatient acute rehabilitation services, at least 18% of Magee’s patients would seek care at an Einstein IRF. These diversion analyses also lead to predictions of significant post-Transaction price increases.

64. Offering hospital coverage in the Northern Philadelphia Area and the Montgomery Area and IRF coverage in the Philadelphia Area is important for a commercial insurer to market a health plan provider network successfully to employers with employees in these areas. Other hospitals and IRFs outside of these geographic markets are not adequate substitutes for Jefferson and Einstein. Today, Jefferson and Einstein serve as key providers of inpatient GAC hospital services and inpatient acute rehabilitation services for healthcare consumers in these areas.

65. The Transaction would increase Respondents’ bargaining leverage in contract negotiations with commercial insurers. This increase in bargaining leverage would cause the Respondents to negotiate higher reimbursement rates and more favorable reimbursement terms. Indeed, Jefferson’s strategic plan is to utilize its larger scale resulting from its recent consolidations with hospital systems and IRFs to increase its bargaining leverage and extract more favorable rates from commercial insurers. Jefferson’s CFO, noting that Jefferson has “achieved significant scale and leverage in the market,” advised Jefferson’s President and CEO, “we have significant leverage and need to use it as part of our financial improvement plan over the next few years.” In analyzing the Transaction, Jefferson’s President and CEO stated, “[w]e have to continue strategically on the path to essentiality and Einstein is the key We become the path to any new payor that wants to serve Philadelphia.”

66. The growth of “narrow network” and “tiered” health insurance products—which, in contrast to “broad networks,” include less than all of the hospitals in a geographic market—can be informative about alternative options within an insurer network. Such networks offer a tradeoff to consumers by including fewer participating hospitals (or fewer participating hospitals in a preferred benefit tier), but at often significantly discounted prices relative to other available provider networks. Hospitals are willing to accept the lower reimbursement terms required to participate in narrow and tiered networks with the expectation that they will gain increased volumes of patients and procedures. Today, commercial insurers treat Respondents as substitutes when constructing narrow network or tiered network products for patients in the Northern Philadelphia, Montgomery, and Philadelphia Areas.

67. By eliminating competition between Einstein and Jefferson, the Transaction will give Respondents leverage to negotiate more favorable terms to participate in narrow and tiered networks, including securing higher reimbursement rates.

C.

The Transaction Would Eliminate Vital Quality and Service Competition

68. Competition drives hospitals to invest in quality initiatives, new technologies, amenities, equipment, and service offerings to differentiate themselves from competitors. Jefferson and Einstein compete with one another across other various non-price dimensions. The Transaction would eliminate this competition, which has provided GAC patients in the Northern Philadelphia and Montgomery Areas, and IRF patients in the Philadelphia Area, with higher quality care and more extensive healthcare service offerings. Jefferson and Einstein closely track each other's quality and brand recognition, and Respondents have substantially invested in improving and expanding their services and facilities to compete against one another.

69. Patients benefit from this direct competition in the quality of care and services that Respondents offer them. The Transaction will dampen the merged firm's incentive to compete on quality of care and service offerings to the detriment of all patients who use these hospitals, including commercially insured, Medicare, Medicaid, and self-pay patients.

VIII.

ENTRY BARRIERS

70. Neither entry by new market participants nor expansion by current market participants would deter or counteract the Transaction's likely harm to competition for inpatient GAC hospital services in the Northern Philadelphia or Montgomery Areas, or to inpatient acute rehabilitation services in the Philadelphia Area.

71. New entry or expansion into the relevant markets would not be likely or timely enough to offset the Transaction's likely harmful competitive effects. Construction of a new hospital (including an IRF) involves high costs and significant financial risk, including the time and resources it would take to conduct studies, develop plans, acquire land or repurpose a facility, garner community support, obtain regulatory approvals, and build and open the facility. Expansion of existing hospitals and repositioning by non-hospital providers to become hospitals would encounter similar barriers, including substantial expense and time associated with planning, receiving regulatory approvals, and construction.

72. Potential entry or expansion also would be insufficient to counteract the anticompetitive effects of the Transaction. Entrants would face significant challenges in replicating the competitiveness and reputation of either Einstein or Jefferson. Both Einstein and Jefferson have established reputations for and substantial expertise in providing quality care, have multiple hospitals in the relevant markets, generate a billion dollars or more in annual revenue, provide healthcare services to tens of thousands of inpatients per year, and offer broad clusters of both inpatient GAC hospital services and inpatient acute rehabilitation services.

IX.

EFFICIENCIES

73. Respondents have not substantiated verifiable, merger-specific efficiencies that would be sufficient to rebut the strong presumption and evidence of the Transaction's likely significant anticompetitive effects in the relevant markets.

X.

VIOLATION

COUNT I – ILLEGAL AGREEMENT

74. The allegations of Paragraphs 1 through 73 above are incorporated by reference as though fully set forth herein.

75. The Integration Agreement constitutes an unfair method of competition in violation of Section 5 of the FTC Act, as amended, 15 U.S.C. § 45.

COUNT II – ILLEGAL ACQUISITION

76. The allegations of Paragraphs 1 through 73 above are incorporated by reference as though fully set forth herein.

77. The Transaction, if consummated, may substantially lessen competition in the relevant markets in violation of Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18, and is an unfair method of competition in violation of Section 5 of the FTC Act, as amended, 15 U.S.C. § 45.

NOTICE

Notice is hereby given to the Respondents that the first day of September, 2020, at 10:00 a.m., is hereby fixed as the time, and the Federal Trade Commission offices at 600 Pennsylvania Avenue, NW, Room 532, Washington, D.C. 20580, as the place, when and where an evidentiary hearing will be had before an Administrative Law Judge of the Federal Trade Commission, on the charges set forth in this complaint, at which time and place you will have the right under the Federal Trade Commission Act and the Clayton Act to appear and show cause why an order should not be entered requiring you to cease and desist from the violations of law charged in the complaint.

You are notified that the opportunity is afforded you to file with the Commission an answer to this complaint on or before the fourteenth (14th) day after service of it upon you. An answer in which the allegations of the complaint are contested shall contain a concise statement of the facts constituting each ground of defense; and specific admission, denial, or explanation of

each fact alleged in the complaint or, if you are without knowledge thereof, a statement to that effect. Allegations of the complaint not thus answered shall be deemed to have been admitted.

If you elect not to contest the allegations of fact set forth in the complaint, the answer shall consist of a statement that you admit all of the material facts to be true. Such an answer shall constitute a waiver of hearings as to the facts alleged in the complaint and, together with the complaint, will provide a record basis on which the Commission shall issue a final decision containing appropriate findings and conclusions and a final order disposing of the proceeding. In such answer, you may, however, reserve the right to submit proposed findings and conclusions under Rule 3.46 of the Commission's Rules of Practice for Adjudicative Proceedings.

Failure to file an answer within the time above provided shall be deemed to constitute a waiver of your right to appear and to contest the allegations of the complaint and shall authorize the Commission, without further notice to you, to find the facts to be as alleged in the complaint and to enter a final decision containing appropriate findings and conclusions, and a final order disposing of the proceeding.

The Administrative Law Judge shall hold a prehearing scheduling conference no later than ten (10) days after the Respondents file their answers. Unless otherwise directed by the Administrative Law Judge, the scheduling conference and further proceedings will take place at the Federal Trade Commission, 600 Pennsylvania Avenue, NW, Room 532, Washington, D.C. 20580. Rule 3.21(a) requires a meeting of the parties' counsel as early as practicable before the pre-hearing scheduling conference (but in any event no later than five (5) days after the Respondents file their answers). Rule 3.31(b) obligates counsel for each party, within five (5) days of receiving the Respondents' answers, to make certain initial disclosures without awaiting a discovery request.

NOTICE OF CONTEMPLATED RELIEF

Should the Commission conclude from the record developed in any adjudicative proceedings in this matter that the Transaction challenged in this proceeding violates Section 5 of the Federal Trade Commission Act, as amended, and/or Section 7 of the Clayton Act, as amended, the Commission may order such relief against Respondents as is supported by the record and is necessary and appropriate, including, but not limited to:

1. If the Transaction is consummated, divestiture or reconstitution of all associated and necessary assets, in a manner that restores two or more distinct and separate, viable and independent businesses in the relevant service and geographic markets, with the ability to offer such products and services as Jefferson and Einstein were offering and planning to offer prior to the Transaction.
2. A prohibition against any transaction between Jefferson and Einstein that combines their businesses in the relevant markets, except as may be approved by the Commission.

3. A requirement that, for a period of time, Jefferson and Einstein provide prior notice to the Commission of acquisitions, mergers, consolidations, or any other combinations of their businesses in the relevant markets with any other entity operating in the relevant markets.
4. A requirement to file periodic compliance reports with the Commission.
5. Any other relief appropriate to correct or remedy the anticompetitive effects of the Transaction or to restore Einstein as a viable, independent competitor in the relevant service and geographic markets.

IN WITNESS WHEREOF, the Federal Trade Commission has caused this complaint to be signed by its Secretary and its official seal to be hereto affixed, at Washington, D.C., this 27 day of February, 2020.

By the Commission, Chairman Simons recused.

April J. Tabor
Acting Secretary

SEAL: