UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Alexis J. Gilman
Bureau of Competition
Mergers IV Division
(202) 326-2579
agilman@ftc.gov

May 16, 2016

VIA E-MAIL

Cynthia H. Dellinger, Esq.
Assistant General Counsel
West Virginia Health Care Authority
100 Dee Drive
Charleston, WV 25311
cdellinger@hcawv.org

Douglas L. Davis, Esq.
Assistant Attorney General
Office of the Attorney General of WV
P.O. Box 1789
Charleston, WV 25326
Douglas.L.Davis@wvago.gov

Re: **Reply to Cabell Huntington Hospital, Inc.'s Response to Public Comments Regarding the Application for Approval of Cooperative Agreement (File No. 16-2/3-001)**

Dear Ms. Dellinger and Mr. Davis:

On behalf of FTC Bureau of Competition staff, and pursuant to a request by the West Virginia Health Care Authority and W.V. Code § 16-29B-28(e)(2), I respectfully submit the attached written reply to Cabell Huntington Hospital, Inc.'s Response to Public Comments regarding its Application for Approval of Cooperative Agreement.

Please note that the reply comment itself is public, but the attachments to the comment are submitted on a confidential/non-public basis pursuant to the protective order entered in this case by the WVHCA.

If you have any questions, please feel free to contact me.

Sincerely,

Alexis James Gilman
Assistant Director
Bureau of Competition

Enclosures

BEFORE THE WEST VIRGINIA HEALTH CARE AUTHORITY

Re: CABELL HUNTINGTON HOSPITAL, INC.
Cooperative Agreement File No. 16-2/3-001

FEDERAL TRADE COMMISSION BUREAU OF COMPETITION STAFF'S REPLY TO CABELL HUNTINGTON HOSPITAL'S RESPONSE TO PUBLIC COMMENTS

I. INTRODUCTION

On May 4, 2016, Cabell Huntington Hospital ("Applicant") provided the West Virginia Health Care Authority ("Authority") with a response to public comments submitted to the Authority.[1] These public comments regard Applicant's cooperative agreement application relating to its acquisition of St. Mary's Medical Center ("St. Mary's"), which is currently under review by the Authority pursuant to W. Va. Code §§ 16-29B-26, 28, and 29 ("West Virginia Cooperative Agreement Law" or "WVCAL"). The staff of the Federal Trade Commission's ("FTC") Bureau of Competition, which provided a public comment to the Authority,[2] respectfully submits this reply to Applicant's Response.

As explained below, Applicant's Response does not allay concerns that the proposed cooperative agreement will result in serious competitive harm and that this harm will not be outweighed by the purported benefits of the proposed cooperative agreement. In Section II, we correct Applicant's misrepresentations regarding the WVCAL's legal standard, and we describe how FTC staff's submission correctly applied the WVCAL factors and standards. In Section III, we explain how Applicant has failed to rebut FTC staff's analysis regarding the likely anticompetitive effects of the proposed cooperative agreement. In Section IV, we describe how Applicant has failed to rebut FTC staff's conclusion that many of the claimed benefits from the proposed cooperative agreement are unsubstantiated, not specific to the merger with St. Mary's, and unlikely to outweigh the substantial competitive harm caused by the proposed cooperative agreement. In Section V, we correct Applicant's mischaracterization of the FTC declaration process, and we explain why the letters of support that Applicant touts are unreliable. FTC staff respectfully reiterates its request that the Authority deny Applicant's cooperative agreement application.

II. APPLICANT MISREADS THE WVCAL AND MISREPRESENTS FTC STAFF'S SUBMISSION

Applicant incorrectly argues that FTC staff have misconstrued the WVCAL by merely putting forth an antitrust argument, rather than following the standard set out in the WVCAL. Applicant further argues that antitrust analysis is "irrelevant" to the Authority's decision

[1] Cabell Huntington Hospital, Inc.'s Response to Public Comments, Cooperative Agreement File No. 16-2/3-001 (May 4, 2016) [hereinafter "Response"].
[2] Federal Trade Commission Bureau of Competition Staff Submission to the West Virginia Health Care Authority Regarding Cooperative Agreement Application of Cabell Huntington Hospital (April 18, 2016) [hereinafter "FTC staff submission"].

regarding the cooperative agreement application. This argument is flawed for two reasons. First, it misreads the WVCAL. Contrary to Applicant's assertion, the WVCAL *does* require an analysis of the proposed cooperative agreement's anticompetitive effects. Second, contrary to Applicant's mischaracterization, FTC staff's submission properly applied the WVCAL's standard for approval of cooperative agreements.

A. Applicant Ignores the Plain Text of the WVCAL in Asserting Antitrust Analysis is "Irrelevant"

The WVCAL provides that the Authority "shall approve a proposed cooperative agreement and issue a certificate of approval if it determines, with the written concurrence of the Attorney General, that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from a reduction in competition from the proposed cooperative agreement."[3] Thus, the WVCAL *explicitly requires* the Authority to conduct an analysis of the proposed cooperative agreement's likely effects on competition, and to weigh those competitive effects against the proposed cooperative agreement's likely benefits. This is what FTC staff did.

The WVCAL also provides that "[i]n reviewing an application for cooperative agreement, the Authority shall give deference to the policy statements of the Federal Trade Commission."[4] Thus it was entirely appropriate for FTC staff to refer to the analysis set out by the U.S. Department of Justice ("DOJ") and Federal Trade Commission Horizontal Merger Guidelines ("Merger Guidelines")[5] in its submission.[6]

B. Applicant Mischaracterizes FTC Staff's Submission

Applicant also incorrectly claims that FTC staff argues that any reduction in competition is enough to deny the application, and that FTC staff's submission did not address whether the benefits of the transaction outweigh any disadvantages as required by the WVCAL. Both contentions are false. FTC staff carefully followed the analytical framework set out by the WVCAL for approval of a cooperative agreement by weighing the proposed cooperative agreement's likely competitive harm against its potential benefits.

FTC staff's submission first evaluated the competitive effects of the proposed cooperative agreement, as called for by WVCAL § 28(f)(3). In Section IV of its submission (pages 8–38), FTC staff described how the proposed cooperative agreement was likely to substantially reduce competition for inpatient general acute care ("GAC") services and outpatient

[3] W. Va. Code § 16-29B-28(f)(3).
[4] W. Va. Code § 16-29B-28(d)(4)(C).
[5] 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"].
[6] Applicant's argument is particularly curious given that Applicant makes antitrust claims in its cooperative agreement application and its Response. In both of these submissions, Applicant proposes a relevant product market and geographic market, calculates market shares, and assesses competitive effects—all antitrust concepts. Applicant even cites to federal antitrust case law to support its arguments. Thus, Applicant criticizes FTC staff for conducting an antitrust analysis on the one hand, while conducting its own antitrust analysis on the other. Applicant cannot have it both ways.

surgical services in the Four-County Huntington Area. Notably, in Section IV.F (pages 38–40), FTC staff reviewed the four statutory factors set out by WVCAL § 28(f)(5) that the Authority is required to consider in its evaluation of the proposed cooperative agreement's impact on competition.

Next, in Section V of its submission (pages 40–47), FTC staff explained why the Assurance of Voluntary Compliance ("AVC") and the WVCAL's rate and quality regulation provisions are unlikely to restore lost competition. Thus, these checks on the Applicant's conduct do not change FTC staff's conclusions that substantial harm to competition is likely to result from the proposed cooperative agreement.

Importantly, FTC staff's submission did not end there. In Section VI (pages 47–57), FTC staff evaluated Applicant's claims regarding the benefits of the proposed cooperative agreement. FTC staff's submission responded thoroughly to Applicant's submission regarding each of the nine potential benefits set out in WVCAL § 28(f)(4). FTC staff concluded that many of Applicant's claims were highly speculative and vague, not substantiated, and that many of the claimed benefits could be accomplished through means other than the proposed cooperative agreement.

Finally, as called for by WVCAL § 28(f)(3), in Section VI (pages 47–57) FTC staff weighed the proposed cooperative agreement's likely benefits against the disadvantages likely to result from the proposed cooperative agreement's reduction of competition. FTC staff concluded any benefits from the proposed acquisition are likely to be modest in scope, could be achieved without the proposed merger, and certainly do not outweigh the substantial competitive harm the proposed acquisition is likely to cause.

Unfortunately, Applicant's Response includes several other misrepresentations regarding FTC staff's submission. Applicant claims that the FTC argues the Authority and Attorney General are incapable of supervising cooperative agreements. But FTC staff is not questioning the competence or ability of the Authority or the Attorney General. Instead, Section V.B of FTC staff's submission argues that the WVCAL's rate and quality regulation provisions are flawed and contain several loopholes. FTC staff is concerned that these flaws and loopholes are so numerous and fundamental that they will create opportunities for the hospitals to increase prices—opportunities that even the best efforts of the Authority or the Attorney General are unlikely to foreclose completely.

Applicant also contends that FTC staff urges the Authority to "ignore" the AVC. This too is wrong. On the contrary, FTC staff treats the AVC as a relevant factor in its assessment of the proposed cooperative agreement. Section V.A of FTC staff's submission thoroughly evaluates the AVC. FTC staff concluded that the AVC's price and quality regulation provisions are highly unlikely to prevent or substantially mitigate the competitive harm likely to result from the proposed cooperative agreement. Applicant surely disagrees with FTC staff's conclusion, but that does not mean FTC staff has somehow asked the Authority to "ignore" the AVC. Indeed, we ask the Authority to pay close attention to its flaws and shortcomings when evaluating the AVC's ability to restrain the harmful effects of the competition eliminated by the proposed cooperative agreement.

III. APPLICANT FAILS TO REBUT FTC STAFF'S CONCLUSION THAT THE PROPOSED COOPERATIVE AGREEMENT WILL LEAD TO SUBSTANTIAL COMPETITIVE HARM

Applicant argues that FTC staff's analysis of the likely competitive effects of the proposed cooperative transaction is incorrect (curiously, after having previously argued that competitive effects analysis is somehow "irrelevant" to the WVCAL's standard for approval). But Applicant's Response merely repeats the flawed and baseless arguments made in its original application. The Applicant has failed to rebut FTC staff's well-supported conclusions regarding the proposed cooperative agreement's likely competitive harm.

A. Applicant Fails to Rebut FTC Staff's Conclusion that the Four-County Huntington Area Is the Proper Relevant Geographic Market

Applicant contends that the Authority has already considered and rejected FTC staff's proposed geographic market of Cabell, Wayne, and Lincoln counties in West Virginia and Lawrence County in Ohio (the "Four-County Huntington Area"). Presumably, Applicant is referring to the Authority's determination of the "proposed service or study area" in the Authority's CON Decision.[7] But the Authority's determination of the "study area" in the CON Decision was *not* a determination of the relevant geographic market guided by antitrust principles for the purposes of calculating the hospitals' market shares or evaluating the proposed cooperative agreement's competitive effects under the WVCAL. Rather, the "study area" was defined using "traditional health care planning assumptions and the Authority's standard approach to developing a study area for acute care services, which is the 25/10 study area."[8] As explained at the CON hearing, under the "25/10 study area" method, a given county is included as part of a hospital's study area if (a) 25% of the given county's discharges use that hospital for care, or (b) 10% of that hospital's discharges originate from the given county.[9] This is not a method for determining a relevant geographic market for purposes of analyzing the competitive effects of a proposed cooperative agreement.

As discussed below, the relevant question in defining the geographic market is whether a hypothetical monopolist controlling all of the relevant services in the proposed geographic market could profitably impose a small but significant and non-transitory increase in price ("SSNIP").[10] This method is particularly informative here, where Cabell and St. Mary's are in fact the only hospitals in the proposed relevant geographic market. Therefore, this analysis will actually reflect whether the merged Cabell-St. Mary's system could profitably impose a price increase.

Further, the CON Decision does not support Applicant's claim that the Authority specifically considered and rejected the Four-County Huntington Area. According to the CON

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[7] *In re Cabell Huntington Hospital, Inc.*, West Virginia Health Care Authority, CON File #14-2-10375-A (March 16, 2016) at 18 [hereinafter "CON Decision"].
[8] CON Decision at 15–16.
[9] Dec. 21, 2015 CON Hearing Transcript at 29–30.
[10] Merger Guidelines § 4.2.1.

Decision, Applicant proposed a "study area" consisting of the Four-County Huntington Area plus Mason, Mingo, and Putnam counties in West Virginia.[11] This issue was *not* in dispute during the CON process—Steel of West Virginia acknowledged that Applicant's study area included the same seven counties, and in fact distinguished the study area from the Four-County Huntington Area "that both CHHI and the FTC have identified as CHH's primary service or market area and in which both the FTC and SWVA assert competition would be eliminated by the proposed merger."[12] Importantly, Steel of West Virginia did not propose an alternative area. The Authority then adopted Applicant's proposed seven-county study area without further discussion.[13] Thus, Applicant has no basis to claim that the Authority rejected the Four-County Huntington Area as a relevant geographic market for the current purpose of evaluating the proposed cooperative agreement when it adopted the seven-county study area for the purpose of the CON Decision in March.

Even assuming, for the sake of argument, that the seven-county study area used in the CON Decision was relevant to the cooperative agreement application process, it still would not change the fact that the combined entity would face little post-merger competition. The seven-county study area includes four other facilities besides Cabell and St. Mary's—Three Gables Surgery Center, Pleasant Valley Hospital, CAMC Teays Valley, and Williamson Memorial Hospital.[14] As explained in FTC staff's submission in Section IV.B.2.a, these hospitals are at best distant competitors to Cabell and St. Mary's, either because they are small medical facilities, have a pre-existing business relationship with one of the merging hospitals, and/or because they compete only to a limited extent in discrete portions of the overly broad seven-county study area.

- Three Gables Surgery Center in Proctorville, Ohio, is an ambulatory surgery center that provides outpatient surgical services and a negligible amount of inpatient surgical services.[15] Thus it is not a meaningful competitor to Cabell or St. Mary's for the provision of inpatient GAC services. Its limited significance is reflected in the market share for outpatient surgical services as well. Further, Gables has a "close business relationship" with St. Mary's, which likely reduces Three Gables' competitive incentives.[16]

- Pleasant Valley Hospital ("PVH") operates a 101-bed general acute care facility (i.e., one-third of the beds at each of Cabell and St. Mary's) and a nursing and rehabilitation center in Point Pleasant, West Virginia, approximately 50 miles northwest of Huntington.[17] In 2013, PVH entered into a Joint Management Services

[11] CON Decision at 16.
[12] CON Decision at 18.
[13] CON Decision at 18.
[14] CON Decision at 17–18.
[15] Three Gables Decl. ¶ 6.
[16] Three Gables Decl. ¶ 11. Specifically, a St. Mary's entity, St. Mary's Medical Management ("SMMM"), manages Three Gables. SMMM employs Three Gables' administrator, negotiates contracts on behalf of Three Gables, provides general operational support for Three Gables, and has a minority ownership interest in Three Gables. *Id.*
[17] Cabell Huntington Hospital, *CHH & PVH Complete Joint Management Services Agreement*, http://cabellhuntington.org/news/wns/chh-and-pvh-complete-joint-management-services-agreement

Agreement with Cabell,[18] likely reducing PVH's incentives to compete against Cabell. PVH publicly states that its mission is to provide care to "residents of Mason and Jackson counties in West Virginia and Gallia and Meigs counties in Ohio," suggesting it does not compete for patients residing in the Four-County Huntington Area (and competes in only *one* of the counties in the seven-county study area).[19]

- CAMC-Teays Valley is a small, 70-bed (i.e., less than one-quarter of the beds at each of Cabell and St. Mary's) community hospital located in Hurricane, West Virginia. It lacks the breadth and depth of services provided by Cabell and St. Mary's.[20] As a community hospital, it focuses on offering general medical services to residents of the Putnam County area.[21] It does not offer obstetrics services, trauma services, open heart surgery, neurosurgery, a catheterization lab, a neonatal ICU, a pediatric ICU, or a burn unit.[22] Accordingly, any competition between CAMC-Teays Valley Hospital and the Huntington hospitals is limited to a few communities on the western side of Putnam County, and nowhere else in the Four-County Huntington Area (or the seven-county study area).[23]

- Williamson Memorial Hospital ("Williamson Memorial") is a 75-bed (i.e., less than one-quarter of the beds at each of Cabell and St. Mary's) general acute care hospital located in Williamson, West Virginia, approximately 80 miles south from Huntington.[24] Williamson Memorial's CEO declared that patients from Huntington do not travel to Williamson for care, nor do patients from Williamson travel to Huntington for care, because it would involve traveling nearly two hours over mountainous state roads.[25] Consequently, she does not consider Williamson Memorial a competitor to Cabell or St. Mary's.[26]

Finally, the geographic market proposed by Applicant in its cooperative agreement application is different, and much larger, than the study area that it proposed and the Authority adopted in the CON Decision. While the Authority's study area includes seven counties in two states, the Applicant's proposed geographic market includes 61 zip codes spread over 18 counties in three states.[27] For example, it includes portions of Kanawha County, West Virginia, Gallia County, Ohio, and Magoffin County, Kentucky—all of which were not included in the Authority's study area.[28] Defining this enormous area as the relevant geographic market is completely inconsistent with the available evidence in this case, both quantitative and qualitative.

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[18] Cabell Huntington Hospital, *CHH & PVH Complete Joint Management Services Agreement*, http://cabellhuntington.org/news/wns/chh-and-pvh-complete-joint-management-services-agreement
[19] Pleasant Valley Hospital, *About*, http://pvalley.org/about/
[20] CAMC Decl. ¶ 9.
[21] CAMC Decl. ¶ 5.
[22] CAMC Decl. ¶ 5.
[23] CAMC Decl. ¶ 9.
[24] Williamson Memorial Decl. ¶¶ 1, 3.
[25] Williamson Memorial Decl. ¶ 6.
[26] Williamson Memorial Decl. ¶ 7.
[27] Application for Approval of Cooperative Agreement, Cabell Huntington Hospital, Inc., CON File #14-2-10375-A (March 25, 2016) at Exhibit J-1 [hereinafter "Application"].
[28] Application at Exhibit J-1; CON Decision at 18.

The remainder of Applicant's geographic market discussion in the Response simply repeats the arguments it made in the original application. Again, Applicant argues that because Cabell and St. Mary's draw some patients from outside the Four-County Huntington Area, the relevant geographic market must be expanded. This argument fundamentally misunderstands geographic market analysis. If Cabell and St. Mary's drew a handful of patients from California, that would not extend the geographic market to California.

As explained in Section IV.B.2 of FTC staff's submission, a relevant geographic market is the geographic "arena of competition affected by the merger."[29] Under court decisions and the Merger Guidelines, the relevant question in defining the geographic market is whether a hypothetical monopolist controlling all of the relevant services in the proposed geographic market could profitably impose a price increase.[30] This way of defining markets captures the common-sense idea that the "arena of competition affected by the merger" does not include every firm in every area that imposes *any* competitive constraint on the merging parties, no matter how small. Rather, it includes only the firms that impose *enough* of a competitive constraint on each other's prices that the elimination of those constraints would make a price increase profitable. For this reason, a properly defined geographic market need not, and often will not, include the area from which *all or even nearly all* of the merging parties' (or a hypothetical monopolist's) customers come from; it only needs to consist of the smallest area in which a hypothetical monopolist could profitably impose a price increase.[31] Though some people within the Four-County Huntington Area may travel outside the area for care, this does not change the fact that most patients in the Four-County Huntington Area strongly prefer not to travel and would not do so if prices for hospital services increased. Therefore, a hypothetical monopolist that controlled all of the hospitals within that area would be able to profitably impose a price increase. The fact that some patients travel outside of the area in no way contradicts the determination that the Four-County Huntington Area is a proper geographic market.

Here, the critical question is whether a hypothetical monopolist controlling all hospitals within the Four-County Huntington Area would profitably be able to implement a small but significant price increase. The answer is yes. In its submission, FTC staff described how Dr. Capps' quantitative analysis and substantial evidence from third parties align to show that Cabell and St. Mary's are overwhelmingly the top two choices for residents of the Four-County Huntington Area; that more distant hospitals are not close substitutes; and that a health plan network with neither Huntington hospital would be very unattractive, and almost certainly so unattractive as to be unmarketable to employers and patients in Huntington. Notably, Applicant does not rebut this evidence. Because most residents in the Four-County Huntington Area would *not* accept a network that includes only hospitals outside of the Four-County Huntington Area, it would be profitable for a hypothetical monopolist to implement a price increase. Thus, the Four-County Huntington Area is the location in which competition will be substantially reduced and constitutes the proper geographic market within which the Authority should analyze the effects of the proposed cooperative agreement.

[29] Merger Guidelines § 4.2.
[30] Merger Guidelines § 4.2.1.
[31] Merger Guidelines § 4.1.1.

B. Applicant Fails to Rebut FTC Staff's Conclusion That Cabell and St. Mary's Are Closest Competitors, Not Complements

In its Response, Applicant repeats its flawed argument that the hospitals are complements (not substitutes) because each hospital has some differentiation in service offerings. Therefore, according to Applicant, health plans have to contract with both hospitals to offer a viable health insurance product in Huntington. Applicant further incorrectly asserts that "a combined Cabell-St. Mary's hospital will therefore not have market power to increase prices to payors."[32] In other words, Applicant asserts that, due to the hospitals' different strengths, Cabell and St. Mary's *already* have monopoly power. Thus, according to Applicant's logic, the reason that the proposed cooperative agreement cannot cause prices to rise is that the hospitals are already monopolists.

This argument is deeply flawed. While FTC staff concurs that Cabell and St. Mary's already exert some bargaining leverage in negotiations with health plans, the proposed cooperative agreement will substantially *increase* this leverage. The reason for this is straightforward—Cabell and St. Mary's are each other's closest competitors in the eyes of patients, employers, health plans, other hospitals, and the Applicants themselves.

Much of the FTC's evidence on this point has gone unrebutted. Applicant does not dispute that Cabell and St. Mary's view each other as close competitors in the ordinary course of business. Nor does Applicant dispute the views of numerous health plans, local employers, and outlying hospitals that the two hospitals are each other's closest competitor. This evidence, which obviously undermines Applicant's contention that the hospitals are complements, remains unrebutted. Further, Applicant does not dispute that any non-overlapping or minimally overlapping services between Cabell and St. Mary's are at least partly attributable to suspect coordination between the hospitals. Nor does Applicant dispute that the close competition between Cabell and St. Mary's has led to a reduction in the differentiation between the hospitals.

Applicant claims that Dr. Capps' diversion ratio analysis confirms its arguments regarding complementarity if the diversion ratios are "properly viewed by separate service line."[33] But the analysis by Dr. Gautam Gowrisankaran, Applicant's economic expert, shows the opposite. In the portion of Dr. Gowrisankaran's report that Applicant cites, St. Mary's is the closest substitute to Cabell for every single service line he shows. For those same service lines, Cabell is the closest substitute to St. Mary's for every single service line except cardiac surgery.[34] Dr. Capps' diversion ratio analysis, which covers *all* service lines, including non-overlapping services, further confirms that Cabell and St. Mary's are close substitutes for a large majority of patients.[35]

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[32] Response at 7.

[33] Response at 7.

[34] Note, however, that Dr. Gowrisankaran's diversion ratios show that St. Mary's is Cabell's closest substitute for cardiac surgery.

[35] As discussed in FTC staff's submission, diversion ratios measure the degree of competition between the merging parties. Dr. Capps' diversion ratio analysis explicitly considers where patients go across *all* services and thus accounts for the asymmetry in service lines across the merging hospitals. His results show that Cabell and St. Mary's are each other's closest competitors for a large majority of patients. Therefore, Applicant's argument that there is some undefined minimum level of patient volume required to make a particular service an "overlapping"

This strong evidence of close competition between Cabell and St. Mary's would typically lead to a conclusion that their merger would likely cause significant consumer harm. However, Applicant attempts to avoid this conclusion by presenting a faulty argument that the hospitals are complements by relying on the work of Dr. Gowrisankaran. He ignores the vast array of competing services offered by both hospitals, and he incorrectly argues that the existence of a few non-overlapping services at both hospitals means the hospitals are complements arther than substitutes. In his rebuttal report, Dr. Capps explained why this analysis is flawed.[36] A brief summary of these flaws is below:

- Dr. Gowrisankaran's analysis rests on a faulty foundation. He draws an overly sharp distinction between the first stage of hospital competition (where healthcare providers compete to be included in health plans' networks) and the second stage (where providers compete for patients). He uses this exaggerated distinction to dismiss evidence, such as diversion ratios, that indicate consumers view the two hospitals as closest competitors. But the two stages of competition are *closely connected* to each other. A health plan's demand for a given hospital is derived from its members' demand for that hospital and its services. As Applicant itself notes in its Response, "hospitals' bargaining power is based on attractiveness to enrollees."[37] It follows that hospitals that are close substitutes for patients are very likely to be close substitutes for health plans. Dr. Gowrisankaran, however, rejects this common-sense notion.

- Dr. Gowrisankaran's analysis also ignores the perspective of patients when assessing the proposed cooperative agreement. He admits that "[h]ospitals will compete to attract patients by using high-quality treatments and patient amenities."[38] Therefore, by eliminating competition between these two closest substitutes, patients will be directly harmed through reduced amenities and lower quality health care. This harm would come in addition to the increased insurance premiums, deductibles, and co-pays that consumers would face as a result of the hospitals' increased negotiating leverage with health plans.

- Taken to its logical conclusion, Dr. Gowrisankaran's argument suggests that only a merger of hospitals that perfectly overlap in every single service line can be anticompetitive. This is inconsistent with competition law and common sense. Indeed, the Merger Guidelines make clear that mergers of firms selling differentiated products can be anticompetitive, particularly when the merging parties are close competitors.[39] Further, Applicant's argument assumes that the hospitals are complements to each other because members of a health plan with only one

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service between Cabell and St. Mary's is irrelevant to evaluating the competitive effects of the proposed cooperative agreement.

[36] The executive summary of Dr. Capps' rebuttal report is attached to this reply as Attachment 1.

[37] Response at 7.

[38] Response Exhibit A (Gowrisankaran Report) at ¶ 158.

[39] Merger Guidelines § 6.1 ("A merger between firms selling differentiated products may diminish competition by enabling the merged firm to profit by unilaterally raising the price of one or both products above the pre-merger level. . . . [t]he extent of direct competition between the products sold by the merging parties is central to the evaluation of unilateral price effects.").

Huntington hospital in network would greatly dislike having to travel to more distant hospitals for the services the in-network Huntington hospital did not offer. But this reluctance to travel applies just as strongly to the much more numerous services that both hospitals do offer in competition with one another, and this has an even stronger effect in making Cabell and St. Mary's substitutes for each other.

- Dr. Gowrisankaran's arguments regarding complementarity and geographic market definition are entirely inconsistent with each other. He argues that because Cabell and St. Mary's are complements, a health plan cannot offer a viable health insurance product in Huntington without both hospitals in-network. Thus, he implies that patients will not accept a health plan with just one Huntington hospital and will not travel outside of the Four-County Huntington Area for the other services that only the out-of-network hospital offers.[40] In contrast, with respect to geographic market definition, he argues that the merger poses no competitive risk because Huntington residents can easily travel to outlying hospitals to obtain care. Both arguments cannot be true.

- Dr. Gowrisankaran's conclusions are based on a selective and mistaken review of the litigation record. He ignores the wealth of evidence that Cabell and St. Mary's compete with each other for inclusion in provider networks and to attract patients.

- Applicant relies on selective health plan support of the transaction to support their contention. This reliance is misplaced with respect to evaluating the cooperative agreement. First, certain health plans have never supported the merger. Second, the health plans that express some support for the merger have provided evidence to FTC staff that supports our arguments and conclusions. Third, it is not surprising that some health plans expressed public support for the merger: faced with the risk that a virtual merger-to-monopoly may be approved, it would be less risky to support the merger than to face the wrath of the merged firm if the deal is consummated. Finally, the Applicant's argument is invalid because in this instance the interests of some health plans are not necessarily aligned with those of consumers. These health plans may have their own strategic and business considerations for supporting the transaction. For example, these health plans may be better off relative to other health plans, but those advantaged health plans' members might not be better off—indeed, we submit that they are not. Therefore, the impact of this transaction on consumers should be judged based upon an examination of the totality of the evidence and analysis, not merely on whether certain health plans support the transaction.

C. Applicant Incorrectly Argues That Market Shares Are Meaningless in Evaluating Hospital Mergers

Applicant asserts that market shares and concentration levels (measured by the Herfindahl-Hirschman Index or "HHI") are meaningless in the context of hospital mergers. Applicant's argument appears to be that there is no way to assign market shares at the first stage

[40] This argument is also wrong as a factual matter. Multiple health plans have had or currently have only Cabell or St. Mary's, but not both, in-network.

of hospital competition (where hospitals are negotiating with health plans for network inclusion). This argument rests on a faulty assumption—that the first stage of hospital competition is completely independent of the second stage of hospital competition (where hospitals compete to attract patients). But, as explained previously, health plans are negotiating *on behalf of* their patient members. A health plan's demand for a given hospital is thus necessarily derived from its members' demand for that hospital and its services. Thus, patient preferences regarding hospitals, as evidenced through market shares based on patient discharges or patient days, are very informative in understanding the bargaining dynamic between health plans and hospitals. Courts evaluating healthcare provider mergers consistently define markets and calculate market shares and market concentration as part of their analysis.[41] Applicant gives no reason why the Authority should do otherwise. To our knowledge, completely disregarding market shares would be unprecedented in merger analysis.

Even if market shares and concentration levels were meaningless in this context, it would not change FTC staff's conclusions regarding the proposed cooperative agreement, as those conclusions rely upon a large body of corroborating evidence, both qualitative and quantitative,[42] which demonstrates that this transaction will harm consumers. As described in Sections IV.C and D of FTC staff's submission, there is copious direct evidence that Cabell and St. Mary's compete vigorously against each other on price, quality, and service to the benefit of consumers. Thus, even if Applicant's argument were correct (which it is not), it would not change the competitive effects analysis.

D. Applicant Fails to Rebut FTC Staff's Conclusion That Conduct Restrictions Will Not Prevent Substantial Reduction in Competition

Applicant asserts that conduct restrictions, namely the AVC and the WVCAL's rate and quality regulation provisions, will prevent any anticompetitive price increases. But Applicant misrepresents the basic functioning of these conduct restrictions, misstates antitrust law and policy regarding conduct remedies, and ultimately fails to rebut FTC staff's conclusions regarding these conduct restrictions.

Applicant claims that the WVCAL gives the Attorney General a "veto power on any price increases." This statement is misleading, as the Attorney General's power to regulate prices is limited. The WVCAL contains two provisions addressing the Attorney General's role in regulating rates. First, the WVCAL gives the Attorney General the power to reject proposed "rate increases" (presumably referring to chargemaster rates) only if the proposed increases "may inappropriately exceed competitive rates for comparable services in the hospital's market area which would result in unwarranted consumer harm or impair consumer access to health care."[43] As explained in Section V.B of FTC staff's submission, it is not yet clear how the Attorney

[41] *See, e.g., Saint Alphonsus Med. Ctr. – Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 786 (9th Cir. 2015); *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 568 (6th Cir. 2014); *FTC v. OSF Healthcare Sys.*, 852 F.Supp. 2d 1069, 1079 (N.D. Ill. 2012).

[42] A key piece of quantitative evidence is the diversion ratios discussed above. It is important to note that the calculation of diversion ratios does not involve market definition in any way, so they stand as a source of evidence independent of market definition. That is, regardless of whether FTC staff or the Applicant is right about the geographic market definition, the diversion ratios still hold.

[43] W. Va. Code § 16-29B-28(i)(1)(B).

General will assess whether such rates "inappropriately exceed competitive rates for comparable services in the hospital's market area" since none of those terms are defined in the statute. And monitoring proposed rate increases and determining "competitive rates" is very likely to be an ongoing, difficult, and resource-intensive administrative burden. Thus, the Attorney General can only reject price increases that meet the vague and complicated standard that is set forth by the WVCAL.

Second, the WVCAL gives the Attorney General authority to reject a reimbursement agreement if the Attorney General determines that a "reimbursement agreement with a third party payor includes pricing terms at anti-competitive levels."[44] As noted above, the WVCAL provides no guidance as to what constitutes an "anti-competitive" rate level. Again, there will be ongoing and challenging administrative burdens when regulating pricing terms. Coupled with the apparent lack of pricing restrictions on physician and other medical and ancillary services, the gaps in the WVCAL undermine Applicant's claim that the law gives the Attorney General the ability to counter competitive harm effectively. Again, the Attorney General can only reject price increases that meet the vague and complicated standard that is set forth by the WVCAL.

More generally, Applicant asserts that conduct remedies are "valid and appropriate" means to deal with anticompetitive mergers. This is incorrect. The only support Applicant cites for this statement is a 20-year old federal district court case, *FTC v. Butterworth Health Corp.*[45] But the *Butterworth* court's decision in this respect is an outlier, and its approach has not been followed in any recent hospital merger cases.[46] For example, the *Butterworth* decision was based on faulty premises—since proved wrong—that non-profit hospitals would not exercise market power to raise prices and that increases in market concentration lead to *lower* prices.

Further, Applicant's argument is squarely at odds with mainstream antitrust law and policy regarding merger remedies. The U.S. Supreme Court has long instructed that structural remedies (injunctions and divestitures) are the "natural remedy" for unlawful mergers and

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[44] W. Va. Code § 16-29B-28(i)(1)(B).

[45] 946 F. Supp. 1285 (W.D. Mich. 1996).

[46] *See, e.g.*, *OSF*, 852 F. Supp. 2d at 1085–86 (rejecting proposed conduct restriction by merging parties because "it does not eliminate the concern about potential anticompetitive effects underlying the FTC's prima facie case"); *In re ProMedica Health Sys., Inc.*, No. 9346, 2012 WL 2450574 at *66 (F.T.C. June 25, 2012) (holding divestiture "is desirable because, in general, a remedy is more likely to restore competition if the firms that engage in pre-merger competition are not under common ownership" and there are "usually greater long term costs associated with monitoring the efficacy of a conduct remedy than with imposing a structural solution") (quoting *In re Evanston Nw. Healthcare Corp.*, No. 9315, 2007 WL 2286195 at *77 (F.T.C. Aug. 6, 2007)); *Commonwealth v. Partners Healthcare Sys.*, No. SUCV2014-02033-BLS2, 2015 WL 500995, at *1–2 (Sup. Ct. Mass. Jan. 30, 2015) (explaining "so-called 'conduct-based' remedies" are "temporary and limited in scope—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"). Additionally, when the commitment to freeze prices expired after the Butterworth Health merger in Grand Rapids, Michigan, in the first year, the merged hospitals raised prices 12%. "Spectrum Hikes Charges 12 Percent," Grand Rapids Business Journal, June 4, 2004, available at http://www.grbj.com/articles/63939. Price hikes in recent years have continued to exceed inflation. See "Spectrum Health Plans Another Significant Rate Hike at Grand Rapids Hospitals," June 7, 2011, mlive.com, available at http://www.mlive.com/business/west-michigan/index.ssf/2011/06/spectrum_health_plans_8_percen.html; "Health care costs in West Michigan escalate because of market concentration, report finds," January 18, 2015, MiBiz.com, available at https://mibiz.com/item/22152-health-care-costs-in-west-michigan-escalate-because-of-market-concentration,-report-finds.

acquisitions, because they are "simple, relatively easy to administer, and sure."[47] In a 2011 policy statement on merger remedies, the DOJ made clear that structural remedies, rather than conduct remedies, are typical for horizontal mergers.[48] Similarly, in a 2004 joint report, the FTC and DOJ explained that they would not accept "community commitments," or agreements with state Attorneys General promising not to raise prices for a specified period of time, as a resolution to likely anticompetitive effects from a hospital merger.[49] The agencies explained that such commitments "do not solve the underlying competitive problem when a hospital merger has changed market circumstances in ways that increase the likelihood that market power will be exercised" and "are an ineffective short-term regulatory approach to what is ultimately a problem of competition."[50]

Applicant otherwise fails to respond to FTC staff's analysis of the AVC or the WVCAL's rate and quality regulations. Notably, Applicant does not appear to dispute that the AVC and WVCAL's terms are flawed and leave room for price increases, or that they do nothing to restore valuable quality and service competition lost through the proposed cooperative agreement.

IV. APPLICANT FAILS TO REBUT FTC STAFF'S CONCLUSION THAT CLAIMED BENEFITS FROM THE PROPOSED COOPERATIVE AGREEMENT ARE UNLIKELY TO OUTWEIGH THE PROPOSED COOPERATIVE AGREEMENT'S LIKELY HARM

Much of FTC staff's analyses of Applicant's claimed benefits from the proposed cooperative agreement were not even addressed, much less rebutted, in Applicant's Response. Notably, FTC staff's conclusions regarding the merger-specificity of many of Applicant's claims remain unrebutted. Applicant does not meaningfully address the WVCAL's instruction that, in evaluating the application, the Authority should consider "[t]he availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement."[51] Further, Applicant does not dispute that alternative buyers were interested in purchasing St. Mary's, or that several alternative buyers are still interested in purchasing St. Mary's if Applicant does not.

Similarly, Applicant does not respond to FTC staff's arguments that many of its claims lack substantiation. In fact, much of Applicant's letter simply repeats the application's vague and perfunctory assertions regarding potential benefits from the transaction, without providing any additional evidence or specific commitments that Applicant will actually achieve these potential benefits. The Merger Guidelines instruct that "[e]fficiency claims will not be

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[47] *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 329–31 (1961).
[48] U.S. Dep't of Justice, Policy Guide to Merger Remedies (June 2011) at 5, https://www.justice.gov/atr/public/guidelines/272350.pdf ("[I]f a competitive problem exists with a horizontal merger, the typical remedy is to prevent common control over some or all of the assets, thereby effectively preserving competition. Thus, the Division will pursue a divestiture remedy in the vast majority of cases involving horizontal mergers.").
[49] U.S. Dep't of Justice and Federal Trade Comm'n, Improving Health Care: A Dose of Competition (July 2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf, at 28–29 [hereinafter "Improving Health Care"].
[50] Improving Health Care at 29.
[51] W. Va. Code § 16-29B-28(f)(5)(D).

considered if they are vague, speculative, or otherwise cannot be verified by reasonable means."[52]

In an attempt to rehabilitate its claims regarding cost savings, Applicant has submitted a report by Lisa N. Ahern ("Deloitte Report"). The Deloitte Report estimates that the proposed cooperative agreement will result in $16 million in merger-specific annual recurring cost savings.[53] This is less than half of The Camden Group's ("Camden") Business Plan of Operational Efficiencies ("BPOE Report") estimate of $36 million that Applicant previously submitted to the Authority in the CON proceeding. This striking discrepancy between both the cost savings estimates and the methodologies used by Deloitte and Camden calls into question the reliability of both sets of estimates.[54]

Notably, the Deloitte Report's cost savings estimate represents a very small percentage of the two hospitals' combined operating costs. Even a modest post-merger price increase will exceed the merging parties' claimed cost savings, even assuming all those savings will be fully passed through to consumers, which the merging parties have not shown. Thus, it is highly unlikely that such cost savings will reverse the proposed cooperative agreement's harm to consumers, as the Merger Guidelines require the merging parties to demonstrate.[55]

Even the Deloitte Report's reduced cost savings estimate is suspect. Dr. Thomas Respess III, FTC staff's cost-efficiencies expert, provided an expert analysis of the Deloitte Report, which is attached on a non-public basis to this reply as Attachment 2. Based on his analysis, Dr. Respess concluded that there are no significant cognizable net cost savings to be achieved by the proposed cooperative agreement. In particular, Dr. Respess's report finds the following:

- With respect to savings from certain clinical consolidations, Ms. Ahern has ignored or dismissed evidence of obstacles to consolidation, including regulatory hurdles and capacity problems.

- In many categories, most prominently in the information technology area, the Deloitte Report's projected cost savings estimates are not supported by ordinary course documents or other evidence. Instead, these claims are supported only by recent, mid-litigation conversations between Ms. Ahern and hospital executives. In some areas, such as information technology, the ordinary course documents appear to contradict Ms. Ahern's claims. At best, Ms. Ahern's conversations with executives appear to reflect aspirations rather than fully-formed plans. As a result, many of the projected cost savings claims presented in the Deloitte Report are largely unsubstantiated.

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[52] Merger Guidelines § 10.
[53] Response Exhibit B (Deloitte Report) at ¶¶ 25–26.
[54] In nearly every savings category, Ms. Ahern employed analytical methods significantly different from Camden's. As Ms. Ahern herself explains, unlike Camden, she did not estimate staffing reductions based on "standardization relative to peer group metrics"; did not calculate supply or third-party vendor purchasing efficiencies based on "general experience"; and "did not base savings estimates on the standardization of supplies purchasing across the two hospitals." Response Exhibit B (Deloitte Report) at ¶ 18.
[55] Merger Guidelines § 10 ("[T]he Agencies consider whether cognizable efficiencies likely would be sufficient to reverse the merger's potential to harm customers in the relevant market, e.g., by preventing price increases in that market.").

- The lack of substantiation in the information technology area is especially significant because the Deloitte Report's recommendation departs dramatically from Camden's. Whereas the BPOE Report recommended creating a bridge between Cabell and St. Mary's separate electronic health records platforms, the Deloitte Report's savings estimates are premised on the notion that Cabell will implement the Cerner Millennium system as a single platform across both hospitals. But deposition testimony on Cabell's actual plans is conflicting, and the Assurance of Voluntary Compliance requires that Cabell and St. Mary's establish an integrated and interactive medical record system "[i]n the manner set forth the in the BPOE."[56] Moreover, although it is widely known that implementing a new EHR platform across hospitals is enormously expensive, the Deloitte Report projects a net savings in the information technology area, based on unsubstantiated claims about Cabell and St. Mary's stand-alone plans. In sum, the Deloitte Report's savings estimates in the IT area are not reliable.

- The Deloitte Report's projections of certain staffing cuts differ from those made in the BPOE Report, and many other staffing cuts are presented without adequate explanation or substantiation.

- The Deloitte Report's savings projections for medical and other hospital supplies, as well as certain professional fees, rely on a price-matching analysis that compares the prices that Cabell and St. Mary's pay for products and services and assumes that the combined entity will purchase at the lower of the two prices. However, the Deloitte Report provides no explanation of why the price differential exists today, why we should expect the price differential to be eliminated post-acquisition, why Cabell and St. Mary's could not independently obtain the better prices that the other receives today, or why these savings are unique to Cabell and St. Mary's and could not be achieved through an alternative merger or acquisition. In addition, in several areas, the Deloitte Report extrapolated estimates based on analysis of a limited set of purchases to the full range of Cabell's and St. Mary's purchases, without any explanation of why the limited set analyzed is representative of the whole.

- Under the Merger Guidelines, merging parties bear the burden of showing that their proposed efficiencies are merger-specific.[57] For many savings categories, the Deloitte Report fails to meet this burden. For example, for projected savings relating to supply purchasing and professional fees, Ms. Ahern has not demonstrated why her claimed savings—which do not appear to depend on proximity or any other factors unique to Cabell and St. Mary's—are unlikely to result from other transactions that constitute real, practical alternatives to the acquisition of St. Mary's by Cabell. Also, Ms. Ahern does not examine the potential for Cabell and St. Mary's to improve their productivity or achieve better pricing for supplies and services independently. Ms. Ahern simply asserts,

[56] *In re Cabell Huntington Hospital, Inc.'s Acquisition of St. Mary's Medical Center*, Assurance of Voluntary Compliance, Nov. 4, 2015, at 10.
[57] Merger Guidelines § 10.

based on statements by hospital executives, that both Cabell and St. Mary's "are currently operating as leanly [sic] possible."[58]

- The Merger Guidelines require efficiencies estimates to be reduced by any costs that are produced by the merger or incurred in achieving efficiencies.[59] The proposed cooperative agreement presents a substantial offsetting cost that must be accounted for—namely that St. Mary's employee salaries are significantly lower than Cabell employee salaries,[60] and are likely to be increased to levels closer to Cabell salaries as the two organizations are integrated. The Deloitte Report disagrees, claiming that the compensation gap will be closed through a "convergence plan" that would freeze some Cabell employee salaries for at least six years.[61] This proposal—first identified in the Deloitte Report—is unrealistic and, if put into place, could potentially harm hospital quality. Instead, an increase in St. Mary's salaries remains the most likely path to salary convergence. This represents a substantial cost likely to result from the proposed cooperative agreement, and any estimate of cost savings must be reduced accordingly.

Apart from providing the Deloitte Report, Applicant has put forth no new evidence or arguments regarding its claimed benefits from the transaction. In particular, Applicant has not rebutted FTC staff's arguments that its claims regarding improved quality of care are unsubstantiated and not merger-specific.[62] Further, Applicant did not respond to FTC staff's arguments regarding the lack of meaningful remedies in the cooperative agreement application. As noted in Section VI of FTC staff's submission, the application lacks any plan of separation that would allow the Authority to break up Cabell and St. Mary's should they fail to live up to their commitments. As a result, it may be challenging, perhaps impossible, for the Authority to remedy any breach of the proposed cooperative agreement should the merging parties fail to keep their commitments. In sum, it has been 18 months since Cabell and St. Mary's signed their Definitive Agreement, and they still cannot tell the Authority or the community what their specific plans are, when they will be achieved, how they will be achieved, and how much they will cost. As a result, the Authority does not have before it reliable benefits to weigh against the likely competitive harm.

V. APPLICANT MISCHARACTERIZES FTC STAFF'S DECLARATION PROCESS AND ITS OWN LETTERS OF SUPPORT

In its Response, Applicant makes a number of misrepresentations regarding the third party declarations cited in FTC staff's submission.[63] Contrary to Applicant's baseless claims,

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[58] Response Exhibit B (Deloitte Report) at ¶ 222.
[59] Merger Guidelines § 10.
[60] 2014 Cabell UFR; 2014 St. Mary's UFR; 2013 Cabell UFR; 2013 St. Mary's UFR; 2012 Cabell UFR; 2012 St. Mary's UFR; 2011 Cabell UFR; 2011 St. Mary's UFR (available at http://www.hcawv.org/vs5FileNet/qspec.aspx).
[61] Response Exhibit B (Deloitte Report) at ¶ 136, fn. 233.
[62] In particular, FTC staff's quality of care expert, Dr. Patrick Romano, concluded that virtually all of the Applicant's quality-improvement claims, including claims relating to population health management, were too vague to be credited or were unlikely to be realized, and that even those quality efficiencies that might be achievable could be pursued independently or through alternative mergers or affiliations. Dr. Romano's report is attached to this reply as Attachment 3.
[63] Response at 9.

FTC staff's declarations were developed through a standard process that typically involved multiple interviews with witnesses and a detailed review and editing process by the witness to ensure accuracy and truthfulness.[64] Further, declarations obtained by FTC staff were signed by the witness under oath, unlike the letters of support that Applicant touts. Applicant's claim that FTC staff's role in the drafting process invalidates the declarations is particularly surprising given that nearly all of the letters of support Applicant submitted to the HCA were form letters drafted by Applicant.[65]

Applicant places particular emphasis on the letters of support it has obtained from certain health plans. But these letters of support should not be taken as evidence that the proposed cooperative agreement will be good for consumers. As discussed previously, evidence in the record and FTC staff's experience in certain hospital merger cases demonstrate that health plans may publicly support a merger that might be anticompetitive in order to preserve their post-merger business relationship with the merging hospitals or for other business reasons that do not necessarily align with preserving competition for the benefit of consumers.

Further, the Merger Guidelines warn that a customer's support for a merger should not be taken as evidence a merger is competitively benign when that customer is able to pass on anticompetitive price increases to end consumers:

> When direct customers of the merging firms compete against one another in a downstream market, their interests may not be aligned with the interests of final consumers, especially if the direct customers expect to pass on any anticompetitive price increase. A customer that is protected from adverse competitive effects by a long-term contract, or otherwise relatively immune from the merger's harmful effects, may even welcome an anticompetitive merger that provides that customer with a competitive advantage over its downstream rivals.[66]

Applicant's letters of support are suspect for two additional reasons. Many of the letters cite the Authority's rate review function as an important reason for their support of the proposed cooperative agreement. However, the West Virginia Legislature recently repealed the Authority's rate review function, and it is an open question how the views of community members would change in the absence of rate review. Furthermore, these letters of support were signed without the community members having actual knowledge of Cabell's post-acquisition plans, since Cabell has refused to make those plans public (and continues to refuse to do so).

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[64] The reference to questions about the declarations in the *Staples* case is particularly inapposite since the judge in that case ruled in favor of the FTC and granted a preliminary injunction blocking the merger of Staples and Office Depot.

[65] For example, eight of Applicant's proffered local employer letters of support contain this exact phrase: "We believe that combining Cabell and St. Mary's would be a critical step toward reversing the trend of rising healthcare costs that has afflicted the Huntington region." Letter from Appalachian Power (undated); Letter from Engines, Inc. (July 7, 2015); Letter from Jennmar Mcsweeney, LLC (June 26, 2015); Letter from Metropolitan Huntington LLC (July 1, 2015); Letter from Neighborgall Construction Company (Oct. 31, 2014); Letter from Raymond James & Associates (Feb. 10, 2015); Letter from Somerville & Company, PLLC (Nov. 14, 2014); Letter from WesBanco Bank, Inc. (June 11, 2015).

[66] Merger Guidelines § 2.2.2.

Finally, it should also be noted that multiple health plans serving the Huntington area did *not* sign letters of support for the proposed cooperative agreement.

VI. CONCLUSION

Applicant's Response contains several mischaracterizations of FTC staff's submission and of the evidentiary record. Further, Applicant's Response fails to address or rebut a number of important conclusions in FTC staff's submission, including the following:

- Cabell and St. Mary's are each other's closest competitors, so a cooperative agreement between them will significantly increase the combined entity's bargaining leverage with health plans.[67]

- Cabell and St. Mary's vigorously compete to provide high-quality care and advanced services to residents of the Four-County Huntington Area, and the elimination of that competition following the cooperative agreement would harm area patients.[68]

- The AVC's provisions are flawed and create opportunities for the combined entity to raise prices post-merger, and do not restore important quality and service competition lost through the proposed cooperative agreement.[69]

- Similarly, the WVCAL's rate and quality regulation provisions are insufficient and will create opportunities to raise prices post-merger, regardless of the Authority's or the Attorney General's best efforts to limit such price increases.[70]

- Applicant's claimed benefits from the proposed cooperative agreement are in many cases unsubstantiated, not specific to this merger, and do not outweigh the competitive harm from the proposed cooperative agreement.[71]

- Applicant has put forth no meaningful remedy that would allow the Authority to separate Cabell and St. Mary's and restore the current competitive landscape should they fail to live up to their commitments.[72] Such remedies are, in any case, difficult if not impossible to implement after the hospitals integrate.

In conclusion, FTC staff respectfully requests that the Authority deny the proposed cooperative agreement. The likely harm to consumers far outweighs the likely claimed benefits.

[67] FTC staff submission, Section IV.C.1.
[68] FTC staff submission, Section IV.D.
[69] FTC staff submission, Section V.A.
[70] FTC staff submission, Section V.B.
[71] FTC staff submission, Section VI.
[72] FTC staff submission, Section VI.

Respectfully submitted,

ALEXIS JAMES GILMAN
Assistant Director
Mergers IV Division

MARK D. SEIDMAN
Deputy Assistant Director
Mergers IV Division

Bureau of Competition
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580
(202) 326-2579
agilman@ftc.gov

MICHELLE YOST HALE
ELISA KANTOR
ELIZABETH ARENS
MELISSA DAVENPORT
JEANINE BALBACH
STEPHANIE R. CUMMINGS
NATHANIEL HOPKIN
SAM SHEINBERG
SVETLANA GANS
MICHAEL PERRY
JEANNE NICHOLS
MATTHEW D. MCDONALD
STEVE VIEUX
Attorneys

VADIM EGOUL
Legal Intern