Federal Trade Commission Supplemental Staff Submission to Indiana Health Department Regarding 2025 Certificate of Public Advantage Application of Union Health and Terre Haute Regional Hospital

Pursuant to Indiana Code 16-21-15

PUBLIC VERSION (REDACTED)
March 17, 2025

Bureau of Competition
Bureau of Economics
Office of Policy Planning

The staff of the Federal Trade Commission's ("FTC") Bureau of Competition, Bureau of Economics, and Office of Policy Planning (collectively, "FTC staff")[1] respectfully submits this supplemental public comment regarding Union Hospital, Inc.'s ("Union Health") proposed acquisition of Terre Haute Regional Hospital, L.P. ("THRH") (collectively, the "Parties") from HCA Healthcare. We appreciate the opportunity to present our views in connection with the Indiana Department of Health's ("IN DOH") review of the Parties' second Certificate of Public Advantage ("COPA") application pursuant to Indiana Code 16-21-15 ("Second Application").[2]

Last September, FTC staff submitted a lengthy public comment ("Prior FTC Comment") that urged the IN DOH to deny the Parties' first COPA Application filed on September 14, 2023 ("Original Application").[3] Our comment analyzed the proposed merger and concluded that it presented a substantial risk of serious harm to competition and consumers through higher healthcare costs, lower quality, reduced innovation, reduced access to care, and depressed wages for hospital employees. FTC staff's analysis showed that the proposed merger's effects would likely be felt most acutely by patients and hospital workers in Vigo County, where the merged entity would have a combined share of 74% of all commercially insured inpatient hospital services provided to county residents. In late November 2024, Union Health voluntarily withdrew its application just days before the IN DOH was set to make its decision.

On February 5, 2025, the Parties tried again to bring their four-year quest to merge to fruition, submitting a Second Application covering the same assets as their Original Application. FTC staff continue to have the same concerns that we raised about the Original Application. The Second Application presents little new information. Indeed, most of the content is repackaged prior material. For example, most of the attachments supporting the Second Application were appended to the Original Application, and neither hospital presented new financial documents or strategic plans. Accordingly, the analysis in the Prior FTC Comment on the Original Application still applies, and we incorporate it by reference into this supplemental comment.

This supplemental comment addresses the limited additional information advanced by the Parties since they withdrew their Original Application in November 2024.[4] Specifically, this comment discusses the Parties' newly emphasized arguments defending the proposed merger, including recent suggestions that THRH might close if the Second Application is denied. This

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[1] These comments express the views of the FTC's Bureau of Competition, Bureau of Economics, and Office of Policy Planning. These comments do not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

[2] 2025 Application for Certificate of Public Advantage Submitted by Union Hospital, Inc. and Terre Haute Regional Hospital, L.P. to Indiana Department of Health (Feb. 5, 2025), https://www.in.gov/health/cshcr/files/COPA-2025-Application-Reduced.pdf (redacted).

[3] *See* FTC Staff Submission to Indiana Health Department Regarding the COPA Application of Union Health and Terre Haute Regional Hospital (Sept. 5, 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/in_copa_comment_9-5-24_public_redacted.pdf.

[4] This supplemental comment does not address the Amended and Restated Application for Certificate of Public Advantage Submitted by Union Hospital, Inc. and Terre Haute Regional Hospital, L.P. to Indiana Department of Health on August 26, 2024, which is currently listed as "Withdrawn" on the IN DOH website. That information was not made available in time to be considered during the last public comment period that ended on September 6, 2024.

comment also explains why the Parties' purported commitments make little difference and do not adequately protect against the clear risks of anticompetitive harm.

In sum, despite their repackaging, the Parties' Second Application is effectively not so different than the original. FTC Staff continues to doubt that the regulatory conditions imposed by the IN DOH would effectively mitigate the potential anticompetitive harms to patients in the Terre Haute area—both in the near term and in the decades to come. Instead, the proposed merger is likely to lead to higher costs and worse healthcare outcomes for Indiana consumers, as well as lower wage growth for hospital workers. FTC Staff asks the IN DOH to deny the COPA and prevent the merging of Vigo County's only two hospitals.

I. The Parties' Recent Claims Do Not Support COPA Approval

A. THRH Is Unlikely to Close Without this Anticompetitive Merger

The Parties argue that, without the COPA, THRH's "ongoing operational challenges and declining trajectory" would negatively affect patients.[5] The Second Application has numerous statements about THRH's allegedly deteriorating financial and competitive position, most of which were not included in the Original Application.[6] Additionally, public-facing discussion of the COPA's merits is often framed in terms of THRH going out of business if this merger does not occur. In a recent Indiana Senate committee hearing on Senate Bill 119 ("SB 119"), which would revoke Indiana's COPA statute, Union Health CEO Steven Holman suggested as much, and some state senators followed with understandable concerns about a THRH closure.[7]

In principle, FTC staff shares the concern and never wants to see a valued hospital exit a community. But there are credible reasons to doubt Union Health's suggestions that HCA Healthcare would close THRH if the COPA is denied.[8] Notably, the Parties did not represent in their Original Application or in their Second Application that THRH would close if the COPA application is denied. When Union Health's CEO was pushed on this point at a 2021 legislative hearing on the COPA law, he predicted that THRH would not exit the market absent the merger, stating, "I do not believe the other system would leave the community."[9]

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[5] Second Application at 49.

[6] Second Application at 7–9, 57–58, 65, 67, 69, 76, 83, 95, 96 (describing THRH's declining position in the market over the last year, including financial and operational challenges, physician departures, and service line reductions).

[7] *See* Indiana General Assembly 2025 Session, Senate Health and Provider Services Committee Hearing on SB 119 (Feb. 12, 2025), https://iga.in.gov/session/2025/video/committee_health_and_provider_services_3900/. In this hearing, Union Health CEO Steven Holman said, "Some have asked, well why don't you just let [THRH] close and then just go ahead and buy the real estate and then you don't need a COPA." Senator Liz Brown asked Union Health's CEO whether he could "explain to me the difference between the hospital merging or the hospital closing." Yet another legislator, Senator Shelli Yoder, explained the predicate behind the COPA law: "We were more concerned about, were we going to lose this other hospital… What this community was saying was, we've got two hospitals, one is going to close."

[8] Representatives from HCA Healthcare, THRH's parent company, did not testify at the Senate Committee Hearing on SB 119.

[9] *See* Testimony by Steven Holman of Union Health at Indiana General Assembly 2021 Session, Senate Health and Provider Services Committee Hearing on SB 416 (Feb. 10, 2021) (emphasis added), https://iga.in.gov/session/2021/video/committee_health_and_provider_services_3900.

FTC staff closely evaluated this specific issue, analyzing THRH's financial condition based on documents provided by the Parties in their Original Application. As discussed in the Prior FTC Comment,[10] FTC staff found that THRH was profitable from 2018 to 2023 and financially stable; [redacted] Nothing in the Second Application changes FTC staff's confidence that THRH is unlikely to close without the merger. The Parties did not submit any new financial statements or other information to support the claim that THRH is in dire financial straits.

FTC staff's prior analysis of THRH's financial health was primarily based on nonpublic information, and therefore most of it had to be redacted from the public version of the Prior FTC Comment. In the interest of increased transparency to the public, FTC staff have now engaged in additional analysis, using publicly available data from the Healthcare Cost Report Information System (HCRIS). The Centers for Medicare & Medicaid Services (CMS) generates HCRIS data from cost reports that it requires from all Medicare-certified hospitals, including the Parties. The hospitals submit detailed financial information that includes revenues and expenses, and CMS then verifies the information. While the HCRIS data does not precisely match the line items in THRH's financial statements, it provides another snapshot of the financial health of the hospital.

Table 1: THRH Select Financial Indicators for Fiscal Years 2018-2022
Dollars in Thousands
(Source: HCRIS data from CMS)

	FY 2022	FY 2021	FY 2020	FY 2019	FY 2018
Total Income	$112,677	$128,919	$132,661	$139,721	$143,038
Total Cost	$96,105	$110,371	$110,777	$122,061	$125,653
Net Income	$16,572	$18,548	$21,884	$17,661	$17,385

As Table 1 shows, HCRIS data demonstrates that THRH was profitable because its net income was positive and steady between 2018–2022.[11] In 2022, THRH had a higher net income (as a percent of total income) than 83% of other hospitals in the HCRIS data. For years 2018–2021, THRH had a higher net income (as a percent of total income) than between 73–84% of all other hospitals. THRH's profitability both in absolute terms and compared to other hospitals in the United States shows no sign that it is at significant risk of closing if IN DOH denies the Second Application.

[10] *See* Prior FTC Comment at 10–14.

[11] HCRIS data for THRH is not available beyond Fiscal Year 2022. Net income is calculated from taking an aggregation of all patient revenue and all revenue from other sources and subtracting out an aggregation of all operating expenses and all other expenses. Other revenue and other expenses are provided at the discretion of THRH and are not exactly specified, so a more detailed breakdown is not possible.

B. Hospitals' Claims of Potential Closures Are Often Proven False

When facing antitrust scrutiny, merging hospitals often claim that sell-side hospitals would close without the merger, recognizing that the FTC takes such concerns seriously. But, whenever these self-serving claims are actually tested, they are nearly always proven false.[12] The Parties point to the FTC's challenge of Novant Healthcare's purchase of two CHS hospitals in their Second Application, as analogous to the hospitals' purported challenges in Vigo County.[13] Indeed, IN DOH should take a closer look at that proposed merger as it is instructive—only not in way that Union Health and THRH suggested.

When the FTC challenged Novant's purchase of two CHS hospitals in North Carolina last year, the hospital-defendants claimed that CHS's two hospitals would fail without the merger: "[these hospitals] cannot afford to continue sustaining losses" and "there is no buyer waiting in the wings to rescue these hospitals."[14] One CHS hospital, Lake Norman Regional, was supposedly "small and declining, lacking the network and resources to be a viable competitive option for patients," with utilization and quality metrics that were allegedly poor and declining.[15] CHS also claimed that the smaller hospital—Davis Regional Psychiatric—would certainly go out of business.[16]

FTC analysis contradicted this testimony, demonstrating, among other things, that Lake Norman Regional was still providing quality healthcare to patients.[17] The district court credited the hospital executives' fearmongering and denied the FTC's request for a preliminary injunction.[18] But an appellate court later enjoined the acquisition pending appeal and the hospital-defendants abandoned the merger.[19] Despite the hospital-defendants' insistence that no other buyer would step in and its suggestion that the two struggling hospitals could fail, two alternate buyers quickly purchased CHS's hospitals shortly after the merger fell through.

Both hospitals still serve their local communities today, a point that Union Health and THRH have failed to mention to the IN DOH.[20] In December 2024, after Novant and CHS terminated their merger agreement, Duke University Health System bought the so-called "small

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[12] *See* Table 2, *infra,* and accompanying text. *See also* David Balan, *Hospital Mergers That Don't Happen*, NEJM CATALYST (Oct. 24, 2016) ("Stepping back, we can see that in all four cases whose final disposition is known, alternative affiliations were ultimately made.").
[13] Second Application at 50.
[14] FTC v. Novant Health, Case No. 5:24-cv-00028-KDB-SCR, Defendants' Amended Opposition to Plaintiff's Request for Preliminary Injunction, at 8–9.
[15] *Id*. at 5–6 (cleaned up).
[16] FTC v. Cmty. Health Sys., 736 F. Supp. 3d 335, *345 (W.D.N.C. 2024).
[17] *Id*. at *357.
[18] *Id*. at *346.
[19] FTC v. Novant Health, Inc., 2024 U.S. App. LEXIS 14787 at *4, (4th Cir. 2024).
[20] The Parties stated that CHS "had no other bidders for the hospitals despite reasonable efforts to sell them to others. The court found that under these circumstances the public interest favored allowing the merger to proceed rather than risk the loss of services from the community. The same is true in Terre Haute." Second Application at 50. What the Parties fail to mention is that CHS quickly found other bidders for the hospitals after the Novant/CHS transaction fell through, and those hospitals are still in service today. FTC staff believe this would also be a likely outcome in Terre Haute, based on our analysis of THRH's financial condition as stable.

and declining"[21] Lake Norman hospital from CHS for $280 million, a similar price to Novant's offer. Duke Health announced that, with the acquisition, it would support hospital providers and employees in their mission to deliver exceptional care.[22] Another healthcare system, Iredell Health, purchased Davis Regional Psychiatric, the smaller CHS hospital. Iredell's President and CEO said that the hospital is "an important investment in our community and allows us to continue to expand with those needs."[23]

As the Novant/CHS example shows, FTC staff's rigorous analysis of hospitals' performance has consistently proven to be more accurate than hospital executives' self-serving statements. The FTC takes hospital closure concerns seriously and has not challenged mergers with hospitals that are truly failing financially and cannot remain viable without the proposed acquisition. In numerous mergers that cannot be disclosed due to confidentiality protections, the FTC has not intervened in such circumstances. One public example is the FTC's closed investigation into the Scott & White Healthcare's acquisition of King's Daughter Hospital in Texas. There, the evidence revealed that King's Daughter's financial condition would have likely caused the hospital to close in the future and there were no other viable buyers.[24] The FTC did not challenge the merger even though it presented competitive concerns.

In fact, a review of FTC challenges to hospital mergers from the past decade, shown below, reveals that none led to any hospitals shutting down or terminating services in local communities.[25]

Table 2: Antitrust Hospital Merger Challenges

Antitrust Merger Challenge	**Result of Merger Challenge**	**Sell-side hospital closed?**	**Current state of sell-side hospital?**
Novant/CHS	2024—hospitals abandoned merger after court decision	No	Hospitals still in business, purchased by another entity
John Muir/San Ramone Medical Center	2023—hospitals abandoned merger	No	Hospital still in business with prior ownership structure

[21] FTC v. Novant Health, Case No. 5:24-cv-00028-KDB-SCR, Defendants' Amended Opposition to Plaintiff's Request for Preliminary Injunction, at 5.
[22] Duke Health, *Duke Health to Acquire Lake Norman Regional Medical Center* (Dec. 11, 2024), https://corporate.dukehealth.org/news/duke-health-acquire-lake-norman-regional-medical-center.
[23] Susanna Vogel, *CHS Offloads Two North Carolina Hospitals to Iredell Health*, HEALTHCARE DIVE (Oct. 3, 2024), https://www.healthcaredive.com/news/chs-iredell-health-hospitals-acquisition-north-carolina/728790/.
[24] Fed. Trade Comm'n, Statement of Bureau of Competition Director Richard Feinstein on the FTC's Closure of its Investigation of Consummated Hospital Merger in Temple Texas (Dec. 23, 2009), https://www.ftc.gov/sites/default/files/documents/public_statements/ftcs-closure-its-investigation-consummated-hospital-merger-temple-texas/091223scottwhitestmt.pdf.
[25] FTC staff relied on public information to determine the current operating status and ownership of each hospital the FTC prevented from being acquired by a competitor within the last ten years. FTC staff involved in this comment are also unaware of any hospital closures following pre-2015 FTC merger challenges.

Antitrust Merger Challenge	Result of Merger Challenge	Sell-side hospital closed?	Current state of sell-side hospital?
	after antitrust challenge announced		
Hackensack Meridian/Englewood	2021—hospitals abandoned merger after court decision	No	Hospital still in business with prior ownership structure
HCA/Steward	2021—hospitals abandoned merger after antitrust challenge announced	No	Hospitals still in business, purchased by another entity
Advocate/Northshore	2017—hospitals abandoned merger after court decision	No	Hospital still in business with prior ownership structure
Hershey Medical Center/Pinnacle Healthcare	2016—hospitals abandoned merger after court decision	No	Hospitals still in business, purchased by another entity

C. FTC's Public Comments Are Tailored to the Union Health/THRH Acquisition

Union Health has recently suggested that FTC staff's public comments should be discounted because the FTC opposes COPAs generally and that FTC staff's public comments opposing different COPAs are virtually identical.[26] Union Health ignores that the FTC issued civil investigative demands to Union Health and HCA/THRH and reviewed thousands of business documents to investigate this particular proposed merger. Our team consisted of lawyers, economists, and financial analysts who evaluated the specifics of the proposed Union Health/THRH merger and clearly presented our analysis of it in the Prior FTC Comment.[27]

To be sure, many COPAs present similar issues, and the FTC most frequently weighs in where there are competitive concerns. For context, very few proposed hospital mergers involve a COPA application. Many hospital mergers present no competitive concerns after preliminary FTC review. By contrast, COPA applications often involve a considerable cost and delay for merging hospitals. And, if approved, a COPA often imposes significant regulatory burdens on the merging hospitals and the state. Therefore, in many cases, a rational hospital would only pursue a COPA if necessary to immunize the merger from the antitrust laws. Unsurprisingly, the FTC

[26] Indiana General Assembly 2025 Session, Senate Health and Provider Services Committee Hearing on SB 119 (Feb. 12, 2025), https://iga.in.gov/session/2025/video/committee_health_and_provider_services_3900/.
[27] *See, e.g.*, Prior COPA Comment at 10–14 (financial condition), 23–27 (market shares), 20–23 (diversion ratios), and 57–59 (labor analysis).

finds that most mergers subject to COPAs would likely result in price increases, declines in quality of care, and lower wages for hospital employees.

Union Health's CEO suggested that the IN DOH should approve this anticompetitive merger because opponents have not offered sufficient alternative means to improve public health outcomes facing Vigo County.[28] This argument misses the point. The main goal of blocking a proposed anticompetitive hospital merger is to prevent the status quo from getting worse due to a loss of competition. Union Health is already the largest healthcare provider in Vigo County with wide responsibility for the patient population. If the population currently faces serious health challenges, eliminating Union Health's closest competitor is unlikely to improve conditions. Indeed, if the IN DOH denies the Parties' Second Application and finally puts an end to their four-year-long quest to merge, Union Health and THRH will regain their full incentive to compete with one another on quality, accessibility, and price.[29]

D. Public Concerns About the Ballad Health COPA Are Relevant to IN DOH's Analysis

In the Prior FTC Comment, FTC staff provided detailed information about the Ballad Health COPA in Tennessee and Virginia that may be useful to the IN DOH as it evaluates the Union Health/THRH COPA application. In the recent Senate committee hearing, Union Health CEO Steven Holman complained that it was inappropriate to compare its proposed COPA to that of Ballad Health,[30] which has been the subject of public criticism in the time since its COPA was implemented in 2018. Mr. Holman further stated that he has spoken with the CEO of Ballad Health, who claimed that Ballad Health has been successful and that the public criticism was based on cherry-picked data.[31]A 2024 news article stated, "Ballad has failed to meet the baseline values on 75% or more of all quality measures in recent years—and some are not even close—according to reports the company has submitted to the health department."[32] FTC staff continues to believe that public concerns expressed about Ballad Health are relevant to the IN DOH's consideration of the proposed Union Health COPA.[33]

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[28] Indiana General Assembly 2025 Session, Senate Health and Provider Services Committee Hearing on SB 119 (Feb. 12, 2025), https://iga.in.gov/session/2025/video/committee_health_and_provider_services_3900/ ("the state of Indiana is being used on a national thing against hospital mergers…But really not one person, every time is an article gets picked up has called me and said hey here's three more ideas to improve the health of the community because you don't need a COPA.").
[29] *See* Prior FTC Comment at 34–35.
[30] Indiana General Assembly 2025 Session, Senate Health and Provider Services Committee Hearing on SB 119 (Feb. 12, 2025), https://iga.in.gov/session/2025/video/committee_health_and_provider_services_3900/.
[31] Indiana General Assembly 2025 Session, Senate Health and Provider Services Committee Hearing on SB 119 (Feb. 12, 2025), https://iga.in.gov/session/2025/video/committee_health_and_provider_services_3900/ (Steve Holman: "I want to tell you I've been in constant contact with the CEO of Ballad Health, and what he tells me is there has been cherry picked data….").
[32] Brett Kelman, *Tennessee Gives This Hospital Monopoly an A Grade – Even When It Reports Failure*, KFF HEALTH NEWS (May 29, 2024), https://kffhealthnews.org/news/article/tennessee-a-grade-ballad-health-hospital-monopoly/.
[33] *See* FTC Prior Comment for more detailed discussion of the public criticism of Ballad Health. *See also* Brett Kelman and Samantha Liss, *These Appalachia hospitals made big promises to gain a monopoly. They're failing to deliver*, USA TODAY (Sept. 29, 2023), https://www.usatoday.com/story/news/nation/2023/09/29/ballad-health-hospitals-fall-short-quality-and-charity-care/70975091007/.

FTC staff relies on a large body of research and studies regarding hospital consolidation when evaluating hospital mergers operating under COPAs. In 2022, FTC staff issued a COPA Policy Paper and Key COPA Facts describing studies of prior COPAs in North Carolina, Montana, and Maine, finding that they resulted in higher prices and reduced quality of care, despite regulatory commitments designed to mitigate these anticompetitive effects.[34] This research collectively demonstrates the difficulty of implementing a COPA and monitoring a hospital monopoly in perpetuity with the goal of achieving better results than through competition.

That said, the Ballad Health COPA is also relevant to our analysis as it involves ostensibly the most rigorous state COPA oversight that we have observed. Yet there are still significant concerns about its effectiveness in mitigating the harmful effects of the underlying hospital merger. Since staff filed the Prior FTC Comment, the Tennessee COPA Monitor for Ballad Health from 2018–2024 said that the state's lenient grading system allowed Ballad Health to continue operating under the COPA even when Ballad Health failed to meet the state's quality-of-care goals; he is unconvinced that the state-sanctioned monopoly had prevented any hospital closures or benefited local residents overall.[35] The IN DOH should heed his warning as it evaluates whether COPA oversight would prevent harm to patients, employers, and healthcare workers from the proposed combination of the only two hospitals in Vigo County.

Furthermore, the terms and conditions Ballad Health agreed to when its COPA was approved have been amended four times since 2018,[36] arguably weakening the commitments that were supposed to protect the public from anticompetitive effects of the merger. In addition, the terms and conditions were suspended for two years during the COVID-19 pandemic.[37] Similarly,

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[34] *See* Fed. Trade Comm'n, FTC POLICY PERSPECTIVES ON CERTIFICATES OF PUBLIC ADVANTAGE 3–4 (2022), https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf.

[35] *See* Brett Kelman, *The Only Hospital in Town: Six Years Into an Appalachia Hospital Monopoly, Patients Are Fearful and Furious*, KFF HEALTH NEWS (Dec. 6, 2024), https://kffhealthnews.org/news/article/ballad-health-tennessee-virginia-hospitals-merger-monopoly-complaints/.

[36] At the request of Ballad Health, the Tennessee Department of Health has amended the COPA Terms of Certification ("TOC") four times during the first five years of the COPA. *See* Fourth Amended and Restated Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health (Jul. 1, 2023), https://www.tn.gov/content/dam/tn/health/documents/copa/FourthAmendedandRestatedTOCGoverningtheCOPA_FINAL.pdf. Some of the modifications to the original TOC include the following: multiple changes to the methodology used to calculate pricing limitations; multiple changes to the target quality measures used to evaluate Ballad Health's performance; expanding the physician employment cap in certain specialty areas; altering Ballad Health's annual spending commitment in the local community; and lifting prohibitions on Ballad Health's ability to enter into noncompete agreements with physicians and oppose certificate of need applications filed by potential new entrants into the market. *See also* Letter from Morgan McDonald, Tennessee Dep. of Health Commissioner to Alan Levine, CEO of Ballad Health (Dec. 20, 2022), https://www.tn.gov/content/dam/tn/health/documents/copa/2022-12-20-TDH-AG-response-to-Ballad-A1-rate-cap-request.pdf ("We encourage Ballad to negotiate vigorously for appropriate market-based increases. No provision specifically prohibits Ballad from seeking increases, even from Standard Payors . . . up to or even exceeding the Addendum 1 Rate Cap.").

[37] The Ballad Health COPA TOC were suspended from March 2020 through July 2022, which may have created an opportunity for Ballad Health to increase its prices without regard to the rate regulations it normally would have been subject to under the COPA agreement. *See* Letters from Tennessee Attorney General Herbert Slatery to Alan Levine Regarding Suspension of TOC Provisions, Chairman & CEO of Ballad Health dated Mar. 31, 2020, https://www.tn.gov/content/dam/tn/health/documents/copa/2020-03-31%20Temporary%20Suspension-Letter%20-

in the Parties' Terms and Conditions, there is a process for modifying the commitments that Union Health has proposed.[38] If the COPA is approved, there is no guarantee that these commitments would continue unchanged, which would cast further doubt on the COPA's effectiveness.

E. IN DOH Should Consider State-Wide COPA Effects and the Impact on All Patients

The parties indicate in the Second Application and in recent public statements that the proposed merger's impact is limited to Vigo County and the surrounding service area.[39] Union Health echoed this sentiment at the Senate Health and Provider Services Committee Hearing on SB 119 on February 12, 2025.[40] However, IN DOH should consider the costs of the proposed merger that extend beyond the immediate service area.

Although the primary locus of merger effects is Vigo County, any impact would still be felt across the state. Several businesses headquartered elsewhere in Indiana (e.g., Steel Dynamics, Ivy Tech Community College, Green Leaf., Inc.) have Terre Haute-based employees. Such businesses would directly experience higher costs if hospital and physician prices increased for employees in and around Vigo County.

Similarly, the state itself would also be forced to absorb increased healthcare costs for state employees that live in Vigo County. For example, Indiana State University has many employees in Vigo County. Any increase in healthcare costs for those employees on the state health plan would come out of the state's budget. And while the legislation provides that the hospitals would cover "reasonable costs" of COPA oversight,[41] there would still be state employees and resources devoted to monitoring Union Health as the law requires active supervision.

Finally, the proposed merger's competitive harm would also extend beyond commercially insured patients and affect patients insured by Medicare and Medicaid. These patients would experience any decline in quality of care as well as reduced access to services–stemming from longer travel and wait times, consolidated facilities and services, less investment in available technology and equipment, and other restrictions.[42]

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executed.pdf, and Dec. 3, 2021, https://www.tn.gov/content/dam/tn/health/documents/copa/2021-12-03-AG-and-TDH-Reasonable-Recovery-Letter-to-Ballad.pdf.

[38] *See* Second Application COPA Terms and Conditions at 14 ("Union Hospital may at any time notify the Department and request one or more modifications to the Terms and Conditions due to changes in circumstances that have materially affected its ability to comply with one or more of the Terms and Conditions . . .").

[39] *See, e.g.,* Second Application at 31 ("this should not be interpreted as a disregard for the health care costs paid by the residents of Vigo County and the other counties in the Service Area, or by health care payors."), at 33 ("Union Hospital has no plans to reduce the types of health care services provided to the residents of Vigo County or the other counties of the Service Area").

[40] Indiana General Assembly 2025 Session, Senate Health and Provider Services Committee Hearing on SB 119 (Feb. 12, 2025), https://iga.in.gov/session/2025/video/committee_health_and_provider_services_3900/ (Sen. Bohacek: "So, this [COPA] does not impact anywhere else in the state, correct?" Sen. Goode: "Correct." Sen. Bohacek: "Okay so for me this is no different than a food and beverage tax.").

[41] I.C. § 16-21-15-6.

[42] *See* Prior FTC Comment at 17, 44.

F. Union Health's Sunk Costs Should Not Justify State Approval

At the recent Senate committee hearing on SB 119, Union Health suggested that its Second Application should be approved because it spent several years and $3 million complying with the IN DOH's requests.[43] But Union Health's gamble is not a reason to approve the Second Application. Union Health made a business decision to apply for a COPA despite obvious competitive concerns with its plan to acquire its closest competitor. Union Health knew that it would incur time and financial costs associated with the application, even if the IN DOH ultimately denied its COPA application as contrary to the state's interest.

Further, Union Health has largely controlled the timing throughout this process. It has pursued this COPA for years, first lobbying to enact the COPA law in 2021, then submitting its COPA application in September 2023. The Parties had ample chance to provide information supporting their COPA in the 14 months that IN DOH reviewed the Original Application. But, in late November 2024, Union Health voluntarily withdrew its application just days before the IN DOH's decision deadline of December 4, 2024. Had Union Health not withdrawn its Original Application, the COPA process would already be completed.

II. The Parties' Proposed Commitments Would Not Prevent the Likely Competitive Harm

The Parties' Second Application offers 45 purported "commitments" that they claim would mitigate the competitive harms resulting from the proposed merger.[44] The Parties professed that they designed new commitments to address the IN DOH's feedback on the Original Application, as well as the many concerns expressed in the public comments submitted to the IN DOH.[45] At first glance, the commitments may appear to be a significant development. Upon closer look, however, most of these commitments are not substantively new; they are merely repackaged content from the Original Application, much of which FTC staff already addressed in the Prior FTC Comment. The limited new commitments are largely aspirational and do not change our concerns with their COPA Application.

We provide this analysis of the proposed commitments, following the order of the Parties' Second Application Exhibit B. Attachment A is a table that walks through FTC staff's responses to each of these commitments and complements this section. We also identify which of the commitments are merely recycled material and include cross-references to the Original Application and the Prior FTC Comment that provides more detailed information on the commitments.

We note at the outset that, in addition to their individual limitations, these 45 alleged commitments also suffer from questionable enforceability. Each of them includes an "Accountability Mechanism" that requires annual reporting and addressing "Noncompliance"

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[43] *See* Indiana General Assembly 2025 Session, Senate Health and Provider Services Committee Hearing on SB 119 (Feb. 12, 2025), https://iga.in.gov/session/2025/video/committee_health_and_provider_services_3900/.

[44] See Second Application Exhibit B (Commitments) for a complete list of the 45 commitments. These are also repeated throughout the main Second Application that is publicly available on the IN DOH's website, at 69–97.

[45] Staff Report, *Union Health Discusses Key Differences Between Its Two COPA Applications*, TRIBUNE-STAR (Mar. 5, 2025), https://www.tribstar.com/news/local_news/union-health-discusses-key-differences-between-its-two-copa-applications/article_8d22581a-f91b-11ef-88ce-0b668404b80a.html.

under proposed Terms and Conditions. These Terms and Conditions resemble what other states have tried, with limited success, to achieve the promised benefits of COPAs. Specifically, the Terms and Conditions provide that in the event of noncompliance, the IN DOH may issue a plan of correction, impose a fine (any amount is unspecified and must be reasonable based on impact), or revoke the COPA. The Prior FTC Comment discusses our concerns with these types of remedies, including evidence that similar remedies have failed in other states.[46] In theory, a plan of correction or fine could offer some deterrence. In reality, however, it would be extremely difficult to force the Parties to achieve the commitments through such mechanisms. For example, a plan of correction or fine to address failures to report quality metrics would not force the Parties to actually maintain or improve their quality.[47]

The last option of revoking the COPA is the opposite of a deterrent. Withdrawing the COPA after Vigo County's only two hospitals merge would not restore competition. Instead, it would merely remove state oversight of a dominant healthcare provider, and once hospital assets are consolidated, antitrust enforcement to restore the lost competition would be extremely difficult and highly unlikely.[48]

A. Quality Commitments

The Second Application proposes three quality commitments that the Parties claim would "ensure that the quality of health care services provided in the Service Area does not decline as a result of the Merger."[49] However, none of them would actually require Union Health to maintain or improve its quality of care. Plus, they are all repackaged material from the Original Application.

Quality Commitment #1 restates Union Health's plan to implement a common clinical IT platform across the Combined Enterprise, which they claim would "support quality improvement, care management, and population health improvement efforts."[50] Union Health already identified this platform in the Original Application, though they revised their cost and completion time estimates.[51] And FTC staff addressed it in the Prior FTC Comment, noting that the benefits of devoting time and resources to this effort may be overstated and unnecessary to improve quality of care.[52]

Quality Commitments #2 and #3 restate Union Health's plan to report quality measures and patient satisfaction measures in its Annual Report, so that the IN DOH can monitor its performance post-merger.[53] FTC staff addressed the limitations of quality reporting

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[46] *See* Prior FTC Comment at 66–69, 71–73.
[47] *See* Prior FTC Comment at 68 ("Due to the complexities of assessing quality, no mechanism exists to impose a conduct remedy sufficient to offset a loss of quality competition. It is difficult to envision how a supervisor of the COPA would be able to effectively force the combined hospital system to achieve a particular quality metric.").
[48] *See* Prior FTC Comment at 71–74.
[49] Second Application Exhibit B at 1.
[50] Second Application Exhibit B at 1.
[51] The only change in the Second Application is an increase in the associated time and money to complete the effort. Original Application at 31 (claiming this effort would cost $15 million and take one year to complete, compared with the revised $17.5 million and 24 months estimate).
[52] *See* Prior FTC Comment at 42–44.
[53] Second Application Exhibit B at 1–2. *See also* Original Application at 44–45.

commitments in the Prior FTC Comment.[54] Merely reporting these measures does nothing to guarantee improvements. Also, publicly reporting these measures would offer little benefit to patients post-merger, because they would no longer have an alternative Vigo County hospital to which to switch for general acute care services if Union Health reported poor quality and patient satisfaction. While the Parties now identify the specific metrics they would report in the Second Application,[55] the limitations FTC staff previously described still apply.

B. Pricing Commitments

The Second Application proposes eight pricing commitments that the Parties claim would "ensure that the Merger does not lead to a significant increase in the cost of health care services provided by the Combined Enterprise."[56] However, these commitments would be difficult for IN DOH to implement and monitor and are unlikely to constrain costs. Only Pricing Commitment #2 is new; the other seven were already included in the Original Application.

Pricing Commitment #1 and Pricing Commitment #2 propose rate regulations that are fully described in an Addendum to the Parties' Exhibit B.[57] Putting aside whether these regulations would actually work, both commitments last for seven years at most, after which there would be no charge protections for affected patients and employers. Furthermore, the rate regulations could end even earlier if Union Health voluntarily terminates the COPA after five years, which is allowed under the COPA Act,[58] and the IN DOH decides it is no longer necessary per the Terms and Conditions.[59] Evidence from other COPAs demonstrates that hospitals often exploit the end of price controls by dramatically increasing prices once a COPA is terminated. For example, Mission Health in North Carolina increased its commercial inpatient prices by at least 38% and Benefits Health in Montana increased its commercial inpatient prices by at least 20% following the termination of their respective COPAs.[60] These commitments are no substitute for the protection provided by competition.

Pricing Commitment #1 is already required by the COPA Act. It states Union Health "will not increase the charge for each individual service the Combined Enterprise offers by more than the increase in the preceding year's annual average of the Consumer Price Index for Medical Care."[61] The Prior FTC Comment describes how using the medical care CPI as a benchmark for future price increases would be insufficient to contain costs and is a poor substitute for pricing pressure from competition.[62] Also, it may not apply to evolving delivery and payment models, as it only attempts to limit Union Health's ability to raise prices under existing fixed-rate contracts.

[54] *See* Prior FTC Comment at 71, 74.
[55] *See* Second Application Exhibit B, Addendum 1 (Quality Measures) and Addendum 2 (Patient Satisfaction Measures). Some of these measures were identified in the Original Application, where the Parties acknowledge that most of the metrics are a requirement for participation in federal programs for acute care hospitals. *See* Original Application at 44.
[56] Second Application Exhibit B at 2–5.
[57] Second Application Exhibit B, Addendum 3 (Pricing Limitations).
[58] I.C. § 16-21-15-5. *See* Prior FTC Comment at 72–73 for a full discussion of the potential consequences of this provision.
[59] *See* Union Health COPA Terms and Conditions § 9.3.
[60] *See* FTC Key COPA Facts, https://www.ftc.gov/system/files/ftc_gov/pdf/Key_COPA_Facts.pdf.
[61] Second Application Exhibit B at 2.
[62] *See* Prior FTC Comment at 69–70.

Furthermore, the language in the statute is ambiguous as to whether this would apply to increases in the chargemaster or actual rates negotiated with payors. If the Parties interpret this as a limit on chargemaster increases, then it may not limit price increases at all. Although the hospitals do extend the time period covered by Pricing Commitment #1 to seven years, as noted above, it is still unlikely to be an effective mechanism for controlling costs.

Pricing Commitment #2 states Union Health would limit price increases in payor negotiations in compliance with Addendum 3. They state this commitment "will help mitigate the risk of significant health care cost increases by limiting the rates that Union Hospital may negotiate with payors post-Merger with respect to the Combined Enterprise."[63] However, FTC staff identified several potential weaknesses that the IN DOH should discuss with payors when evaluating this Commitment, including:

In addition to FTC staff's concerns with Addendum 3, we encourage the IN DOH to speak directly with all categories of payors identified in the Addendum to fully assess the potential effects of Pricing Commitments #1 and #2. Payors are in the best position to understand how the various rate formulas and compliance processes would work, as well as the possible ways that Union Health may be able to circumvent the spirit of the pricing commitments. Notably, Addendum 3 and the Terms and Conditions do not appear to be publicly available on the IN DOH's website, which does not allow payors and other stakeholders to assess the potential effectiveness (or lack thereof) of the purported pricing limitation. Generally, these types of price limitations are difficult to administer (particularly when the price commitment language is ambiguous and subject to interpretation, like it is here) and are unlikely to protect consumers from anticompetitive price increases.

[63] Second Application Exhibit B at 3.
[64] *Id.*

Pricing Commitment #3 states that Union Health would implement its chargemaster for all services provided across the Combined Enterprise. This proposal was also included in the Original Application and FTC staff have already addressed it in the Prior FTC Comment.[65] In general, a hospital's chargemaster may not reflect the actual rates it negotiates with individual payors and Union Health may not always offer lower contract rates than THRH. For this reason, limitations based on a hospital's chargemaster are unlikely to effectively control prices.

Pricing Commitments #4–8 are general commitments to negotiate in good faith with payors. These were also included in the Original Application, and FTC staff already addressed them in the Prior FTC Comment.[66] The bottom line is that the hospitals should already act in good faith. These commitments still fail to define exactly what would be required of the Parties and provide no objective assurance that they would be achieved.

C. Preservation of Access Commitments

The Second Application proposes ten "Preservation of Access Commitments" the Parties claim would "ensure the Merger does not have a negative impact on access to health care services."[67] However, many of them involve service lines or facilities that have already been identified for consolidation or repurposing in the Original Application—which means there would likely be a reduction in patient access—and FTC staff already addressed these situations in the prior FTC Comment.[68] All of these purported commitments would also only apply for the duration of the COPA, so there would be no long-term patient access guarantee. Even during the COPA term, there is still a process to allow Union Health to make material service line changes.

Access Commitment #1 claims to "maintain inpatient acute care facilities"[69] and Access Commitment #2 promises to "maintain Emergency Rooms at both the Union Hospital facility and Regional Hospital facility during the COPA Term."[70] The Original Application included these same plans.[71] Even if Union Health honors these commitments and maintains both hospital facilities post-merger, the community would still not receive the full benefits of competition. As the owner of both Vigo County hospitals, Union Health would no longer have an incentive to improve quality of care and access to services at one hospital in order to attract patients from the other. Moreover, once the COPA ends, there is no guarantee that Union Heath would maintain both facilities.

Access Commitment #3 offers to "maintain at least a Level III trauma program at the Union Hospital facility during the COPA Term."[72] As the Parties' own actions demonstrate, this purported commitment is no substitute for competition. Before the Parties decided to merge, Vigo County residents benefited from Level III trauma centers at both local hospitals. Nearly a year after the Parties signed their merger agreement, THRH discontinued its Level III trauma

[65] *See* Prior FTC Comment at 51–52.
[66] *See* Prior FTC Comment at 52, 73–74.
[67] Second Application Exhibit B at 5.
[68] *See* Prior FTC Comment at 36–40.
[69] Second Application Exhibit B at 5.
[70] *Id.*
[71] *See* Original Application at 37.
[72] Second Application Exhibit B at 5.

center in August 2024—prior to merger/COPA approval.[73] So not only was this service line already identified for consolidation in the Original Application,[74] THRH proceeded with the shutdown before COPA approval. Normally merging hospitals must maintain assets and continue competing against each other until the merger actually closes. The Parties should not benefit from a claim that they would preserve access to the only Vigo County Level III trauma center remaining, after their merger agreement likely already reduced residents' Level III trauma center access.

Access Commitment #4 offers to "maintain an Intensive Care Unit (ICU) at the Union Hospital facility during the COPA Term" and to increase the number of ICU beds at Union Hospital from 24 to 36 within three years.[75] This commitment is nothing more than a sleight of hand because the Parties' Original Application already planned to consolidate ICUs,[76] which would reduce access to ICU services available to THRH patients. Also, once the COPA ends, there is no guarantee that Union Health would maintain adequate ICU services in the long term.

Relatedly, Access Commitment #5 states that within one month of the proposed merger, "Union Hospital will convert the Regional Hospital ICU into an Acuity Adaptable Unit (AAU)" and would maintain the AAU for the COPA term.[77] This appears to revise a previously identified service line change. In the Original COPA Application, Union Health stated it would convert the THRH ICU into a Clinical Decision Observation Unit.[78] Now, Union Health states that it would convert it to an AAU instead, and that this would "ensure patients in the Service Area have continued access to ICU-level services at the Regional Hospital facility." FTC staff urges IN DOH to evaluate the clinical implications of this change, including whether AAU services are comparable to ICU services.

Access Commitment #6 states that "Union Hospital will continue to offer cardiac catheterization services at the Union Hospital facility and the Regional Hospital facility during the COPA Term."[79] In the Original Application, Union Health previously planned to consolidate cardiac catheterization services at Union Hospital.[80] This change would preserve access to these services at both hospitals, but only for the term of the COPA. And even during the COPA term, this commitment is worse than the status quo in which both facilities must compete on quality, cost, and access to attract patients.

Access Commitment #7 would require Union Hospital to obtain approval from the IN DOH at least 60 days in advance of "making any material changes to a Service Line if the change would adversely impact the health outcomes, health care access, and quality of health care of the Service Area." The Parties then define "Service Line" as "Cardiology, Emergency Medicine, General Surgery, Oncology, Orthopedics, Neurology/Neurosurgery,

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[73] See Prior FTC Comment at 36–37 for a full discussion of the concerns about the discontinuation of THRH's Level III trauma center.
[74] *See* Original Application at 38.
[75] Second Application Exhibit B at 6.
[76] Original Application at 39.
[77] Second Application Exhibit B at 6.
[78] Original Application at 40.
[79] Second Application Exhibit B at 6.
[80] Original Application at 39.

Obstetrics/Gynecology, Pediatrics, Pulmonology, Trauma, and Urology." [81] However, this may be another example of the Parties mischaracterizing service lines that they already identified for consolidation in the Original Application, including Oncology, Pediatrics, and Trauma.[82] The key language to understand in this commitment is the caveat that this approval requirement "does not apply to any changes described in the Commitments as those changes are considered pre-approved by the Department as part of the COPA approval process."[83] If this "pre-approval" applies to any of the previously planned service line consolidations, then the net effect would actually be a significant reduction in access relative to the status quo. This Commitment would also put the IN DOH in the difficult and constant position of having to direct Union Health's business decisions based on information provided (and curated) by the self-interested hospital monopoly. Prior experiences with COPAs in other states demonstrate how challenging such regulation can be for state health agencies.[84] Also, this is another example of how malleable COPA commitments can be when subsequent modifications are allowed.

Access Commitment #8 states that within six months of the merger, Union Health would consolidate wound care services at Union Hospital and add two additional wound care treatment rooms. By "consolidate," the Parties mean that they would eliminate the service at THRH, harming patients who prefer that facility. This is another example of the Parties attempting to mischaracterize pre-planned consolidation as preserving access, and this was already included in the Original Application.[85] The Parties also claim that consolidating wound care services at a single location would increase Union Health's volumes and support the long-term stabilization of the program. As explained in the Prior FTC Comment, a volume-outcome relationship is only relevant for certain complex procedures, and only then when a hospital operates below a minimum threshold prior to the merger.[86] The IN DOH should fully evaluate whether this argument applies here. Further, this commitment only lasts for the COPA term, so there is no guarantee what wound care services Union Health would offer after five years.

Access Commitment #9 states that Union Health would maintain chemotherapy infusion services at Union Hospital during the COPA term. It then offers an ambiguous statement about expanding access to these services in the event the services currently offered at Regional Hospital are consolidated.[87] Again, this is a service line that was already identified for

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[81] Second Application Exhibit B at 6–7.
[82] Original Application at 38–40.
[83] Second Application Exhibit B at 6–7.
[84] *See, e.g.*, FTC Public Workshop, *A Health Check on COPAs*, (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/session1_transcript_copa.pdf (statement of M. Callister on Benefis Health COPA at 37–38: "[T]he state becomes the referee for all disputes between the hospital and other market participants, like doctors, third-party payers, health plans, and competing service providers like home health care providers…. So it would seem like anytime one of those players didn't think it was getting what it wanted in its negotiations with the hospital, they called us. We became the referee, and I found that very difficult to do as a regulator…. Another problem was politics. There was tremendous political pressure on the Montana Attorney General throughout the entire process."; statement of K. Sturgis on Mission Health COPA at 43: "And then [the legislature] said, hey, Sturgis, you get to regulate this. I said well, that's a bad idea, too. I don't have the skill set. I didn't have the skill set. But more than that, the ultimate regulatory evasion that happens is just not a path that I can recommend.").
[85] Second Application Exhibit B at 7.
[86] FTC Prior Comment at 37.
[87] Second Application Exhibit B at 7.

consolidation in the Original Application,[88] so it seems disingenuous for the parties to discuss it merely as a hypothetical. If these services were consolidated at Union Hospital, consistent with this purported commitment, this would not preserve access. It would instead reduce access and harm patients who prefer to receive chemotherapy infusion services at THRH.

Access Commitment #10 states that within six months of the merger, Union Health would consolidate Mother-Baby/NICU/Pediatric Units at Union Hospital, so that expectant mothers would have access to Level III maternal and neonatal care for the COPA term. The Original Application already identified these services for consolidation,[89] and the Prior FTC Comment addressed it.[90] To repeat, consolidating services would reduce access, not preserve it. Likewise, it is disingenuous for the Parties to make any claim about preserving Level III trauma services after THRH discontinued its trauma center just last summer—seemingly in anticipation of the merger and before the Parties obtained COPA approval.

D. Enhancement Commitments

The Second Application proposes eleven Enhancement Commitments the Parties claim would "ensure that the benefits of the Merger outweigh the potential disadvantages"; the Parties warn that they would not implement these facility and service enhancements without the proposed merger.[91] Based on the limited information the Parties presented, it is unclear how Union Health would specifically achieve these commitments or whether Union Health could achieve them without the merger.

Enhancement Commitment #1 states that Union Health would invest at least $30 million into THRH facilities over five years.[92] However, the Second Application provides no specific breakdown of planned improvements and corresponding costs. The Original Application pledged that Union Health would invest $10.5 million in THRH facilities and included a specific breakdown of the planned improvements and corresponding costs.[93] This revised commitment is vague, however, and might be similar to or less than the amount that HCA would likely spend on THRH in the ordinary course of business absent the merger. Certainly, HCA has the resources to make this investment itself, [redacted][94]

Enhancement Commitment #2 states that, over the next five years, Union Health would invest at least $75 million into its own Union Hospital facility over five years.[95] Investments in Union Health's facility surely benefit patients, but they likely have little to do with this COPA application. In fact, Union Health makes significant investments in the ordinary course of

[88] *See* Original Application at 38–40.
[89] *See* Original Application at 38–40.
[90] FTC Prior Comment at 36–38.
[91] Second Application Exhibit B at 8.
[92] Second Application Exhibit B at 8.
[93] Original Application at 37.
[94] *See* Prior FTC Comment at 11–14.
[95] Second Application Exhibit B at 8.

business. FTC staff reviewed Union Health's audited financial statements from 2018 to 2023.[96] Even with a conservative analysis that excludes a spike in 2020, Union Health spent on average more than $15.5 million per year on the purchase of property and equipment, with an average of $19 million in the last three years. Therefore, Enhancement Commitment #2 offers no greater investment than what Union Health likely would make absent the merger.

Table 3: Union Health System Inc. & Subsidiaries Net Investments for Fiscal Years 2017-2022 (Source: Union Health's Audited Financial Statements)

	Purchase of Property & Equipment	Proceeds from Sale of Property & Equipment	Net
CY2023	$16,193,673	$21,876	$16,171,797
CY2022	$17,707,451	$19,118	$17,688,333
CY2021	$23,601,473	$39,078	$23,562,395
CY2020	$73,471,222	$6,432	$73,464,790
CY2019	$10,898,326	$23,529	$10,874,797
CY2018	$10,965,607	$12,387	$10,953,220
CY2017	$27,316,633	$1,484,637	$25,831,966
Average of last 3 years (CY2021 - CY2023)			**$19,140,842**
Average of last 5 years (CY2018 - CY2023, excluding CY2020)			**$15,850,108**

Enhancement Commitment #3 states that Union Health would invest at least $5 million to add oncology treatment-related technology over three years.[97] In the Original Application, Union Health had offered to invest $3 million to add oncology treatment-related technology.[98] The Second Application does not explain this revised amount or whether Union Health would likely make the same investment if its COPA application is denied.

Enhancement Commitments #4–6 state that Union Hospital would recruit an additional 15 Primary Care Physicians and Advance Practice Providers, 21 Specialty Physicians, and 3 pharmacists in the first five years following the merger.[99] The Original Application discussed physician shortages in Vigo County and the recruiting difficulties the Parties face.[100] Union Health claimed the proposed merger would aid in physician recruitment, but it failed to explain why. Likewise, the Second Application does not provide any details about how Union Health would recruit the additional staff. Further, this proposed merger is unnecessary for joint recruitment efforts. The FTC is aware, based on input from clinical quality experts working on past hospital merger litigations, that independent hospitals outside major cities often work

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[96] *See* IN Dep't of Health, Union Health Audited Financial Statements, *available at* https://www.in.gov/health/cshcr/reports-on-health-care-facilities/hospital-reports/. FTC staff excluded calendar year 2020 from our calculations, as it appeared to have been a much higher amount compared to the other years and thus may not be representative. We also note that these figures were for the entire Union Health system, and not just for Union Hospital.
[97] Second Application Exhibit B at 8.
[98] Original Application at 39.
[99] Second Application Exhibit B at 9.
[100] Original Application at 50.

together to attract specialists and subspecialists. Hospitals will jointly sponsor or call on independent physicians who then practice at multiple hospitals to provide care locally.

Enhancement Commitment #7 states that Union Hospital would increase the number of behavioral health inpatient beds during the COPA term, with a goal of adding at least 20 beds. The Original Application already noted Union Health's plan to enter a joint venture that would invest $15 million over five years to expand behavioral health inpatient beds. The only revised aspect of Enhancement Commitment #7 appears to be that it now quantifies the number of beds that Union Health would add.

Enhancement Commitment #8 states that Union Hospital would expand its after-hours nurse access program across the Combined Enterprise in the first 120 days after the merger.[101] However, the Second Application lists "After Hours Access Nurse" services as currently offered by both Union Hospital and THRH.[102] It therefore is unclear whether this commitment offers any benefit beyond the status quo or why the merger is necessary to achieve it. Also, the Original Application touts Union Health's Virtual Nursing Program, and it is unclear if this commitment is part of that or something additional.

Enhancement Commitments #9–11 state that Union Health would increase the number of Well Child Checks, Medicare Annual Wellness Visits, and Transitional Care Management Services across the Combined Enterprise during the COPA term.[103] The Parties do not explain whether the proposed merger is necessary to achieve any of these commitments. Presumably, Union Health and THRH could both implement these initiatives on their own.

E. Employment and Economic Impact Commitments

The Second Application proposes five Employment and Economic Impact Commitments the Parties claim would "mitigate any negative impacts on the affected workforce and [] evaluate the impact of the Merger on the economy."[104] The Parties already included most of these commitments in the Original Application.

Employment Commitments #1–3 state that Union Hospital would offer employment to all THRH employees at their same or better salary and hourly wage levels, and would honor full credit for paid time off balances for employees who transition to Union Hospital.[105] .[106] FTC staff raised concerns about the limits of these commitments in the Prior FTC Comment.[107] We also note that in the last round of public comments submitted to the IN DOH, several employees of both Union Health and THRH expressed their concerns about future employment post-merger.

[101] Second Application Exhibit B at 10.
[102] *See* Second Application at 14. *See also* Original Application at 10.
[103] Second Application Exhibit B at 10–11.
[104] Second Application Exhibit B at 11.
[105] Second Application Exhibit B at 11–12.
[106]
[107] FTC Prior Comment at 56.

Employment Commitment #4 states that "Union Hospital will conduct annual employee and physician satisfaction surveys to help reduce turnover and improve retention of employees of the Combined Enterprise."[108] These surveys are unlikely to be meaningful for hospital employees post-merger, however, as they would have no alternative hospital in Vigo County where they can seek employment in the event of negative working conditions at Union Hospital. Union Health and THRH could also conduct such surveys without the proposed merger.

Economic Impact Commitment #5 states that Union Health "will work to establish a study in partnership with a nonprofit organization or a postsecondary educational institution to study the economic impact of the COPA." It then provides some vague details about how the study would be conducted. There are good reasons to doubt that the study would produce an unbiased result. Union Health would control the underlying data (and would determine what data is "reasonably necessary to facilitate the study") and may contribute funding to the study even though it is self-interested in the results. There would also be no need for a study without the COPA. And if the study identified economic problems associated with the merger, there would be no effective remedy because it is nearly impossible to undo a consummated hospital merger.

F. Population Health Commitments

The Second Application proposes five Population Health Commitments the Parties claim would "monitor progress around the population health improvement initiatives the Combined Enterprise is implementing as a result of the Merger."[109] Most of these commitments were already included in the Original Application.

Population Health Commitments #1–2 state that Union Health would expand its Health Equity Plan and Population Health Improvement Plan to cover all patients receiving care from the Combined Enterprise.[110] These commitments were included in the Original Application,[111] and have already been addressed in the Prior FTC Comment.[112] The merger is unnecessary for the Parties to implement these initiatives on their own. Union Health already has a Health Equity Plan and a Population Health Improvement Plan, and THRH/HCA has adequate resources and expertise to implement these types of plans independently. The proposed merger is not necessary to develop or implement these plans.

Population Health Commitments #3–4 state that Union Health would provide at least twelve "pop-up clinics" each year to serve the homeless community and establish a new food access point to help address food insecurity.[113] The Parties identified both of these initiatives in the Original Application.[114] The only new aspect is the number of "pop-up clinics" Union Health would conduct each year. The proposed merger is not necessary to accomplish these goals.

[108] Second Application Exhibit B at 12.
[109] Second Application Exhibit B at 13.
[110] Second Application Exhibit B at 13.
[111] *See* Original Application at 21, 23.
[112] *See* Prior FTC Comment at 40–42.
[113] Second Application Exhibit B at 14.
[114] *See* Original Application at 27–28.

Commitment #5 states that Union Health would "establish a research study in partnership with a nonprofit organization or a postsecondary institution to study the impacts of the COPA on the community's health metrics and outcomes as described in I.C. § 16-21-15-4.5."[115] However, the authority and parameters of the study that Union Health proposes are unclear. The COPA Act authorizes the IN DOH to conduct this study, not Union Health. According to the statute, Union Health's only role is to supply data it owns or maintains that is related to the COPA and required to conduct the study. The COPA Act does not authorize Union Health to establish the study itself. As explained earlier, if Union Health were to conduct the study of its own performance, the objectivity and credibility of the results may be called into question.

G. Other Commitments

Other Commitment #1 states that Union Health would expand its financial assistance policy to all patients seeking care at the Combined Enterprise, and that it would maintain the generosity level of the policy as it is at the time of the merger throughout the COPA Term. Union Health claims that this "will ensure that low-income patients who are uninsured will not be adversely impacted by the Merger."[116] This commitment was included in the Original Application.[117] THRH already has its own charity care and financial assistance policies, so the expansion of Union Health's policies is not a unique result of the merger. While it is laudable that Union Health provides charity care, it does not have to wait for approval of its COPA application to provide additional financial assistance. Other Commitment #1 also does not mitigate the real concerns about merger-related price increases and reduced quality and access for low-income patients.[118]

Other Commitment #2 states that Union Health would "reinvest into the Combined Enterprise the cost savings realized in the first five years of the Merger to help improve the health status of the community" and that this is consistent with the requirement in I.C. § 16-21-15-7(d)(1).[119] However, Union Health's interpretation of this provision of the COPA Act is puzzling. I.C. § 16-21-15-7(d)(1) requires a hospital operating under a COPA to "invest the realized cost savings from the identified efficiencies and improvements included in the certificate of public advantage application *in the areas of Indiana the hospital serves for the benefit of the community*" (emphasis added) for the first five years of the merger. However, Union Health is stating that it would reinvest the cost savings *into its own Combined Enterprise*. This does not appear to be the kind of community investment contemplated under the COPA Act, and therefore this commitment likely does not fulfill the COPA statutory requirements.

Other Commitment #3 states that Union Health would invest at least $6.9 million in graduate medical education each year during the first five years of the merger.[120] It is unclear exactly how Union Health would invest these funds. Without more specific requirements, it

[115] Second Application Exhibit B at 14.
[116] Second Application Exhibit B at 15.
[117] Original Application at 41–43.
[118] *See, e.g.*, Cory Capps, Dennis Carlton & Guy David, *Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?*, NAT'L BUREAU OF ECON. RES. (Feb. 2017 working paper) (showing that hospitals' charity care does not increase with market power), https://www.nber.org/system/files/working_papers/w23131/w23131.pdf.
[119] Second Application Exhibit B at 15.
[120] Second Application Exhibit B at 15.

could be difficult for the IN DOH to hold Union Health accountable for achieving this commitment. Union Health also did not explain whether it needs this merger to make such investments in graduate medical education, particularly as it already educates and trains health professionals through its family medicine residency program.[121] Considering Union Health's warnings about the poor health and "unhealthy behaviors of the Service Area's residents,"[122] it should invest available funds in graduate medical education or other efforts that promote community health, not anticompetitive attempts to acquire its closest competitor.

III. Conclusion

As we stated in our Prior FTC Comment and we re-affirm here, competition between Union Health and THRH incentivizes them to drive healthcare costs down and provide superior care, improving patient outcomes. Patients, employers, and hospital employees in the Terre Haute area and throughout Indiana likely benefit from this competition. Should the proposed merger between Union Health and THRH go forward, these benefits would be lost, and Indiana citizens would likely face higher costs and reduced quality of care.

For the reasons described above and in our Prior FTC Comment, FTC staff respectfully encourages the IN DOH to deny Union Health and THRH's COPA Application. Thank you for the opportunity to comment and we stand ready to answer any questions you may have in connection with your review.

[121] Second Application COPA Terms and Conditions at 6.
[122] Second Application at 54.

ATTACHMENT A: FTC RESPONSES TO UNION HEALTH COMMITMENTS

Quality Commitments

#	Description	FTC Response
1	Implement Common Clinical IT Platform	➢ Repeated from Original Application (19) ➢ Increases cost and time of implementation from $15 million/1 year to $17.5 million/2 years ➢ Accountability mechanism insufficient ➢ Addressed in Prior FTC Comment (38–39)
2	Report on Quality Metrics	➢ Repeated from Original Application (44) ➢ Annual reporting on quality metrics already required by statute, I.C. § 16-21-15-8, but this does not guarantee quality improvements ➢ Now identifies specific metrics that will be reported; most required for participation in federal programs ➢ Public reporting offers less value to patients when competition is eliminated; no other hospital to select if quality declines ➢ Accountability mechanism insufficient ➢ Addressed in Prior FTC Comment (74)
3	Report on Patient Satisfaction Measures	➢ Repeated from Original Application (70) ➢ Now identifies specific metrics that will be reported ➢ Public reporting offers less value to patients when competition is eliminated; no other hospital to select if patient satisfaction declines ➢ Accountability mechanism insufficient

Pricing Commitments

#	Description	FTC Response
1	Comply with Pricing Limitation Set Forth in I.C. § 16-21-15-7(c): Do not increase charge for individual service by more than the increase in preceding year's annual average of CPI for Medical Care (Addendum 3)	➢ Repeated from Original Application (65) ➢ Already required by COPA statute ➢ Increases period to 7 years; unknown if this limitation will end early in the event of voluntary termination of the COPA after 5 years per I.C. § 16-21-15-5 and the Terms and Conditions ➢ After 7 years there would be no price protections for patients and employers in Vigo County ➢ Unlikely to effectively control costs ➢ Ambiguous language; unclear if this applies to chargemaster (in which case likely will not prevent price increases) or negotiated rates ➢ Accountability mechanism insufficient ➢ Addressed in Prior FTC Comment (69–70)
2	Price Increase Limitation in Payor Negotiations (Addendum 3)	➢ Imposes period of 7 years; unknown if this limitation will end early in the event of voluntary termination of the COPA after 5 years per I.C. § 16-21-15-5 and the Terms and Conditions ➢ After 7 years there would be no price protections for patients and employers in Vigo County ➢ Potential weaknesses with various components of Addendum 3 that require full evaluation ➢ Excludes services that some commercial patients use; higher prices for these services could affect everyone who buys insurance; hospitals could drive

		up rates on non-regulated services to make up for pricing limitations on regulated services ➢ Unlikely to protect consumers from anticompetitive price increases ➢ Accountability mechanism insufficient
3	Implement Union Hospital Chargemaster for All Services Provided Across Combined Enterprise	➢ Repeated from Original Application (17) ➢ Chargemaster may not reflect actual negotiated rates, therefore unlikely to effectively control prices ➢ Accountability mechanism insufficient ➢ Addressed in Prior FTC Comment (51)
4	Negotiate in Good Raith with Payors to Include Combined Enterprise in Health Plans Offered in Service Area	➢ Repeated from Original Application (66) ➢ Should already be acting in good faith ➢ Accountability mechanism insufficient ➢ Addressed in Prior FTC Comment (52, 74–75)
5	Not Unreasonably Refuse to Negotiate with Potential New Payor Entrants or Payors with Small Market Shares	➢ Repeated from Original Application (66) ➢ Should already be acting in good faith ➢ Accountability mechanism insufficient ➢ Addressed in Prior FTC Comment (74–75)
6	Attempt to Include Reasonable Provisions for Value-Based Incentives in Payor Contracts	➢ Repeated from Original Application (66) ➢ Should already be acting in good faith ➢ Accountability mechanism insufficient ➢ Addressed in Prior FTC Comment (52–54)
7	Honor Payor Contract Terms and Not Unilaterally Terminate Without Cause Prior to Slated Expiration Date	➢ Repeated from Original Application (66) ➢ Should already be acting in good faith ➢ Accountability mechanism insufficient ➢ Addressed in Prior FTC Comment (74–75)
8	Negotiate Risk-Based Arrangements with Payors in Good Faith	➢ Repeated from Original Application (66) ➢ Should already be acting in good faith ➢ Accountability mechanism insufficient ➢ Addressed in Prior FTC Comment (52–54)

Preservation of Access Commitments

#	Description	FTC Response
1	Maintain Inpatient Acute Care Facilities at Both Union Hospital and THRH during COPA Term	➢ Repeated from Original Application (19) ➢ Community will not receive benefits of competition, even if both hospital facilities are maintained post-merger ➢ Commitment only lasts for COPA term ➢ Accountability mechanism insufficient
2	Maintain ER at Both Union Hospital and THRH during COPA Term	➢ Repeated from Original Application (63) ➢ Community will not receive benefits of competition, even if both ER facilities are maintained post-merger ➢ Commitment only lasts for COPA term ➢ Accountability mechanism insufficient
3	Maintain Level III Trauma Program at Union Hospital during COPA Term	➢ Repeated from Original Application (38) ➢ Consolidation of trauma services was already planned; reduces access ➢ THRH discontinued Level III trauma center in August 2024 prior to merger/COPA approval ➢ Commitment only lasts for COPA term ➢ Addressed in Prior FTC Comment (37) ➢ Accountability mechanism insufficient

4	Maintain ICU at Union Hospital during COPA Term and Expand Number of ICU Beds from 24 to 36	➢ Repeated from Original Application (39) ➢ Consolidation of ICU services was already planned; reduces access ➢ Commitment only lasts for COPA term ➢ Accountability mechanism insufficient
5	Convert THRH ICU into AAU and Maintain for COPA Term	➢ Previously planned to convert THRH ICU into a Clinical Decision Observation Unit (40) ➢ Clinical implications should be evaluated, including whether AAU services are comparable to ICU services ➢ Commitment only lasts for COPA term ➢ Accountability mechanism insufficient
6	Continue Cardiac Catheterization Services at Both Union Hospital and THRH during COPA Term	➢ Previously planned to consolidate cardiac catheterization services at Union Hospital (39) ➢ Would now preserve access to these services at both hospitals, but because the hospitals would now be owned by the same system, patients would not benefit from the cost and quality competition that currently exists ➢ Commitment only lasts for COPA term ➢ Accountability mechanism insufficient
7	Obtain IDOH Approval 60 Days in Advance of Material Change to Service Line if it would adversely impact health outcomes, access, and quality of care	➢ Commitment only applies to future changes ➢ Does not account for changes and consolidation already planned or in progress, as these changes would be considered "pre-approved" ➢ Places significant burden on IN DOH to direct business decisions of hospital based on information controlled by Union Health ➢ Accountability mechanism insufficient
8	Consolidate Wound Care Services at Union Hospital and add two wound care treatment rooms	➢ Repeated from Original Application (38); revised to add two wound care treatment rooms ➢ Consolidation of wound care services already planned; reduces access ➢ Evaluate whether volume-outcomes relationship exists for wound care services ➢ Commitment only lasts for COPA term ➢ Accountability mechanism insufficient
9	Consolidate chemotherapy infusion services at Union Hospital	➢ Original Application identified oncology services for possible consolidation (39) ➢ If consolidation of chemotherapy infusion services was already planned, then reduces access ➢ Commitment only lasts for COPA term ➢ Accountability mechanism insufficient
10	Consolidate Mother-Baby/NICU/Pediatric Units at Union Hospital and maintain Level III maternal and neonatal care	➢ Repeated from Original Application (39) ➢ Consolidation of Mother-Baby/NICU/Pediatric Units already planned; reduces access ➢ Level III trauma services already consolidated; reduces access ➢ Commitment only lasts for COPA term ➢ Addressed in Prior FTC Comment (36–37) ➢ Accountability mechanism insufficient

Enhancement Commitments

#	Description	FTC Response
1	Invest at least $30 million in THRH over 5 years	➢ Repeated from Original Application (37–38) ➢ Increases investment amount from $10.5 million to $30 million, but no specific investments or cost breakdown identified ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient
2	Invest at least $75 million in Union Hospital facility over 5 years	➢ Offers no greater investment than what Union Health likely would make absent the merger; from CY2018 – CY2023 (excluding spike in 2020) Union Health spent average of $15.5 annually on purchase of property and equipment ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient
3	Invest at least $5 million in new oncology treatment-related technology over 3 years	➢ Repeated from Original Application (39) ➢ Increase investment amount from $3 million to $5 million, but no specific cost breakdown identified ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient
4	Recruit at least 15 new Primary Care Physicians and Advance Practice Providers during COPA term	➢ Concept Repeated from Original Application (30, 50–51) ➢ Original COPA Application claimed the Proposed Merger would aid in physician recruitment, but did not specify target categories and numbers ➢ Unclear how this target will be accomplished; no recruiting plans specified ➢ Addressed in Prior FTC Comment (54 n.225) ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient
5	Recruit at least 21 new Specialty Physicians during COPA term	➢ Concept Repeated from Original Application (50–51) ➢ Original COPA Application claimed the Proposed Merger would aid in physician recruitment, but did not specify target categories and numbers ➢ Unclear how this target will be accomplished; no recruiting plans specified ➢ Addressed in Prior FTC Comment (54 n.225) ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient
6	Recruit at least 3 new Pharmacists during COPA term	➢ Original COPA Application claimed the Proposed Merger would aid in physician recruitment, but did not specify Pharmacists ➢ Unclear how this target will be accomplished; no recruiting plans specified ➢ Addressed recruitment efforts in Prior FTC Comment (54 n.225) ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient
7	Add at least 20 new behavioral health inpatient beds during COPA term	➢ Repeated from Original Application (35–36) ➢ Original COPA Application stated a joint venture of $15 million over 5 years was already planned to expand behavioral health inpatient beds, but targeted number was not specified

		➢ Addressed in Prior FTC Comment (32, 48-49) ➢ Accountability mechanism insufficient
8	Expand after-hours nurse access program within first 120 days of Merger	➢ Appears that both Union Health and THRH already offer "After Hours Access Nurse" services; unclear how this is different ➢ Unclear whether this is part of the Virtual Nursing Program already implemented at Union Health ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient
9	Increase number of Well Child Checks for patients 0-18 years during COPA term	➢ Could be achieved without Proposed Merger ➢ Commitment only lasts for COPA term ➢ Accountability mechanism insufficient
10	Increase number of Medicare Annual Wellness Visits to 70%+ for attributed patients during COPA term	➢ Could be achieved without Proposed Merger ➢ Commitment only lasts for COPA term ➢ Accountability mechanism insufficient
11	Increase Transitional Care Management services offered to 90%+ for eligible attributed patients during COPA term	➢ Could be achieved without Proposed Merger ➢ Commitment only lasts for COPA term ➢ Accountability mechanism insufficient

Employment and Economic Impact Commitments

#	Description	FTC Response
1	Offer employment to all THRH employees who are employed at time of the Merger	[redacted] ➢ Public comments indicate employees from both hospitals have concerns about their future employment post-merger ➢ Addressed in Prior FTC Comment (56) ➢ Accountability mechanism insufficient
2	Offer compensation to THRH employees that is the same or better than current levels	[redacted] ➢ Public comments indicate employees from both hospitals have concerns about their future employment post-merger ➢ Addressed in Prior FTC Comment (56) ➢ Accountability mechanism insufficient
3	Honor full credit for paid time off balances of THRH employees who accept employment at Union Health	[redacted] ➢ Public comments indicate employees from both hospitals have concerns about their future employment post-merger ➢ Accountability mechanism insufficient
4	Conduct annual employee and physician satisfaction surveys at Combined Enterprise and report results to IDOH	➢ Unlikely to have meaningful impact due to lack of competitive alternative ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient
5	Work to establish research study in partnership with a nonprofit organization or a postsecondary educational institution of the economic impact of the COPA	➢ Union Health's role is unclear regarding funding and what data is "reasonably necessary" ➢ Objectivity and credibility of the study could be questionable if Union Health conducts a study of its own performance ➢ Not needed if there were no COPA

		➢ No effective remedy if economic problems associated with the merger are identified ➢ Accountability mechanism insufficient

Population Health Commitments

#	Description	FTC Response
1	Expand Union Hospital's Health Equity Plan to cover all Combined Enterprise patients	➢ Repeated from Original Application (20-31) ➢ Could be achieved without Proposed Merger ➢ Addressed in Prior FTC Comment (40-42) ➢ Accountability mechanism insufficient
2	Expand Union Hospital's Population Health Improvement Plan to cover all Combined Enterprise patients	➢ Repeated from Original Application (26–28) ➢ Could be achieved without Proposed Merger ➢ Addressed in Prior FTC Comment (40–42) ➢ Accountability mechanism insufficient
3	Provide at least 12 "pop-up clinics" each year to serve the homeless community	➢ Repeated from Original Application (27) ➢ Now specifies frequency per year ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient
4	Establish access point to help address food insecurity	➢ Repeated from Original Application (27–28) ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient
5	Establish research study on the impacts of the COPA on the community's health metrics and outcomes as described in I.C. § 16-21-15-4.5	➢ Study conducted by IN DOH already required by COPA statute ➢ COPA statute does not create role for Union Health to establish the study; Union Health's only role is supplying required data ➢ Objectivity and credibility of the study could be questionable if Union Health conducts a study of its own performance ➢ Not needed if there were no COPA ➢ No effective remedy if problems associated with the merger are identified ➢ Accountability mechanism insufficient

Other Commitments

#	Description	FTC Response
1	Expand Union Hospital's Financial Assistance Policy to all Combined Enterprise patients during the COPA term	➢ Repeated from Original Application (41–43) ➢ THRH already has its own policies, so expansion of Union Health's policies is not a unique result of the Proposed Merger ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient
2	Reinvest cost savings realized in the first five years of the Merger into the Combined Enterprise consistent with I.C. § 16-21-15-7(d)	➢ Appears to be inconsistent with I.C. § 16-21-15-7(d), which requires cost savings to be invested into the areas of Indiana the hospital serves for the benefit of the community ➢ Instead, Union Health is committing to reinvest cost savings into its own Combined Enterprise
3	Invest at least $6.9 million in Graduate Medical Education each year during the first five years of the Merger	➢ No specific details about how Union Health will invest these funds ➢ Could be achieved without Proposed Merger ➢ Accountability mechanism insufficient