

Complaint

IN THE MATTER OF

CABELL HUNTINGTON HOSPITAL, INC.;
PALLOTTINE HEALTH SERVICES, INC.;
AND
ST. MARY’S MEDICAL CENTER, INC.COMPLAINT AND FINAL ORDER IN REGARD TO ALLEGED
VIOLATIONS OF SECTION 5 OF THE FEDERAL TRADE COMMISSION
ACT AND SECTION 7 OF THE CLAYTON ACT

Docket No. 9366; File No. 141 0218
Complaint, November 5, 2015 – Decision, July 6, 2016

This case addresses the acquisition by Cabell Huntington Hospital, Inc. of St. Mary’s Medical Center, Inc. The complaint alleges that the transaction violates Section 5 of the Federal Trade Commission Act and Section 7 of the Clayton Act by significantly reducing competition in the markets for general acute care inpatient hospital services and outpatient surgical services in Huntington, West Virginia. The order dismisses the Complaint because the West Virginia Health Care Authority issued its written decision approving the Cooperative Agreement.

Participants

For the *Commission*: Elizabeth Arens, Jeanine Balbach, Lucas Ballet, Stephanie R. Cummings, Melissa Davenport, , Svetlana Gans, Elisa Kantor, Michael Perry, Marc Schneider, Sam Sheinberg, and Michelle Yost Hale.

For the *Respondents*: Ken Field, Jones Day and Jeff Brennan, McDermott Will & Emery LLP; David Simon, and H. Holden Brooks, Foley & Lardner LLP.

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act (“FTC Act”), and by virtue of the authority vested in it by the Act, the Federal Trade Commission (“Commission”), having reason to believe that Respondents Cabell Huntington Hospital, Inc. (“Cabell”), Pallottine Health Services, Inc. (“PHS”), and St. Mary’s Medical Center, Inc. (“St. Mary’s”), having executed an agreement pursuant to which Cabell will become the sole

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member, and thereby acquire all the assets, of St. Mary's (the "Definitive Agreement") in violation of Section 5 of the FTC Act, 15 U.S.C. § 45, which if consummated would violate Section 7 of the Clayton Act, as amended, 15 U.S.C. § 18, and Section 5 of the FTC Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint pursuant to Section 5(b) of the FTC Act, 15 U.S.C. § 45(b), and Section 11(b) of the Clayton Act, 15 U.S.C. § 21(b), stating its charges as follows:

I**NATURE OF THE CASE**

1. Cabell's proposed acquisition of St. Mary's (the "Acquisition") is likely to substantially lessen competition for healthcare services in Huntington, West Virginia, and its surrounding communities. The Acquisition would lead to increased healthcare costs for local residents and reduce the merging parties' incentives to maintain and improve quality of care. If allowed to proceed, the Acquisition would create a dominant firm with a near monopoly over general acute care (or "GAC") inpatient hospital services and outpatient surgical services in and around Huntington.

2. Cabell and St. Mary's are general acute care hospitals located only three miles apart in Huntington, and they directly compete with one another to provide inpatient and outpatient services. As the only two hospitals in Huntington, Cabell and St. Mary's have a long history of close competition that has yielded numerous price and quality benefits for consumers.

3. As Cabell's CFO emphasized in 2013, St. Mary's is Cabell's "main competitor for all but our exclusive services," which are limited to three service lines: neonatal ICU, pediatric ICU, and burn. Other documents from the two hospitals, their consultants, and ratings agencies consistently describe Cabell and St. Mary's not only as "competitors," but also as each other's "main," "primary," or "strongest" "competitors," and "long-standing rival[s]." Respondents' own merger consultant testified that Cabell and St. Mary's have been "head-to-head competitors

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for a very long period of time,” which is consistent with testimony from health plan and other industry executives that “Cabell Huntington and St. Mary’s are each other’s closest competitors for inpatient and outpatient services.”

4. Especially in recent years, Cabell and St. Mary’s have competed on the pricing of their healthcare services, vying for inclusion in commercial health plan networks and attempting to “meet and/or beat” the other’s prices for individual services. Cabell and St. Mary’s have also competed vigorously on non-price dimensions, working to improve performance on quality measures, expand service lines, invest in new technology, and otherwise improve hospital quality to attract patients from one another. If consummated, the Acquisition would eliminate this intense competition to the detriment of local employers and residents.

5. That Cabell and St. Mary’s are intense, close competitors also is evidenced by their efforts to coordinate their actions to lessen the competition between them. During its investigation of the proposed Acquisition, the Commission discovered that Cabell and St. Mary’s have engaged in conduct to limit their head-to-head competition through explicit and tacit coordination in the form of joint contracting with health plans, secret territorial agreements not to advertise against one another, and a “gentlemen’s agreement” to allocate service lines between them. Of particular significance, Cabell, St. Mary’s, and other regional hospitals negotiated health plan contracts jointly through a so-called physician hospital organization (“PHO”) for nearly 10 years. Although this so-called PHO is now inactive, contracts that resulted from these negotiations remain in place, and Cabell and St. Mary’s have continued to share information about prospective health plan negotiations.

6. The Acquisition is likely to substantially lessen competition in two relevant markets in which Cabell and St. Mary’s compete to offer services: (1) general acute care inpatient hospital services sold and provided to commercial health plans and their members, respectively; and (2) outpatient surgical services sold and provided to commercial health plans and their members, respectively. The relevant geographic market in which

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to analyze the effects of the Acquisition is no broader than the four counties surrounding Huntington—Cabell, Wayne, and Lincoln counties in West Virginia, and Lawrence County, Ohio (the “Four-County Huntington Area”). Cabell and St. Mary’s each routinely identify these same four counties as their Primary Service Area (“PSA”).

7. Post-Acquisition, the combined entity would account for more than 75% of the discharges in the Four-County Huntington Area for general acute care inpatient services. Similarly, the combined entity would command a high share of the market for outpatient surgical services in the Four-County Huntington Area. These very high market shares and the corresponding concentration levels render the Acquisition presumptively unlawful—by a wide margin—under the relevant case law and the U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines (“Merger Guidelines”).

8. Respondents recognize that the Acquisition will result in extraordinary concentration levels. St. Mary’s CEO wrote in April 2015 that, post-merger, “SMMC and CHH collectively will control almost 90% of the market.” Similarly, according to their own ordinary-course documents, Cabell’s and St. Mary’s *individual* market shares in their PSA have ranged in recent years from 35% to over 40% *for each hospital*. According to these same documents, the next-closest hospital, King’s Daughters Medical Center (“King’s Daughters”), which is approximately a 25-minute drive across state lines into Kentucky, maintains a much smaller market share in Cabell and St. Mary’s PSA. No other hospital holds more than a 5% market share in the PSA.

9. The West Virginia Health Care Authority’s (“WVHCA”) rate review system would not prevent anticompetitive harm from the Acquisition. The WVHCA principally reviews and approves (or disapproves) a hospital’s list prices, or “charges,” as opposed to the prices, or “rates,” negotiated between the hospitals and health plans. Because these negotiated rates are below the list prices/charges, the limit on charges represents a ceiling on negotiated rates but does not preclude a significant increase in those negotiated rates. Furthermore, the WVHCA’s rate review system does not protect competition on non-price dimensions,

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such as quality and service. This rate review scheme is not an adequate substitute for competition.

10. In an attempt to avoid an antitrust challenge to the Acquisition, Cabell and St. Mary's entered into two agreements, conditional on consummation of the Acquisition, that purport to limit the combined entity's conduct for five to seven years: (1) a Letter of Agreement ("LOA") [REDACTED] and (2) an Assurance of Voluntary Compliance ("AVC") between Respondents and the Attorney General of West Virginia. Neither of these temporary agreements would sufficiently protect consumers. Principally consisting of price controls shown by economic theory and evidence to be ineffective, the two agreements would not replace the benefits of competition lost through the Acquisition.

11. Entry or expansion by other providers of the relevant services is unlikely to occur, much less in a manner timely, likely, or sufficient to deter or counteract the loss of price and non-price competition in the near future. Significant barriers to entry, including substantial up-front costs, regulatory restrictions, and the Four-County Huntington Area's demographic profile, make new healthcare providers unlikely to enter the relevant markets.

12. Finally, Respondents' efficiencies and quality claims are largely not verifiable or merger-specific, and any cognizable claims are insufficient to offset the significant competitive harm from the Acquisition.

13. Respondents cannot consummate the Acquisition until they first receive a Certificate of Need ("CON") from the WVHCA and then receive approval from the Catholic Church. Respondents have advised the Commission that, because their CON application is subject to a contested proceeding that may involve significant discovery, the CON process may not be completed for at least several months from now. Additionally, Respondents have advised the Commission that obtaining approval from the Catholic Church may take an additional six to eight weeks following CON approval.

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II.**BACKGROUND****A.****Jurisdiction**

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

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

B.**Respondents**

16. Respondent Cabell is a not-for-profit, 303-bed hospital incorporated under and by virtue of the laws of West Virginia. Cabell is headquartered at 1340 Hal Greer Boulevard, Huntington, West Virginia, 25701. During the fiscal year ending September 30, 2014, Cabell earned \$439 million in revenue.

17. In addition to its main hospital, Cabell owns and operates the 72-bed Hoops Family Children’s Hospital, an outpatient surgery center, and, together with the Marshall University Joan C. Edwards School of Medicine (“Marshall”), the Edwards Comprehensive Cancer Center. Pursuant to a management agreement, Cabell also manages Pleasant Valley Hospital, a 201-bed community hospital located 50 miles northeast of Huntington. Cabell employs approximately ■ physicians and leases approximately ■ physicians from Marshall. Cabell serves as a teaching hospital for Marshall medical students and residents.

18. Respondent PHS is a non-profit organization incorporated under and by virtue of the laws of West Virginia. PHS is run by the Pallottine Missionary Sisters, who are headquartered in

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Florissant, Missouri, and is located in Huntington, West Virginia. PHS owns two hospitals, St. Joseph's Hospital ("St. Joseph's") in Buckhannon, West Virginia, and St. Mary's.

19. Respondent St. Mary's is a not-for-profit, 393-bed Catholic hospital incorporated under and by virtue of the laws of West Virginia. St. Mary's is headquartered at 2900 First Avenue, Huntington, West Virginia, 25702. During the fiscal year ending September 30, 2014, St. Mary's earned \$401 million in revenue.

20. In addition to its main hospital, St. Mary's manages and has a [REDACTED] ownership interest in Three Gables Surgery Center in Proctorville, Ohio. St. Mary's also owns and operates a small emergency room, outpatient laboratory, and imaging center in Ironton, Ohio. St. Mary's employs approximately [REDACTED] physicians. St. Mary's also serves as a teaching hospital for Marshall medical students and residents.

C.

The Proposed Acquisition

21. In the spring of 2013, PHS began to take steps toward the sale of St. Mary's and St. Joseph's. PHS planned to use a request for proposal ("RFP") process that involved identifying potential buyers and asking them to submit bids.

22. In January 2014, Cabell submitted a Letter of Intent for the purchase of St. Mary's. PHS declined the Letter of Intent in favor of pursuing the RFP process. In May 2014, Cabell and [REDACTED] other hospital systems, including not-for-profit, for-profit, and Catholic systems, submitted bids to purchase St. Mary's.

23. In June 2014, PHS began discussions with Cabell about drafting a memorandum of understanding for the sale of St. Mary's to Cabell.

24. On August 1, 2014, Cabell and PHS signed a Term Sheet for the sale of St. Mary's. On November 7, 2014, Respondents signed a Definitive Agreement whereby Cabell would become the sole member and ultimate parent entity of St. Mary's.

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25. Prior to closing the transaction, Cabell must obtain a CON from the WVHCA for the purchase of St. Mary's. Cabell's CON application, filed on April 30, 2015, has been opposed by a local employer. Although the WVHCA was scheduled to hold a hearing on Cabell's application on November 18, 2015, the WVHCA recently continued the hearing, at Cabell's request, for an indefinite period.

26. Respondents also must obtain approval of the Acquisition from the Catholic Church, which Respondents may receive only after obtaining a CON from the WVHCA. Respondents have advised the Commission that this approval may take an additional six to eight weeks.

III.

THE RELEVANT SERVICE MARKETS

27. The first relevant service market in which to analyze the proposed Acquisition is general acute care inpatient hospital services sold and provided to commercial health plans and their members, respectively. This service market consists of the broad cluster of medical and surgical diagnostic and treatment services offered by both Cabell and St. Mary's that typically require an overnight hospital stay. It includes all inpatient services offered by both Cabell and St. Mary's.

28. Although the Acquisition's likely effect on competition could be analyzed separately for each individual inpatient service, it is appropriate to evaluate the likely effects through an analysis of the cluster of GAC inpatient hospital services because each of these services is offered to residents of the Four-County Huntington Area under similar competitive conditions, by similar market participants. Thus, grouping the hundreds of individual GAC inpatient hospital services into a cluster for analytical convenience enables the efficient evaluation of competitive effects with "no loss of analytic power."

29. The second relevant service market is outpatient surgical services sold and provided to commercial health plans and their members, respectively. Outpatient surgical services consist of the

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cluster of general surgery procedures offered by Cabell and St. Mary's that do not require an overnight hospital stay. Outpatient surgical services are a separate relevant market and warrant separate analysis from inpatient services because they are offered by a different set of providers under different competitive conditions. In addition, health plans and patients generally do not substitute outpatient services for inpatient services in the face of a price increase; rather, the decision to provide care on an inpatient or outpatient basis is a clinical decision made by the patient's physician.

30. Although the Acquisition's effect on each outpatient surgical service could be analyzed separately, treatment of outpatient surgical services as a cluster market is appropriate because of the similar competitive conditions that characterize outpatient surgical services in the Four-County Huntington Area.

IV.

THE RELEVANT GEOGRAPHIC MARKET

31. For both relevant service markets, the relevant geographic market in which to analyze the effects of the Acquisition is no broader than the Four-County Huntington Area, which consists of Cabell, Wayne, and Lincoln counties in West Virginia, and Lawrence County, Ohio. Cabell and St. Mary's routinely analyze this area—which they call their “Primary Service Area”—to evaluate market shares in the ordinary course of business.

32. The appropriate geographic market is determined by identifying the geographic boundaries within which a hypothetical monopolist for the services at issue could profitably impose a small but significant and non-transitory increase in price.

33. Residents of the Four-County Huntington Area strongly prefer to obtain GAC inpatient hospital services and outpatient services locally. Patients choose to seek care close to their homes or workplaces for their own convenience and that of their friends and families.

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34. Indeed, Cabell's regulatory filings show that an overwhelming percentage of patients in Cabell and Wayne counties seek inpatient care in Cabell County—that is, at Cabell or St. Mary's.

35. Hospitals outside of the Four-County Huntington Area do not regard themselves as, and are not, meaningful competitors of Cabell or St. Mary's for GAC inpatient hospital services or outpatient surgical services in the Four-County Huntington Area.

36. Because residents of the Four-County Huntington Area clearly prefer to obtain GAC inpatient hospital services and outpatient surgical services in the Four-County Huntington Area, a health plan that had neither Cabell nor St. Mary's in its network would be unattractive to consumers in the area. Health plans have stated that a network lacking both Cabell and St. Mary's would be so unattractive as to not be viable. Accordingly, in response to a small but significant price increase in GAC inpatient hospital services at a merged Cabell/St. Mary's, a health plan serving patients in the Four-County Huntington Area would not attempt to market a network that excluded those two hospitals. Because a majority of patients within the Four-County Huntington Area do not view providers outside of that area as practicable alternatives, the merged hospital system could profitably impose a small but significant price increase in the Four-County Huntington Area. The same competitive dynamic exists for outpatient surgical services.

V.

MARKET STRUCTURE AND THE ACQUISITION'S PRESUMPTIVE ILLEGALITY

37. Following the Acquisition, Cabell would own the only general acute care hospitals within the Four-County Huntington Area, and it would hold a dominant share of the market for general acute care inpatient hospital services. The only other hospital that serves more than a negligible percentage of Four-County Huntington Area residents is King's Daughters, in Ashland, Kentucky. The few other hospitals that serve residents

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in the relevant market are even farther away and have minimal shares.

38. Cabell's post-Acquisition market share for general acute care inpatient hospital services would be over 75%, as measured by share of inpatient admissions of patients residing in the Four-County Huntington Area. This market share far surpasses levels held to be presumptively unlawful by the U.S. Supreme Court and numerous other courts, including those in recent hospital merger cases.

39. The Herfindahl-Hirschman Index ("HHI") is a well-accepted method used to measure market concentration, as reflected in the Merger Guidelines. A merger or acquisition is presumed likely to create or enhance market power, and thus is presumed illegal, when the post-merger HHI exceeds 2,500 points and the merger or acquisition increases the HHI by more than 200 points. Here, the market concentration levels far exceed these thresholds, with a post-Acquisition HHI in the general acute care inpatient hospital services market of over 5,800, and an increase in HHI of over 2,800 points.

40. The market shares and HHI figures for the general acute care inpatient hospital services market for 2013, the most recent year for which state data were available, are summarized in the following table. These figures are conservatively calculated; they attribute market share to all hospitals accounting for admissions of patients residing in the Four-County Huntington Area, regardless of whether the hospital is physically located in the Four-County Huntington Area.

GENERAL ACUTE CARE INPATIENT HOSPITAL SERVICES		
Provider	Market Share	Post-Acquisition
Cabell Huntington Hospital	40.8%	75.4%
St. Mary's Medical Center	34.6%	

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King's Daughters Medical Center	9.8%	9.8%
Our Lady of Bellefonte Hospital	4.4%	4.4%
Charleston Area Medical Center	4.0%	4.0%
Other	6.4%	6.4%
HHI	2,999	5,824
Change in HHI	+2,825	

41. As the above table reflects, no hospital other than the merging parties and King's Daughters serves more than 5% of patients in the Four-County Huntington Area.

42. For outpatient surgical services, Cabell and St. Mary's are again the most significant providers in the Four-County Huntington Area. The only other outpatient surgical facility located in the relevant market is Three Gables Surgery Center ("Three Gables") in Proctorville, Ohio, about a 12-minute drive from Huntington. Three Gables is a multi-specialty surgical facility focusing on orthopedic, gastroenterological, and ENT procedures. Three Gables predominantly performs outpatient procedures and has only eight inpatient beds for the small number of its cases that require an overnight stay. St. Mary's holds the management contract for Three Gables and negotiates health plan contracts on its behalf, and Three Gables' CEO is a St. Mary's employee. Pursuant to the management contract, St. Mary's also has a [REDACTED] ownership interest in Three Gables. Even if Three Gables is treated as an independent competitor despite St. Mary's significant involvement, the Acquisition would result in a high combined market share, a highly concentrated market, and a significant increase in concentration for outpatient surgical services.

43. Under the relevant case law and the Merger Guidelines, the Acquisition is presumptively unlawful by a wide margin, as it

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would significantly increase concentration in markets that are already highly concentrated.

VI.**ANTICOMPETITIVE EFFECTS****A.****Hospital Competition Yields Lower Prices and Higher Quality**

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

45. In the first stage of hospital competition, hospitals compete to be included in health plan networks. To become an in-network provider, a hospital negotiates with a health plan and, if mutually agreeable terms can be reached, enters into a contract. Reimbursement rates (i.e., prices), which the hospital charges for services rendered to a health plan's members, are a central contract term that is negotiated.

46. In-network status benefits a hospital by giving it preferential access to the health plan's members. Health plan members typically pay far less to access in-network hospitals than out-of-network hospitals. Thus, all else being equal, an in-network hospital will attract more patients from a particular health plan than an out-of-network hospital. This dynamic motivates hospitals to offer lower rates to health plans to win inclusion in their networks.

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

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48. A critical determinant of the relative bargaining positions of a hospital and a health plan during contract negotiations is whether other, nearby comparable hospitals are available to the health plan and its members as alternatives in the event of a negotiating impasse. The presence of alternative hospitals limits a hospital's bargaining leverage and thus constrains its ability to obtain higher reimbursement rates from health plans. The more attractive these alternative hospitals are to a health plan's members in a local area, the greater the constraint on that hospital's bargaining leverage. Where there are few or no meaningful alternatives, a hospital will have greater bargaining leverage to demand and obtain higher reimbursement rates.

49. A merger between hospitals that are close substitutes in the eyes of health plans and their members therefore tends to lead to increased bargaining leverage for the merged entity and, as a result, higher negotiated rates, because it eliminates an available alternative for health plans. This increase in leverage is greater when the merging hospitals are closer substitutes for (competitors to) each other.

50. Increases in the reimbursement rates negotiated between a hospital and a health plan significantly impact the health plan's members. "Self-insured" employers rely on a health plan for access to its provider network and negotiated rates, but these employers pay the cost of their employees' healthcare claims directly and thus bear the full and immediate burden of any rate increases in the healthcare services used by their employees. "Fully-insured" employers pay premiums to health plans—and employees pay premiums, co-pays, and deductibles—in exchange for the health plan assuming financial responsibility for paying hospital costs generated by the employees' use of hospital services. When hospital rates increase, health plans pass on these increases to their fully-insured customers in the form of higher premiums, co-pays, and deductibles.

51. In the second stage of hospital competition, hospitals compete to attract patients to their facilities. Because health plan members often face similar out-of-pocket cost for in-network hospitals, hospitals in the same network compete to attract patients on non-price features—that is, by offering better quality

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of care, amenities, convenience, and patient satisfaction than their competitors. Hospitals also compete on these non-price dimensions to attract patients covered by Medicare and Medicaid, and other patients without commercial insurance. A merger of competing hospitals eliminates that non-price competition and reduces their incentive to improve and maintain quality.

52. Although West Virginia has a healthcare regulatory system that includes rate review, hospital competition retains a central role in promoting lower prices and higher quality of care. West Virginia's rate review system creates a ceiling on hospital charges and rates, but it is not a replacement for competition in yielding lower prices, and it does not protect against reductions in non-price competition.

53. The WVHCA reviews and approves a hospital's average charge per inpatient discharge and average charge per outpatient visit, both of which are based on the charges listed in the hospital's chargemaster (price list). The WVHCA calculates average charges annually and applies a methodology to determine a hospital's permitted increase in its average charges for the coming year. Notably, those charges are list prices, not the actual reimbursement rates negotiated by health plans, which are lower.

54. Although the WVHCA also reviews negotiated reimbursement rates that health plans have agreed to pay hospitals, the primary goal of this review is to ensure that the discounted reimbursement rate "does not constitute an amount below the actual cost to the hospital" and thus does not threaten the hospital's financial viability. Contract reimbursement rates rarely have been rejected by the WVHCA, and never have been rejected on the basis that the negotiated discount was too small or that a price increase reflected an undue exercise of a hospital's market power.

55. Because all of Cabell's and St. Mary's health plan commercial contracts establish negotiated reimbursement rates below the chargemaster levels, the WVHCA's rate review system does not foreclose higher prices to health plans and their members post-Acquisition. In other words, rate review may impose an upper limit, but negotiated rates have room to increase before they

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hit that ceiling. Moreover, the WVHCA's rate review does nothing to protect against the loss of quality and service competition.

B.**The Acquisition Would Eliminate Price Competition**

56. As a result of their proximity and service offerings, Cabell and St. Mary's are intense competitors and close substitutes for each other in the eyes of health plans and patients in the Four-County Huntington Area. As a health plan executive succinctly stated, [REDACTED]

The Acquisition would end the hospitals' significant and beneficial incentive to compete on price.

57. A standard economic analysis of the closeness of competition known as diversion analysis, which is based on data about where patients receive hospital services, confirms that Cabell and St. Mary's are very close competitors. In fact, they are each other's closest competitors, by a wide margin. Diversion analyses show that, if Cabell were no longer available to patients, about half of its patients would seek GAC inpatient hospital services at St. Mary's. Similarly, if St. Mary's were no longer available, about half of its patients would seek GAC inpatient hospital services at Cabell. Diversions from Cabell or St. Mary's to other hospitals are significantly smaller.

58. In particular, Cabell and St. Mary's compete for inclusion in health plan networks. For example, writing about a health plan seeking to enter the market, Cabell's CFO stated, "if St. Mary's ends up in their network and not us, we can expect a tongue lashing [from Cabell's CEO]."

59. To win inclusion in health plan networks, Cabell and St. Mary's compete, including on price. Numerous ordinary course of business documents show each hospital carefully monitoring and responding to the other's health plan negotiations, charges, and costs. Indeed, Cabell and St. Mary's track the outcomes of each other's health plan negotiations and try to match or beat the

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other's terms, viewing any negotiated rate advantage over the other as "very helpful."

60. Likewise, health plans have played Cabell and St. Mary's off each other to obtain lower reimbursement rates or more favorable terms. For example, [REDACTED] negotiated a fixed-rate reimbursement structure (which health plans favor because it provides more rate certainty than a discount-off-charges reimbursement structure) in its contract with [REDACTED] and then leveraged that outcome to negotiate a fixed-rate reimbursement structure with [REDACTED].

61. In addition, in 2009 or 2010, [REDACTED] excluded [REDACTED] from its Medicare Advantage network. [REDACTED] was only willing to include [REDACTED] in this network if [REDACTED] provided a substantial discount to bring payments closer to [REDACTED] levels. After it refused, [REDACTED] faced complaints from doctors frustrated by the local [REDACTED] members who turned to [REDACTED] instead of paying more to use [REDACTED] as an out-of-network hospital. In 2011, as a direct result of this competition from [REDACTED], [REDACTED] relented, agreeing to give [REDACTED] the discount it had originally sought in return for inclusion in [REDACTED] Medicare Advantage network.

62. Similarly, in 2010, [REDACTED] threatened to demote [REDACTED] to a "second-tier" hospital in its network because [REDACTED] had higher prices than [REDACTED]. Demotion to the second tier would have subjected [REDACTED] members to higher out-of-pocket costs when using [REDACTED]. Concerned that [REDACTED] members would divert to [REDACTED], [REDACTED] responded by offering [REDACTED] an additional [REDACTED] discount on large claims in return for maintaining its first-tier status. After [REDACTED] rejected this proposal due to concerns about administrative costs, [REDACTED] convinced [REDACTED] to keep [REDACTED] in the first tier by persuading [REDACTED] that, when certain adjustments were made, [REDACTED] prices were comparable to [REDACTED].

63. As these examples show, absent the Acquisition health plans can negotiate lower rates by threatening either to exclude Cabell or St. Mary's from their networks or to assign either

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hospital to a less preferential tier, because the other hospital serves as a close alternative for patients.

64. The Acquisition would eliminate health plans' ability to use competition between Cabell and St. Mary's to negotiate better rates. Because of local residents' strong preference for in-network access to at least one Huntington hospital, health plans could not develop an attractive network that included neither hospital, and Cabell would therefore have increased bargaining leverage with health plans post-Acquisition.

65. Cabell knows that a merger with a competing hospital would increase its bargaining leverage. In a presentation on hospital affiliations, Cabell's CFO identified "Negotiating Power" with "Third party payers" as the first "main reason[]" to affiliate.

66. Health plans have also confirmed that the Acquisition would enhance Cabell's bargaining leverage. Multiple health plans have expressed concerns that the combined Cabell/St. Mary's will have the ability to increase rates. As one health plan executive declared, [REDACTED]

[REDACTED] Likewise, [REDACTED]

[REDACTED] informed Cabell that [REDACTED]

[REDACTED] employee similarly reported [REDACTED]

67. The Acquisition would also eliminate competition to contain list prices and costs. Cabell and St. Mary's closely track each other's list prices. For example, in July 2014, Cabell's CFO explained, "We have a [REDACTED] compared to St. Mary's (higher) for the same DRG's. This is of concern in terms of competitiveness in the future with payers." With respect to the pricing of individual services, St. Mary's deliberately sets its charges lower than Cabell's for many services, and Cabell has lowered its charges on multiple services to match St. Mary's. At times, this competition threatened to become a "downward spiral," as Cabell's CFO put it, with St. Mary's "discount[ing] to meet and/or beat" Cabell's prices.

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68. With respect to cost, Cabell was aware that its higher cost structure, due primarily to higher employee salaries and benefits, placed it at a competitive disadvantage vis-à-vis St. Mary's. Cabell examines St. Mary's salaries and benefits at least once a year. After St. Mary's froze its defined benefit retirement plan, Cabell made plans to do the same. Cabell has received complaints from patients and employers about its higher prices relative to those at St. Mary's and other facilities in the region. After one such complaint, Cabell's CFO wrote, in January 2014, "I believe we have three years at best to get our costs in line with St. Mary's."

69. Aware that the vigorous competition between them forces lower list prices and larger discounts for health plans, and creates pressure to reduce costs, Cabell and St. Mary's have made periodic efforts to limit competition between them.

70. In 1994, Cabell and St. Mary's, along with local physicians, formed a so-called PHO named Tri-State Health Partners, Inc. ("Tri-State"). Two small hospitals in the region, Pleasant Valley Hospital and Williamson Memorial Hospital, subsequently joined Tri-State. Through Tri-State, Cabell and St. Mary's jointly negotiated contracts with multiple health plans, including [REDACTED] and [REDACTED]. These contracts—which are evergreen, meaning that they have no termination date and automatically renew—have identical, low discounts (5% off charges) for both Cabell and St. Mary's.

71. In or about 2003, Tri-State ceased to function and was "administratively dissolved" by the state for failure to file annual reports. Nonetheless, and despite the absence of any clinical integration or other efficiencies that might have once justified the PHO (if such integration or efficiencies ever did exist), Cabell and St. Mary's maintained Tri-State as a "shell" corporation, which kept their favorable, jointly negotiated health plan contracts in place. As a Cabell employee wrote in 2012, "Tri-State Health Partners has ceased ongoing operations. The entity has zero employees, zero revenues and . . . has also been administratively dissolved by the State. My understanding is that the only reason Articles of Dissolution have not been filed is to ensure that a few

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PPO network contracts entered into roughly ten-fifteen years ago remain in place.”

72. To this day, contracts negotiated through Tri-State remain in effect for Cabell and St. Mary’s with [REDACTED], and other area health plans, despite efforts by health plans to renegotiate the contract terms.

73. In 2013, as competition between them intensified, St. Mary’s and Cabell had multiple meetings in an effort to “resurrect” Tri-State and “look for opportunities for this PHO with other contracts.” Cabell and St. Mary’s also communicated with each other in recent years about their individual negotiations, including prospective rates and contract termination, with certain health plans.

74. In addition, prior to 2009, the hospitals maintained a “friendly agreement” whereby each hospital agreed not to put up billboards in the other’s “backyard.” In 2009, St. Mary’s broke this agreement by placing a billboard near Cabell. Cabell responded with the “‘nuclear option,’ buying up as many available billboards in [St. Mary’s] backyard as we could.” In 2011-2012, the hospitals reached a new agreement to allocate billboard locations, and, in 2013-2014, they continued their pattern of negotiation and competitive retaliation on advertising.

75. Evidence also suggests that Cabell and St. Mary’s coordinated by allocating certain high-end service lines. A healthcare marketing firm retained by St. Mary’s wrote in 2013 that the hospitals had maintained a “gentlemen’s agreement,” which allocated services that each hospital would “own” within the market. Pursuant to this understanding, St. Mary’s key services included cardiac care and cancer services. According to this document, the “competitive market” between Cabell and St. Mary’s ended this “mutual understanding,” and Cabell became “very aggressive in growing these services.” The events described by this document are consistent with the facts, including Cabell’s opening of the Edwards Comprehensive Cancer Center in 2006 and Cabell’s 2013 receipt of Certificate of Need approval to offer primary percutaneous coronary intervention (“PCI”), a cardiac catheterization service.

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76. The Acquisition would fulfill and make permanent Cabell and St. Mary's efforts to coordinate, depriving consumers of the competitive benefits from any reduction or cessation of these efforts.

C.**The Acquisition Would Eliminate Quality and Service Competition**

77. Cabell and St. Mary's compete vigorously on non-price dimensions, particularly patient service and clinical quality, and patients benefit substantially from this competition. As St. Mary's CEO acknowledged, competition among hospitals creates "incentives for investing dollars into their operations to provide and improve quality to expand services for patients." Competition between these two hospitals has brought advances in services and quality for residents of the Four-County Huntington Area.

78. Documents and testimony reveal that, prior to announcing the Acquisition, Cabell and St. Mary's were each striving to seize patient volume and market share from the other—and feared the other hospital was doing the same. Documents show that the hospitals viewed each other as "competitive threats" in areas including emergency services, surgery, and cancer care.

79. Cabell and St. Mary's compare their quality and patient satisfaction metrics to one another's. For example, after a quality-ranking company released new, "disturbing" results showing that St. Mary's had scored much higher than Cabell on six service lines, Cabell's Director of Strategic Marketing sent an email to other executives asking, "Is this something we should look into from a quality perspective?" Similarly, St. Mary's benchmarked quality measures, such as average emergency room wait times and patient perceptions of cleanliness, responsiveness, staff and physician communication, pain management, and other factors, against Cabell.

80. Documents comparing emergency room (or "ER") services reflect Cabell's and St. Mary's close competition on

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quality. A St. Mary's executive boasted that patients' transition from the ER to inpatient beds was "seamless," while "one very big issue at CHH is that [patients] would sit for hours." In light of reports that Cabell had low ER volumes and was losing ER market share to St. Mary's, Cabell's VP of Marketing asked, [REDACTED]

Cabell also [REDACTED]

[REDACTED] which St. Mary's executives understood as "yet another move to impact EMS volumes to CHH [Cabell Huntington Hospital] vs. SMMC." St. Mary's has also explored improvements to better compete with Cabell, including a [REDACTED]

81. In addition, Cabell and St. Mary's closely monitor each other's service line and quality-themed advertisements. For example, after a St. Mary's advertisement touted the superiority of its high-definition da Vinci robotic surgical system technology, Cabell's Marketing Director began "working on three different CHH da Vinci newspaper ads to strike back," which would "hammer hard on the lack of da Vinci experience of St. Mary's surgeons." In turn, St. Mary's objected to a Cabell advertisement stating that "more people turn to the Medical Oncology team at the Edwards Comprehensive Cancer Center for Cancer Treatment than any other program in the region" on the grounds that St. Mary's treats more cancer patients than Cabell. Cabell then expressed concern internally that, to retaliate, St. Mary's would "produce a commercial saying that [St. Mary's] ER volume is nearly double ours." Cabell's and St. Mary's responses to each other's quality advertisements reflect the hospitals' intense head-to-head competition on service and quality, and also discipline them to back up their quality claims.

82. Competition has also driven Respondents to offer new technologies and service lines. For example, after St. Mary's purchased a new da Vinci robot for surgical services, Cabell was concerned about losing surgical patients because of its older, limited-capacity da Vinci model. In response, Cabell expanded

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its da Vinci services and acquired two new da Vinci models. Da Vinci robots benefit patients by permitting “much less invasive” surgery.

83. Cardiac services are an area of traditional strength for St. Mary’s. In 2013, however, Cabell overcame St. Mary’s opposition to obtain CON approval to offer emergency PCI cardiac catheterization services. Before Cabell received this CON, patients at Cabell requiring PCI services had been transferred to St. Mary’s. Over the past several years, Cabell has developed plans to further expand and enhance its cardiac program, [REDACTED]

84. Cabell has also increased competition with St. Mary’s for cancer services, another traditional strength of St. Mary’s. In 2006, Cabell opened the Edwards Comprehensive Cancer Center, and its market share for cancer services increased at St. Mary’s expense. Consistent with this strategy of targeting St. Mary’s service lines of traditional strength, recent Cabell documents identify cancer and cardiovascular as two “strategic service lines” for which Cabell has been looking to increase volumes.

85. The elimination of this vigorous and beneficial quality competition between Cabell and St. Mary’s would affect all patients who use these hospitals, including commercially insured, Medicare, Medicaid, and self-pay patients. Post-Acquisition, the hospitals would no longer be spurred by each other to improve the quality of their services, add service lines, obtain new technologies, recruit new physicians, and increase patient safety, comfort, and convenience. Already, these effects from the pending Acquisition can be seen: St. Mary’s has put on hold plans to build [REDACTED]

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D.**Temporary Conduct Remedies Would Not Prevent Competitive Harm or Replicate Market Competition**

86. In an acknowledgment that the proposed Acquisition would produce anticompetitive effects, Respondents attempted to create temporary conduct remedies through Cabell's entry into the LOA [REDACTED] and the AVC with the West Virginia Attorney General.

87. In November 2014, Cabell agreed to the LOA with [REDACTED]

[REDACTED] informed Cabell that [REDACTED]

[REDACTED] The LOA, which is expressly contingent on consummation of the Acquisition, [REDACTED]

88. In the AVC, which was signed in July 2015, Cabell and St. Mary's committed to certain terms temporarily governing the merged entity's conduct post-Acquisition. Among other things, the AVC purports to impose certain limits with respect to hospital charges, operating margins, termination of evergreen health plan contracts, and opposition to certain CON applications. Each of these commitments expires seven years after the Acquisition is consummated.

89. For mergers that may substantially lessen competition, the Supreme Court, other courts, and the federal antitrust agencies strongly prefer "structural" remedies, such as pre-merger injunctions and post-merger divestitures, to preserve competition rather than "conduct" remedies, which rely on courts or enforcement authorities to police post-merger behavior. For example, just this year, in *Commonwealth v. Partners Healthcare System, Inc.*, a Massachusetts court rejected a settlement agreement, similar to but far more detailed than the AVC,

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between merging hospitals and the state attorney general. The court explained that such a conduct remedy “permits consolidation and then attempts to limit the consequences that flow from that by imposing certain restrictions on the defendant’s behavior” and thus “require[s] constant and costly monitoring.” The court further stated that “the remedies that are proposed 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.” The same is true here.

90. First, neither the LOA nor the AVC restores the competition that the Acquisition would eliminate. They simply, and ineffectively, seek to limit the harm that results from the substantial lessening of competition.

91. Even if the LOA and AVC closed off all potential avenues for price increases to consumers during their terms—which they do not—they do not preserve quality competition between Cabell and St. Mary’s. In fact, it is likely that any temporary mitigation of price increases during the effective dates of the LOA and AVC would result in greater non-price harm, as the merged firm exercises its market power to limit quality and service improvements.

92. Nor does the AVC protect health plans that would seek to renegotiate their agreements to obtain better terms from Cabell and St. Mary’s. The provision restricting termination of evergreen contracts preserves agreements that were negotiated by Cabell and St. Mary’s jointly through Tri-State and contain terms favorable to the hospitals. Post-Acquisition, the health plans would be negotiating against a combined Cabell/St. Mary’s—the only hospital provider in the Four-County Huntington Area—and therefore could not take advantage of competition to negotiate more favorable terms.

93. Finally, the AVC and the LOA would terminate no later than seven years from the Acquisition, at which time the combined Cabell/St. Mary’s would be able to use its enhanced bargaining leverage to demand higher prices without any constraint imposed by the AVC and the LOA.

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94. Because other regional hospitals are distant and insufficient substitutes for Cabell and St. Mary's for the majority of patients in the Four-County Huntington Area, health plans would be compelled to pay higher prices after the expiration of the AVC and LOA.

VII.

ENTRY BARRIERS

95. Neither entry by new healthcare providers into the relevant service markets nor expansion by existing market participants would deter or counteract the serious competitive harm likely to result from the Acquisition.

96. New hospital entry in the Four-County Huntington Area would not be likely, timely, or sufficient to deter or offset the Acquisition's harmful effects. Construction and operation of a new general acute care hospital involves major capital investment and serious financial risk and would take many years from the initial planning stage to opening.

97. It is also unlikely that sufficient demand exists for a new GAC inpatient hospital in the Four-County Huntington Area. The Four-County Huntington Area is an economically challenged region with flat population growth and high percentages of Medicare and Medicaid patients, making it unattractive for new hospital development.

98. West Virginia's CON regulations, administered by the WVHCA, pose an additional significant barrier to entry. West Virginia requires that "all health care providers, unless otherwise exempt, must obtain a CON before (1) adding or expanding health care services, (2) exceeding the capital expenditure threshold of \$3,112,828, (3) obtaining major medical equipment valued at \$3,112,828 or more, or (4) developing or acquiring new health care facilities." Under this regulatory regime, enhancing competition is not necessarily grounds for approving new healthcare services; instead, the aim is to develop new institutional health services in an "orderly, economical" manner that "avoid[s] unnecessary duplication." According to the

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WVHCA, “currently, there is no demand for additional beds in the Huntington area.” Thus, West Virginia is unlikely to approve entry that would duplicate services provided by the merged entity.

99. Indeed, West Virginia’s CON regulations have repeatedly thwarted the development of competitive healthcare services in the Four-County Huntington Area. For example, the WVHCA denied a Huntington physician group’s application to acquire an MRI; as a result, the group was compelled to enter into a joint venture with St. Mary’s to obtain the equipment. The WVHCA also denied Cabell’s application to provide fixed open-bore MRI services, which were offered by St. Mary’s.

100. Other GAC hospitals in the communities surrounding the Four-County Huntington Area have no plans to enter or expand into Huntington. In addition, King’s Daughters’ financial struggles following a Department of Justice investigation create a further reason why that hospital is unlikely to expand into the Four-County Huntington Area.

101. Entry of outpatient surgical services providers also would not be likely, timely, or sufficient to deter or offset the Acquisition’s harmful effects. Opening an outpatient surgery center requires considerable time and capital investment, as the opening of Three Gables in 2000 demonstrates. It took four years for Three Gables to open, including two years of planning and two years of construction, and the owners [REDACTED]. In addition, West Virginia’s CON laws apply to outpatient facilities and services. No company or group of physicians has declared plans to open a new outpatient surgical center in the Four-County Huntington Area.

VIII.**EFFICIENCIES**

102. Efficiencies that could outweigh the Acquisition’s likely significant harm to competition are lacking here.

103. [REDACTED]

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[REDACTED]

[REDACTED] These asserted savings have not been substantiated and face multiple practical obstacles.

104. Nor are the claimed cost savings merger-specific. There are significant, unexplored savings opportunities available to Cabell and St. Mary's independently, without the Acquisition, and St. Mary's could also achieve savings through a less competitively-harmful acquisition by one of the multiple alternative bidders in the 2014 RFP.

105. Even if a portion of the claimed efficiencies were to be realized, they would be offset by the costs of integrating the two hospitals,

[REDACTED]

[REDACTED] Post-Acquisition,

[REDACTED] this expense would offset any cognizable savings.

106. Respondents also claim that the Acquisition will lead to quality enhancement opportunities, but these claims are likewise unsubstantiated and largely lack merger-specificity. Respondents assert that the merged entity will realize volume-related improvements in the quality of care through the consolidation of certain clinical service lines. Respondents' analysis on this issue is conclusory and does not account for the fact that the procedures with demonstrated volume-outcome relationships are already largely consolidated at one or the other hospital, and that certain key services may not be consolidated. Respondents also project quality improvements from "standardization" across the two facilities and the building of a "bridge" between the two hospitals' electronic health records systems to render them interoperable. Neither of these initiatives has been substantiated, and neither is merger-specific.

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IX.**VIOLATION****COUNT I – ILLEGAL AGREEMENT**

107. The allegations of Paragraphs 1 through 106 above are incorporated by reference as though fully set forth herein.

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

COUNT II – ILLEGAL ACQUISITION

109. The allegations of Paragraphs 1 through 106 above are incorporated by reference as though fully set forth.

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

NOTICE

Notice is hereby given to the Respondents that the 5th day of April, 2016, at 10 a.m., is hereby fixed as the time, and the Federal Trade Commission offices at 600 Pennsylvania Avenue, N.W., Room 532, Washington, D.C., 20580, as the place, when and where an evidentiary hearing will be had before an Administrative Law Judge of the Federal Trade Commission, on the charges set forth in this complaint, at which time and place you will have the right under the Federal Trade Commission Act and the Clayton Act to appear and show cause why an order should not be entered requiring you to cease and desist from the violations of law charged in the complaint.

You are notified that the opportunity is afforded you to file with the Commission an answer to this complaint on or before the fourteenth (14th) day after service of it upon you. An answer in

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which the allegations of the complaint are contested shall contain a concise statement of the facts constituting each ground of defense; and specific admission, denial, or explanation of each fact alleged in the complaint or, if you are without knowledge thereof, a statement to that effect. Allegations of the complaint not thus answered shall be deemed to have been admitted.

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

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

The Administrative Law Judge shall hold a prehearing scheduling conference not later than ten (10) days after the Respondents file their answers. Unless otherwise directed by the Administrative Law Judge, the scheduling conference and further proceedings will take place at the Federal Trade Commission, 600 Pennsylvania Avenue, N.W., Room 532, Washington, D.C., 20580. Rule 3.21(a) requires a meeting of the parties' counsel as early as practicable before the pre-hearing scheduling conference (but in any event no later than five (5) days after the Respondents file their answers). Rule 3.31(b) obligates counsel for each party, within five (5) days of receiving the Respondents' answers, to make certain initial disclosures without awaiting a discovery request.

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NOTICE OF CONTEMPLATED RELIEF

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

1. If the Acquisition is consummated, divestiture or reconstitution of all associated and necessary assets, in a manner that restores two or more distinct and separate, viable and independent businesses in the relevant markets, with the ability to offer such products and services as Cabell and St. Mary's were offering and planning to offer prior to the Acquisition.
2. A prohibition against any transaction between Cabell and St. Mary's that combines their businesses in the relevant markets, except as may be approved by the Commission.
3. A requirement that, within four months, Cabell and St. Mary's will, individually and without sharing information or otherwise coordinating with one another, renegotiate each still-effective health plan contract that was negotiated through Tri-State Health Partners.
4. A requirement that, for a period of time, Cabell and St. Mary's provide prior notice to the Commission of acquisitions, mergers, consolidations, or any other combinations of their businesses in the relevant markets with any other company operating in the relevant markets.
5. A requirement to file periodic compliance reports with the Commission.
6. Any other relief appropriate to correct or remedy the anticompetitive effects of the transaction or to restore St. Mary's as a viable, independent competitor in the relevant markets.

Final Order

IN WITNESS WHEREOF, the Federal Trade Commission has caused this complaint to be signed by its Secretary and its official seal to be hereto affixed, at Washington, D.C., this fifth day of November, 2015.

By the Commission.

**ORDER RETURNING MATTER TO ADJUDICATION
AND DISMISSING COMPLAINT**

On March 24, 2016, the Commission withdrew this matter from adjudication for thirty days. On April 22, 2016, the withdrawal from adjudication was extended until 11:59 p.m. EDT on the 14th calendar day after the West Virginia Health Care Authority (“WVHCA”) issued its written decision, pursuant to Section 16-29B-28(e)(3) of the Code of West Virginia, regarding the Application of Cooperative Agreement (Acquisition of St. Mary’s Medical Center) filed by Respondent Cabell on March 25, 2016. On June 22, 2016, the WVHCA issued its written decision approving the Cooperative Agreement.

For the reasons outlined in the Statement of the Commission issued concurrently with this Order, the Commission has now determined to return this matter to adjudication for the sole purpose of dismissing the Complaint. Accordingly,

IT IS ORDERED that this matter be, and it hereby is, returned to adjudication;

and

IT IS FURTHER ORDERED that the Complaint in this matter be, and it hereby is, dismissed without prejudice.

By the Commission.

Statement of the Commission

Statement of the Federal Trade Commission

In November 2015, the Commission issued an administrative complaint challenging Cabell Huntington Hospital's proposed acquisition of St. Mary's Medical Center, the only two hospitals in Huntington, West Virginia. The Commission had reason to believe that the acquisition would create a near-monopoly over general acute care inpatient hospital services and outpatient surgical services in the four-county region surrounding Huntington. As alleged in the complaint, this near-monopoly is likely to increase prices and degrade quality of care.

Although our concerns about this transaction remain, the Commission has determined to dismiss the administrative complaint without prejudice. We do so in light of the passage of West Virginia Senate Bill 597 ("SB 597") and the West Virginia Health Care Authority's decision to approve Cabell's cooperative agreement with St. Mary's, with which the West Virginia Attorney General concurred.

This case presents another example of healthcare providers attempting to use state legislation to shield potentially anticompetitive combinations from antitrust enforcement. The Commission believes that state cooperative agreement laws such as SB 597 are likely to harm communities through higher healthcare prices and lower healthcare quality.

Cooperative agreement laws, which seek to replace federal (and sometimes state) antitrust enforcement and judicial review under the antitrust laws with state regulation and supervision of healthcare provider combinations, undervalue the important role that competition plays in the healthcare sector. In general, vigorous competition benefits consumers through lower prices, higher quality goods and services, greater access to goods and services, and innovation. Empirical research demonstrates this holds true in healthcare provider markets as well. As a recently published economic review article notes, "the message from this literature is clear ..., mergers between rival hospitals are likely to raise the price of inpatient care and these effects are larger in

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concentrated markets.”¹ A recent economic working paper confirms this conclusion.² Further, these price increases are likely to be passed on to consumers through higher insurance premiums, deductibles, and copays; reduced coverage; or lower wages.³ Finally, the weight of the existing evidence shows that competition improves clinical hospital quality and lowers mortality rates.⁴

Proponents of cooperative agreement laws claim that antitrust enforcement undermines the policy goals of the Affordable Care Act to improve quality and lower costs through greater coordination among healthcare providers. This is fundamentally incorrect. The ACA did not repeal the antitrust laws, and it certainly does not condone mergers that substantially lessen competition.⁵ In many cases, healthcare providers can advance

1 Martin Gaynor et al., *The Industrial Organization of Health Care Markets*, 53 J. ECON. LIT. 235, 262 (2015); *see also* Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation: Update*, Robert Wood Johnson Found. (June 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

2 Zack Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured* (Nat'l Bur. of Econ. Research, Working Paper No. 21815, 2015), <http://www.nber.org/papers/w21815.pdf>.

3 For empirical evidence on the impact on premiums and wages, *see, e.g., id.*; Erin Trish & Bradley Herring, *How Do Health Insurer Market Concentration and Bargaining Power With Hospitals Affect Health Insurance Premiums?*, 42 J. HEALTH ECON. 104, 112 (2015); Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LABOR ECON. 609–34 (2006).

4 *See* Gaynor et al., *supra* note 1, at 249 (“[T]he evidence indicates that increases in competition improve hospital quality.”); *see also* Martin Gaynor et al., *Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service*, 5 AM. ECON. J.: ECONOMIC POLICY 134 (2013); Zack Cooper et al., *Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms*, 121 ECON. J. 228 (2011); Nathan Wilson, *Market Structure as a Determinant of Patient Care Quality*, 2 AM. J. HEALTH ECON. 241 (2016).

5 In fact, the ACA final program rules specifically recognize antitrust enforcement’s role in ensuring competition in provider markets. U.S. Dep’t of Health & Human Servs., Centers for Medicare & Medicaid Servs., Medicare Program, Medicare Shared Savings Program: Accountable Care Organizations,

Statement of the Commission

the goal of delivering clinically integrated care either on their own or through mergers or other collaborations that raise little or no antitrust concern. Indeed, the Federal Trade Commission and the Antitrust Division of the Department of Justice have issued extensive guidance to providers seeking to collaborate within the bounds of the antitrust laws.⁶ In short, antitrust enforcement is consistent with – not an impediment to – the goals of the ACA.

Proponents of hospital mergers often argue, citing the policy goals of the ACA encouraging greater coordination of care, that a merger is necessary to improve quality and lower costs. Proponents claim those potential benefits as procompetitive efficiencies justifying mergers or collaborations that otherwise may raise antitrust concerns. We understand that coordination of care has the potential to further key goals of healthcare reform and consider those benefits when evaluating a provider merger. The FTC’s and the Department of Justice’s Horizontal Merger Guidelines expressly recognize that mergers may “result in lower prices, improved quality, enhanced service, or new products,” and that these possible benefits must be evaluated and weighed against potential anticompetitive harm.⁷ Claimed benefits, however, are only cognizable if they are merger-specific. Many of the purported benefits of hospital mergers – including coordination of patient care, sharing information through

42 C.F.R. § 425 (2011), 76 Fed. Reg. 67,826 (Nov. 2, 2011), <https://www.gpo.gov/fdsys/pkg/FR-2011-11-02/html/2011-27461.htm>.

6 See, e.g., Fed. Trade Comm’n & U.S. Dep’t of Justice, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011), <https://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf>; Fed. Trade Comm’n & U.S. Dep’t of Justice, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (2000), https://www.ftc.gov/sites/default/files/documents/public_events/joint-venture-hearings-antitrust-guidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf; U.S. Dep’t of Justice & Fed. Trade Comm’n, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), <https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf>.

7 U.S. Dep’t of Justice & Fed. Trade Comm’n, HORIZONTAL MERGER GUIDELINES 29–31 (2010), <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.

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electronic medical records, population health management, risk-based contracting, standardizing care, and joint purchasing – can often be achieved through alternative means that do not impair competition. Ultimately, the Commission challenges few hospital mergers and only does so after thorough investigation indicates, as alleged in this case, that the combination is likely to result in a loss of competition that is not outweighed by improvements in quality and cost efficiencies.

Cooperative agreements that replace antitrust enforcement with state regulatory regimes often protect likely anticompetitive transactions that impose harms far exceeding their benefits. These laws and any accompanying promises providers may make, no matter how well-intentioned or sophisticated, are unlikely to replicate the manifold benefits of competition. For this reason, the Commission has consistently recommended that states not implement such laws.⁸

Serious questions also remain about what happens if the parties to a cooperative agreement fail to achieve the level of benefits promised to state authorities and their local communities. Because healthcare provider mergers are difficult to unwind, there is no easy remedy if a cooperative agreement fails to deliver its promised benefits. In all likelihood, the benefits of competition will be lost, and patients, employers, and communities will suffer the consequences of higher-cost and lower-quality healthcare.

Finally, we emphasize that we will continue to vigorously investigate and, where appropriate, challenge anticompetitive mergers in the courts and, if necessary, through state cooperative agreement processes. Our decision to dismiss the complaint without prejudice does not necessarily mean that we will do the

⁸ See, e.g., Fed. Trade Comm’n Staff Comment Before the Ala. State Senate Re: House Bill 241 and Senate Bill 243 (May 2, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-alabama-state-senate-regarding-alabama-house-bill-241-senate-bill-243/160504commentalabama.pdf; Fed. Trade Comm’n Staff Comment to W.Va. House of Delegates Re: Senate Bill 597 (Mar. 9, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-west-virginia-house-delegates-regarding-sb-597-competitive-implications-provisions/160310westvirginia.pdf.

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same in other cases in which a cooperative agreement is sought or approved.

Complaint

IN THE MATTER OF

**VICTREX PLC,
INVIBIO LIMITED,
AND
INVIBIO, INC.**CONSENT ORDER, ETC. IN REGARD TO ALLEGED VIOLATIONS OF
SECTION 5 OF THE FEDERAL TRADE COMMISSION ACT

*Docket No. C-4586; File No. 141 0042
Complaint, July 13, 2016 – Decision, July 13, 2016*

This consent order addresses Victrex plc's, Invibio, Inc.'s and Invibio Ltd.'s use of exclusive supply contracts. The complaint alleges that respondents violated of Section 5 of the Federal Trade Commission Act by using exclusive supply contracts to maintain monopoly power in the market for implant-grade polyetheretherketone ("PEEK"). The consent order requires Invibio to cease and desist from enforcing most exclusivity terms in current supply contracts and generally prohibits Invibio from requiring exclusivity in future contracts. The order also prevents Invibio from adopting other mechanisms, such as market-share discounts or retroactive volume discounts, to maintain its monopoly power.

Participants

For the *Commission*: Dana Abrahamsen, Wes Carson, Mika Ikeda, Kristin Shaffer, and Charlotte Slaiman.

For the *Respondents*: Barbara Sicalides, Pepper Hamilton LLP.

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as amended, 15 U.S.C. § 41, et seq., and by virtue of the authority vested in it by said Act, the Federal Trade Commission ("Commission"), having reason to believe that Victrex plc, Invibio, Inc., and Invibio Limited (hereinafter collectively referred to as "Invibio" or "Respondents") have violated the provisions of Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, and it appearing to the Commission that a proceeding