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Some Practical Lessons from the ProMedica Hospital Merger Decision

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On March 29, a federal district court in Ohio granted the FTC preliminary relief to prevent ProMedica Health System in Toledo, which had acquired nearby St. Luke's Hospital, from further integrating St. Luke's into the ProMedica system. The basic concern was that the merger would provide ProMedica with market power sufficient to raise the prices that both St. Luke's and the other ProMedica facilities could obtain from commercial health plans.

In May 2010, ProMedica and St. Luke's executed a "joinder agreement" by which ProMedica would become the sole member of St. Luke's. The FTC opened an investigation in July. In August, the FTC and the parties agreed to a hold-separate order limiting ProMedica's ability to control St. Luke's, and the transaction closed in September. The investigation continued, but when ProMedica refused to extend the hold-separate order in early 2011, the FTC filed motion for preliminary injunction to extend it until the case could be tried before an FTC administrative law judge. After conducting a two-day hearing, the court issued the injunction, accompanied by a 115-page opinion with a preliminary antitrust analysis of the transaction.

Subsequently, in May 2011, ProMedica's insurer filed suit for a declaratory judgment, claiming that it is not obligated to pay for ProMedica's defense, notwithstanding that ProMedica's insurance policies specifically covered antitrust claims. In essence, the insurer alleges that ProMedica failed to timely notify it of the claim and, in a renewal application, materially misrepresented facts.

A number of practical pointers emerge from these two actions—relating to planning for and defending hospital mergers and in helping to ensure that if antitrust

litigation follows and the hospital has insurance for antitrust matters, the insurer must cover the claim. Following are several lessons.

1. Watch what you say and write.

Pre-merger comments and documents about the reasons for a merger or its likely effects on competition can be disastrous in an antitrust investigation or litigation, if not fatal.

According to the FTC's complaint, an important reason for the ProMedica/St. Luke's merger was to increase St. Luke's rates from managed-care plans. St. Luke's believed it was obtaining subcompetitive rates and was looking for a mechanism to raise them. The district court noted that prior to the transaction, the St. Luke's CEO told his board that ProMedica would provide it with "incredible access to outstanding pricing on managed care agreements," but he recognized that "[t]aking advantage of these strengths may not be the best thing for the community in the long run." A St. Luke's board presentation stated that an affiliation with ProMedica "has the greatest potential for higher hospital rates. A ProMedica-SLH partnership would have a lot of negotiating clout." And notes of a St. Luke's official proclaimed that a "ProMedica or Mercy [another area hospital system] affiliation could still stick it to employers, that is, to continue forcing high rates on employers and insurance companies." Finally, according to the court, ProMedica made it clear that it intended to increase St. Luke's rates as soon as possible after the transaction. Indeed, the parties admitted in court filings that St. Luke's badly needed higher rates and expected to obtain them through the merger.

Since the ultimate question in any antitrust merger analysis is whether the merger will permit the parties to exercise market power by raising prices, statements and documents as these, even if not fatal, are very telling about the merger's likely effect and thus its lawfulness. Parties considering mergers or other types of collaborative transactions, as well as their consultants and attorneys, should carefully guard against them.

2. Obtain payer support

Perhaps the single most important practical variable in determining whether a problematic hospital merger will be challenged is the views of payers about the effect of the merger on them. They are the customers—the parties that will suffer the anticompetitive effects of the merger if, indeed, it will have anticompetitive effects. As a result, if the matter is litigated, they are arguably the most important witnesses. Absent someone to testify about the likely adverse effect of the merger on them, the plaintiff has little, if any, case.

In the ProMedica case, payers appeared to universally oppose the transaction. For example, one testified that "what little leverage we had in negotiations with [ProMedica] has all but disappeared, and [ProMedica's] ability to demand higher rates… has increased even further." Other area payers said much the same. Payers testified that that they expected ProMedica to increase St. Luke's rates to the much higher levels of the ProMedica hospitals. Payers also testified that especially with St. Luke's as part of the ProMedica system, ProMedica was a "must-have" system—that is, payers had to include ProMedica to construct competitively viable provider networks. One payer went so far as to say that absent a contract with ProMedica, it would be forced to exit the market. So payers, at least in their view, were left with the choice of paying the higher prices that they expected ProMedica to demand, suffering competitively, or withdrawing from the market.

Thus, it is crucial, early on, for the merging parties to attempt to convince payers to support, or at least not oppose, the transaction. Their argument often will be based on the passing-on of efficiencies from the transaction health plans and patients.

3. Post-merger conduct is important.

If the merger has been consummated for period of time, it may be possible to examine its actual effects on competition based on a post-merger track record — most prominently, whether the merger has resulted in higher, supracompetitive prices. This was true, for example, in the FTC's successful challenge to Evanston Northwestern Health Care's acquisition of Highland Park Hospital. The FTC challenged the transaction four years after it was consummated and was able to

show that the merger (and not other factors) resulted in significant price increases to most area health plans. The agencies' new Horizontal Merger Guidelines provide that this type of post-merger direct evidence of actual effects on competition "can be dispositive" of a violation.

Even if there is no evidence of an actual post-merger price increase, the parties' post-merger statements and actions may indicate what the effect is likely to be. In the ProMedica case, the hold-separate order prohibited ProMedica from negotiating prices on behalf of St. Luke's. But the court found that ProMedica, after St. Luke's joined the system, had presented payers with proposals to increase St. Luke's rates by some 22 percent. Payers testified that they expected ProMedica to increase St. Luke's rates by some 20 percent.

4. Retain an economist early on.

For better or worse, no attorney today can adequately represent clients in hospital-merger investigations and litigation without substantial help from a consulting economist specializing in health care antitrust issues. More and more, the enforcement agencies' economists are constructing complex econometric models to predict or assess the price effect of mergers. Indeed, the agencies' Horizontal Merger Guidelines specifically provide that the agencies "may construct economic models designed to quantify the unilateral effects resulting from the merger," including use of "merger simulation" models. Attorneys may understand the results of these models, but rare is the attorney who can construct or implement one, or understand the modeling sufficiently to rebut the agencies' economists' models.

The ProMedica case provides a good example. There, the FTC's economist testified, based on an econometric model known as "willingness to pay" that insured patients placed substantial value on ProMedica's inclusion in payer networks and an even higher value if St. Luke's were part of the ProMedica system. This suggested that the merger would increase ProMedica's bargaining leverage with payers, which could lead to price increases. The FTC also relied heavily on econometric techniques in both its Evanston Northwestern case and in its challenge to Inova Health System's proposed acquisition of Prince William

Hospital. The merging hospitals must have an knowledgeable economist to review and rebut the work of the agency's economist.

5. Carefully estimate efficiencies applying the Merger Guidelines.

The most common argument in favor of a problematic hospital merger is that the merger will generate substantial efficiencies that counteract any adverse effect from a larger market share of higher market concentration. Efficiencies are easy to claim but difficult to prove, and thus the agencies are understandably skeptical about efficiency claims. For this reason, the agencies' Horizontal Merger Guidelines outline a number of requirements that efficiency claims must meet to count in favor of the transaction. These should be kept carefully in mind by the parties themselves and by any consultants they retain to examine and quantify efficiencies.

According to the Merger Guidelines, the estimated efficiencies from the transaction must be merger-specific, substantiated and verifiable, net of any costs necessary to achieve them, and not result in any anticompetitive reductions in output. For purposes of substantiation, from the materials that the parties submit, usually an efficiencies report prepared by an expert in conjunction with the hospitals' business personnel, the agency must be able to verify, about each claimed efficiency, (1) the likelihood of its achievement; (2) its magnitude; (3) how it will be achieved; (4) when it will be achieved; (3) the cost of its achievement; (4) why it is merger-specific; and (5) how it will increase the merged firm's incentive to compete. The bottom line, thus, is that it is pointless to simply submit a report stating that the hospitals will achieve $X in savings over Y period of time without providing substantial detailed back-up information. Substantial detail is essential. And importantly, efficiencies cannot be estimated until the hospitals develop and agree on a post-merger consolidation and integration plan, which should be one of the first orders of business (but rarely is) as hospitals discuss coming together.

The ProMedica court was highly critical of the efficiencies report, suggesting that the hospitals had only begun to consider their post-merger integration plans. The efficiencies study that they submitted was described as only an "initial plan." The report stated that its "estimates . . . are preliminary and subject to further study."

The ProMedica CEO testified that "if we don't find those efficiencies, we will find other efficiencies," leading the court to wonder if the hospitals would actually implement the activities necessary to achieve the efficiencies they claimed. The court noted that the efficiencies report stated that certain claimed efficiencies "may" be achieved, not that they would be achieved. And a St. Luke's official testified that that some of the claimed efficiencies had resulted from "no[] or very little analysis"; about one claimed efficiency, he testified that "I don't believe this claim."

The court noted other shortcomings as well. There were claims of capital avoidance from the merger when the hospital's strategic plans did not reflect the capital projects that would be abandoned in light of the merger. As to some, a St. Luke's official testified that he had no basis for the costs of the projects that would be avoided. There had been no detailed study of potential clinical consolidation possibilities resulting from the merger. Some claimed efficiencies, the court found, were not merger-specific; others were speculative; and others lacked sufficient back-up materials. And the court noted that efficiency claims are particularly suspect if they "are generated outside the usual business planning process." As a result, the court gave the efficiencies report very little credence.

Given that the agencies and courts are skeptical of efficiency claims to begin with, it is crucial that attorneys representing the parties, the parties themselves, and their consultants understand the agencies' requirements for a valid efficiencies argument and build their efficiencies claims around those requirements.

6. Health care reform is no defense.

Several merging hospitals have argued to the agencies that the merger should be permitted to proceed because it would permit them to form the "critical mass" necessary to develop and implement procompetitive new and innovative forms of delivery and reimbursement anticipated by health care reform — for example, development of ACOs. Indeed, much in health care reform does emphasize consolidation and collaboration, but this argument is receiving short shrift from the agencies and, if the ProMedica decision is any indication, from the courts.

In most circumstances, the argument is too speculative to count. An FTC staff reached this conclusion in one hospital-merger investigation that ultimately was not challenged. In ProMedica, the court rejected the argument that the merger was necessary for the formation of an ACO for several reasons, including that an independent St. Luke's would likely participate in ACOs with both ProMedica and Mercy if it remained independent; that, at the time of the decision, no one knew any details about ACOs because CMS had not issued its proposed regulation; and that St. Luke, prior to the merger, had concluded that it was "uniquely positioned for a smooth transition to expected health care reform."

Even if consolidation were necessary to implement an ACO, it is very unlikely that this would trump concern about a large market share or high level of concentration resulting from a merger, even if the argument were a valid legal argument.

7. Read and understand your insurance policies early on.

Antitrust investigations and litigation are notoriously expensive; the cost of even a moderately sized antitrust investigation and litigation can easily reach seven or eight figures because of the huge number of documents that must be reviewed and produced and the need for experts. Thus, it is very important for parties subjected to antitrust investigations to examine, early on, whether they have insurance that may pay some or all the costs of the investigation and any litigation that might follow and, if so, to take all the steps necessary to comply with the terms of the policy.

ProMedica had insurance that covered antitrust matters, yet now finds itself in litigation with its insurer, which claims that it had no duty to cover. ProMedica, according to the insurer's complaint, had a first policy covering the period from September 2009 to September 2010, and a second renewal policy that covered the period from September 2010 to September 2011. Both were claims-made policies.

The chronology of several events is important. As noted above, ProMedica and St. Luke's executed their joinder agreement in May 2010. The FTC opened a non-public preliminary investigation the following July, requesting documents on a voluntary basis. In August, it served ProMedica with a subpoena for testimony, and

later that month with a civil investigative demand requiring the production of documents. Shortly before the civil investigative demand was served, ProMedica entered into a hold-separate order, permitting the transaction to close in September but prohibiting ProMedica from fully integrating St. Luke's into its system.

In late September 2010, ProMedica submitted a renewal application for a policy to cover the period from September 2010 to September 2011. The application asked whether ProMedica, within the last 18 months, had completed, or would complete, any mergers or acquisitions and, if so, to describe the essential terms of each transaction. ProMedica answered "yes" with the explanation that "Yes, we are always contemplating new [transactions]." ProMedica's response, according the complaint, did not mention the St. Luke's transaction. The insurer issued the policy.

The 2009 and 2010 policies required that ProMedica notify the insurer of any claims not later than 90 days after the end of any policy period. The policies defined a "claim" as "a written demand for monetary, non-monetary or injunctive relief" or "a civil… administrative… [or] regulatory . . . proceeding for… injunctive relief commenced by… the filing of a notice of charges, formal investigative order or similar document, against an Insured for a Wrongful Act." Both policies included "related claims" provisions, defining related claims as all claims for wrongful acts involving the same facts, circumstances or events, and providing that related claims were deemed a single claim made when the earliest of the related claims occurred. To complete the relevant chronology, the FTC filed its administrative complaint and motion for preliminary injunction in January 2011, and ProMedica first notified the insurer of the claim on January 13, 2011.

In requesting a declaratory judgment that ProMedica had no coverage, the insurer cited three grounds. First, with respect to the second, 2010 policy, it argues that the issuance of the civil investigative demand and ProMedia's entering into the hold-separate order in August 2010 constituted a "claim"; that the FTC's filing of the administrative and federal-court injunction cases in January 2011 is a related claim that dates back to the first claim in August 2010; so the 2010 policy was not in effect when the claim accrued. Second, the insurer argues that, as to coverage under the first, 2009 policy, the claim accrued in August 2010 but that ProMedica

failed to notify it of the claim until January 2011, more than 90 days after the policy expired in September 2010. Finally, with respect to the 2010 policy, the insurer argues that ProMedica's failure to disclose the joinder with St. Luke's on the application was a material misrepresentation upon which the insurer detrimentally relied.

The lessons from this seem clear. First, at the first hint of an investigation, pull and carefully review the relevant insurance policies to determine whether they might include antitrust coverage. Second, if there is a colorable argument that coverage is available, notify the insurer. The insurer likely will issue a reservation-of-rights-letter, but the duty-to-notify requirement will have been met. Third, take the time to think about and fully answer the questions on insurance applications. Failing to do so is a common ground upon which insurers rely to attempt to deny coverage. Big dollars may be lost.