American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

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Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Avenue, N.W.
Washington, DC 20580

Re: COPA Assessment, Project No. P181200

The American Hospital Association ("AHA"), which represents nearly 5,000 member hospitals, health systems and other health care organizations and 43,000 individual members, submits these comments in response to the Federal Trade Commission's ("Commission" or "FTC") request for comments in connection with the Commission's Certificate of Public Advantage ("COPA") Assessment Project and the June 18, 2019 workshop on the impact of COPAs.[1]

I. OVERVIEW

Hospitals in the U.S. are under tremendous pressure to cut expenses while simultaneously providing quality care and improving access for the uninsured and underinsured. In response to these pressures, some hospitals have chosen to merge to accomplish substantial benefits for their communities. These benefits include cost savings (in both operating and capital costs), quality improvements, combinations of services that can result in both cost savings and quality improvements, the ability to offer new services, purchasing synergies, and efficiencies in purchasing or implementing expensive electronic health record systems, among many others.[2] But all too often, when hospital mergers are reviewed by the antitrust enforcement agencies or challenged in the courts, efficiencies with demonstrable benefits for patients and their communities are given short shrift. Concerns about possible competitive issues outweigh the concrete, real and substantial benefits a merger would bring to the merging hospitals' communities.

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[1] The COPA Assessment Project was announced on November 1, 2017. News Release, FTC Staff Seeks Empirical Research and Public Comments Regarding Impact of Certificates of Public Advantage (Nov. 1, 2017), https://www.ftc.gov/news-events/press-releases/2017/11/ftc-staff-seeks-empirical-research-public-comments-regarding. The request for comments and information on the June 18, 2019 workshop were released on April 12, 2019, and are available at https://www.ftc.gov/news-events/events-calendar/health-check-copas-assessing-impact-certificates-public-advantage.

[2] For a recent catalogue of the kinds of efficiencies hospital mergers frequently produce, see Norman Armstrong & Subramaniam Ramanarayanan, *Taking Stock of the Efficiencies Defense: Lessons from Recent Health Care Merger Reviews and Challenges*, 82 ANTITRUST L. J. 579, 580-81 (2019).

The Horizontal Merger Guidelines issued by the Federal Trade Commission and the Department of Justice indicate that the agencies will credit efficiencies in an antitrust analysis.[3] The experience of many merging hospitals, however, is that the enforcement agencies set such a high standard to establish efficiencies that the Guidelines' promise that efficiencies will be credited is chimerical. And, as the Commission knows well because many of these precedents have been established in FTC litigation, an increasing number of courts have questioned whether there is any role for efficiencies in a merger analysis.[4]

In response to this situation, many state legislatures and hospitals have concluded that a COPA process—in which state regulators typically review competitive issues in the broader context of examining all possible costs and benefits that may flow from a merger—is preferable to an antitrust review that focuses narrowly on competition to the near exclusion of all other considerations. Yet COPAs come at a considerable cost. Obtaining a COPA takes time, effort and expense. Once obtained, a COPA imposes a burden of continuing regulation on the hospitals that requested it. The fact that some hospitals seek COPAs under these conditions speaks to the reality that hospitals do not believe they can obtain antitrust clearance for their merger based on legitimate efficiencies claims. These hospitals have concluded that the expense and continuing burden of a COPA is better than the alternative of not merging and foregoing the benefits for their communities their mergers would provide.[5]

The AHA takes no position in these comments whether COPA laws represent good or bad policy. The AHA urges the Commission—which has made no secret of its opposition to these laws—to consider the possibility that the drive to enact COPA laws and to obtain COPAs is fueled, in part, by the agency's overly harsh treatment of efficiencies claims made by merging hospitals. If the FTC were to credit legitimate claims of efficiencies more frequently, the pressure to enact additional COPA legislation might well diminish, as might the number of hospitals seeking COPAs in the future.

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[3] United States Dep't of Justice & Fed. Trade Comm'n, Horizontal Merger Guidelines §10 (2010), https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf.

[4] The Third and Ninth circuits have questioned whether efficiencies may be used to rebut a prima facie case that a merger is anticompetitive. *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 348 (3d Cir. 2016) (rejecting proposed efficiencies and questioning whether the defense "even exists"); *Saint Alphonsus Med. Ctr. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775, 790 (9th Cir. 2015) ("[w]e remain skeptical about the efficiencies defense in general and about its scope in particular"). The D.C. Circuit in separate panel opinions has both encouraged and (much more recently) questioned the efficiencies defense. *FTC v. H. J. Heinz Co.*, 246 F.3d 708, 720 (D.C. Cir. 2001) ("the trend among lower courts is to recognize the [efficiencies] defense"); *United States v. Anthem, Inc.*, 855 F.3d 345, 353 (D.C. Cir. 2017) (citing *FTC v. Procter & Gamble Co.* 386 U.S. 568 (1967) for the proposition that efficiencies "cannot be used as a defense to illegality"); *but see id.* at 377 (Kavanaugh, J., dissenting) (stating that in light of *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974) courts must "consider the efficiencies and consumer benefits of the merger"). The Eighth and Eleventh Circuits have approved consideration of efficiencies in a merger analysis. *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1053-55 (8th. Cir. 1999) ("evidence of enhanced efficiency in the context of the competitive effects of the merger" should be weighed in the competitive balance); *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1222 (11th Cir. 1991) (efficiencies are "an important consideration in predicting whether the acquisition would substantially lessen competition").

[5] *See generally* Kaley Fendall & David Maas, *Where Art Thou, Efficiencies? The Uncertain Role of Efficiencies in Merger Review*, Competition, The Journal of the Antitrust, UCL and Privacy Section of the California Lawyers Association, 1, 8 (Winter 2017-2018) ("One result of this skepticism of efficiencies may be more interest in 'COPA' laws.").

II. BACKGROUND

The first COPA laws appear to have been enacted in the early 1990s, when at least 18 states enacted COPA legislation.[6] Few COPAs were granted to merging hospitals under those laws.[7] At least one of those—the COPA granted to the two merging hospitals in Great Falls, Montana—was sought and obtained during the pendency of an FTC investigation into the hospitals' proposed merger.[8] The FTC's letter closing its investigation into the Great Falls merger following the grant of a COPA makes clear the agency was focused on competitive concerns, not efficiencies that could flow from the consolidation of the only two hospitals in the city.[9] Yet the Montana Department of Justice, which granted the COPA, found the merger was likely to result in lower health care costs than would occur in the absence of the transaction.[10] The merger, the Department found, would result in "significant cost savings."[11] These included both savings in operating costs and capital costs.[12] The Department also found that the merger would permit the two hospitals to combine and avoid unnecessary duplication of services such as emergency departments, surgical facilities, and OB and pediatric units.[13] And the merger would result in higher patient volumes in several combined services allowing for more efficient and cost effective operations in those services.[14] Perhaps, most importantly, the Department found, "only one full-service hospital is likely to survive in Great Falls."[15] By permitting a merger that the FTC very possibly would have opposed, the Department was able to provide a smooth transition to a single hospital in Great Falls while ensuring—through lengthy and detailed conditions placed on the merger—that cost savings from the merger would be passed on to consumers.[16]

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[6] *See* Federal and State Antitrust Actions Concerning the Health Care Industry, GAO/HEHS-94-220, 10, 12-13 (Aug. 1994) (hereafter "1994 GAO Report"), https://www.gao.gov/assets/230/220139.pdf.

[7] The FTC staff notice of the COPA assessment project states that to the best of the staff's knowledge, only four COPAs were issued for hospital mergers in the 1990s: HealthSpan Hospital System (Minnesota, 1994), Mission Health System (North Carolina, 1995), Benefis Health System (Montana, 1996), and Palmetto Health System (South Carolina, 1998). FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments, 1 n.2 (Nov. 1, 2017), https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa_assessment_public_notice_11-1-17_revised_3-27-19.pdf. Other COPAs were granted during that decade for transactions short of a hospital merger. *See, e.g.*, 1994 GAO Report at 11 (noting that as of May 1994, Maine, Oregon, and Washington each had approved a COPA agreement for joint venture's short of merger).

[8] *See* Amended Findings of Fact, Conclusions of Law, and Certificate of Public Advantage, 43-51, In the Matter of the Application for a Certificate of Public Advantage By the Columbus Hosp. and Mont. Deaconess Med. Ctr., Great Falls, Montana (Mont. Dep't of Justice 1996) (hereafter "Montana COPA Decision"), https://dojmt.gov/wp-content/uploads/2011/05/decisionamended19961.pdf.

[9] Letter from Robert Leibenluft, Assistant Director, Health Care Division, FTC, to Joe Sims (June 28, 1996), https://www.ftc.gov/sites/default/files/documents/closing_letters/columbus-hospital/montana-deaconess-medical-center/960628columbushospitalletter.pdf.

[10] Montana COPA Decision at 10.

[11] *Id.* at 12.

[12] *Id.* at 12-13.

[13] *Id.* at 17-18.

[14] *Id.* at 23.

[15] *Id.* at 20.

[16] *Id.* at 43-79 ("Terms and Conditions").

After a two decade lull, COPA laws again became a subject of interest over the last four years, as Tennessee and Virginia amended their laws[17] to facilitate the approval of the Wellmont Health System/Mountain States Health Alliance merger, and West Virginia enacted a COPA law[18] to allow for the merger of Cabell Huntington Hospital and St. Mary's Medical Center. COPAs were granted in each of these mergers over FTC opposition.[19]

The sequence of events in the Cabell Huntington/St. Mary's merger makes clear that the Commission's opposition to the transaction energized the West Virginia legislature to enact a COPA law and galvanized the parties to obtain a COPA. The hospitals identified substantial efficiencies that would flow from their merger, including cost savings from reduction of full-time equivalent employees (FTEs) and better purchasing rates, quality improvements resulting from consolidation of volumes, and the ability to coordinate care through a standardized, combined EHR. Before the Commission filed its administrative complaint, the hospitals entered into an assurance of voluntary compliance with the West Virginia Attorney General that required the hospitals to achieve these efficiencies and limited their ability to raise prices.[20] Nevertheless, the Commission challenged the transaction in November 2015.[21] In early 2016, shortly before the Commission's administrative trial on the merger was to begin, the legislature—over the opposition of the Commission—enacted the state's COPA statute.[22] The relevant state authorities approved the COPA in June 2016, and the next month the Commission dismissed its complaint, reluctantly concluding the merger was shielded by the state action doctrine.[23]

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[17] In Tennessee, the Hospital Cooperation Act of 1993 was amended on May 18, 2015 (2015 Tenn. Pub. Act, ch. 464) and is found at Tenn. Code Ann. §§ 68-11-1303, *et seq.* In Virginia, section 15.2-5384.1 of the Virginia Code was added. 2015 Session Ch. 741 (Apr. 15, 2015), http://lis.virginia.gov/cgi-bin/legp604.exe?151+ful+CHAP0741.

[18] W. Va. Code § 16-29B-28 (enacted March 12, 2016, *see* http://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB597%20SUB1%20ENR.htm&yr=2016&sesstype=RS&i=597).

[19] The COPAs granted to the Wellmont Health System/Mountain States Health Alliance (known as Ballad Health) by Virginia and Tennessee were issued in late 2017 and early 2018. *See* Letter from Marissa J. Levine, Virginia State Health Commissioner, to Alan Levine and Bart Hove (Oct. 3, 2017), http://www.vdh.virginia.gov/content/uploads/sites/96/2017/10/Order-and-letter-authorizing-a-cooperative-agreement.pdf and Certificate of Public Advantage (issued Jan. 31, 2018 by John J. Dreyzehner, Commissioner, Tennessee Department of Health), https://www.tn.gov/content/dam/tn/health/documents/copa/Executed%20COPA.pdf. The COPA granted to Cabell Huntington Hospital/St. Mary's Medical Center was issued in 2016. *See* Cabell Huntington Hospital, Inc., Cooperative Agreement No. 16-2/3-001 (W. Va. Health Care Authority June 22, 2016), http://hca.wv.gov/About/Documents/Decision.pdf. The FTC opposition to these COPAs is catalogued in the FTC Staff Notice of COPA Assessment, *supra* note 7, at 2 n.5.

[20] In the Matter of Cabell Huntington Hosp. Inc.'s Acquisition of St. Mary's Med. Ctr., Misc. No. 15-C-542 (Cabell Cty. Cir. Ct. filed July 31, 2015), http://ago.wv.gov/Documents/Cabell%20Huntington%20Hospital%20Civil%20Statement%20and%20Assurance.PDF.

[21] Complaint, In the Matter of Cabell Huntington Hosp., Inc., F.T.C. Docket No. 9366 (Nov. 5, 2015), https://www.ftc.gov/system/files/documents/cases/151106cabellpart3cmpt.pdf.

[22] W. Va. Code § 16-29B-28, *supra* note 18; letter from Marina Lao, Ginger Jin, and Markus H. Meier, to Del. Mike Pushkin (Mar. 9, 2016), www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-west-virginia-house-delegates-regarding-sb-597-competitive-implications-provisions/160310westvirginia.pdf#sthash.zATqMkLP.dpuf.

[23] Commission Order Returning Matter To Adjudication and Dismissing Complaint Without Prejudice, In the Matter of Cabell Huntington Hosp., Inc., F.T.C. Docket No. 9366 (July 6, 2016), https://www.ftc.gov/system/files/documents/cases/160706cabellorder.pdf.

III. DISCUSSION

In its invitation for comments, the Commission stated that the agency's staff "have repeatedly taken the position that the antitrust laws do not stand in the way of beneficial collaboration."[24] In the staff's view, "the antitrust laws seek only to prohibit activities that would substantially reduce competition and harm consumers, without countervailing benefits sufficient to outweigh the harm."[25] Because, in the staff's view, the Commission takes these countervailing benefits into account as part of the antitrust analysis, "COPAs and other state action antitrust exemptions for healthcare providers are unnecessary."[26]

But hospitals face a different reality. The strong perception is that the effect of the Commission's approach to efficiencies is to impose a standard so high that it can rarely be met, no matter how substantial the efficiencies and resultant patient benefits may be.[27] The natural result of this hostility to claims of efficiencies by the Commission and the courts has been increased reliance on COPAs to achieve aims that hospitals believe are important and beneficial for their communities.[28]

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[24] FTC Staff Notice of COPA Assessment, *supra* note 7, at 3. And it isn't just the staff that takes this position. When the Commission's challenge to the Cabell Huntington/St. Mary's merger was stymied by the grant of a COPA, the Commission dismissed its administrative complaint and issued a statement asserting that "[m]any of the purported benefits of hospital mergers—including coordination of patient care, sharing information through 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." Statement of FTC In re Cabell Huntington Hospital, Inc., F.T.C. Docket No. 9366 (July 6, 2016), https://www.ftc.gov/system/files/documents/public_statements/969783/160706cabellcommstmt.pdf.

[25] FTC Staff Notice of COPA Assessment, *supra* note 7, at 3.

[26] *Id.*

[27] As a former FTC official and an economist observed recently, "the agencies acknowledge the validity of the efficiencies defense but seem to take a skeptical view toward efficiency claims." Armstrong & Ramanarayanan, *supra* note 2, at 583. Professor Daniel Crane commented in 2011, speaking of efficiencies defenses in mergers generally. "Despite some greater sympathy toward efficiencies in recent years, practitioners report that the agencies usually react with coolness to efficiencies arguments." Daniel A. Crane, *Rethinking Merger Efficiencies*, 110 MICH. L. REV. 347, 358 (2011) (*citing to* Timothy J. Muris, *The Government and Merger Efficiencies: Still Hostile After All These Years*, 7 GEO. MASON L. REV. 729, 751 (1999) and Joseph J. Simons & Daniel A. Crane, Comments to the Federal Trade Commission and Department of Justice Antitrust Division, Unified Merger Analysis, *Integrating Anticompetitive Effects and Efficiencies, and Emphasizing First Principles* (2009)). This hostility to efficiencies is not new. Almost a quarter century ago, then-FTC Commissioner Christine Varney stated that efficiencies justifications "should play a role in [the FTC's] analysis" but only "as a matter of prosecutorial discretion." Christine A. Varney, New Directions at the FTC: Efficiency Justifications in Hospital Mergers and Vertical Integration Concerns, Remarks at the Health Care Antitrust Forum (May 2, 1995), https://www.ftc.gov/es/public-statements/1995/05/new-directions-ftc-efficiency-justifications-hospital-mergers-vertical; *see also* Craig W. Conrath & Nicholas A. Widnell, *Efficiency Claims in Merger Analysis: Hostility or Humility?*, 7 GEO. MASON L. REV. 685, 696 (1999) (two federal antitrust enforcement attorneys commented that "[e]ven if, in theory, evidence can produce a verifiable prediction of efficiencies, in actual practice, the available evidence is difficult to accept").

[28] Several recent studies identify and quantify the savings and community benefits that hospital mergers may produce. These studies include Monica Noether & Sean May, *Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis*, American Hospital Association and Charles River Associates (Jan. 2017), https://www.aha.org/system/files/2018-04/Hospital-Merger-Full-Report-FINAL-1.pdf; Matt Schmitt, *Do Hospital Mergers Reduce Costs?* 52 J. OF HEALTH ECON. 74 (2017); and Deloitte Center for Health Solutions and Healthcare Financial Management Ass'n, *Hospital M&A: When done well, M&A can achieve valuable outcomes* (2017), https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/hospital-mergers-and-

The Horizontal Merger Guidelines plainly state that the agencies will consider efficiencies when they assess the competitive effects of a merger.[29] The Guidelines recognize that "a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products."[30] Therefore, the agencies say, they "will not challenge a merger if cognizable efficiencies are of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market."[31] But to be "cognizable," efficiencies must be "merger-specific" and "verified" and cannot "arise from anticompetitive reductions in output or service."[32]

This is a high evidentiary bar, and hospitals often find that genuine efficiencies may not meet it when they bring a transaction to the Commission for review. The difficulty in meeting this standard is exacerbated by the skepticism with which agency staff sometimes evaluate claims of efficiencies. Each of these three criteria—merger specificity, verifiability and the requirement that the efficiency not arise from an "anticompetitive" reduction in output or service—make it sufficiently difficult for hospitals to have genuine efficiencies credited that the alternative of a COPA looks attractive to them. Consider:

- The requirement of merger specificity may be applied in a way that makes it virtually impossible to satisfy. The agencies sometimes question efficiencies that the proposed merger *will* accomplish because some other transaction—that is not on the table—can be imagined that would achieve the same efficiencies while presenting fewer competitive issues.[33] While the Guidelines claim that "[o]nly alternatives that are practical in the business situation faced by the merging firms are considered in making this determination," claims that efficiencies could be achieved with another transaction often are completely theoretical in the real world in which the hospitals operate. When hospital A proposes to acquire hospital B, it may be the case that an acquisition of hospital C would provide similar efficiencies at slightly less cost to competition, but if the cultures at A and C are incompatible, or if religious affiliations or other impediments stand in the way of a merger with C (perhaps one is a private hospital and the other is owned by a government entity), the alternative transaction will not happen.

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acquisitions.html. The three studies are summarized, and the Noether & May study updated, in Monica Noether & Sean May, *Hospital Merger Benefits, a Review and Extension*, American Hospital Association (Dec. 2018), https://www.aha.org/system/files/2019-01/hospital-merger-benefits-a-review-and-extension-jan-2-19.pdf.

[29] Horizontal Merger Guidelines §10.

[30] *Id.*

[31] *Id.*

[32] *Id.*

[33] *See, e.g.*, Testimony of Mark Seidman, Deputy Assistant Director, Mergers IV Division, Before the Southwest Virginia Health Authority (Oct. 3, 2016), https://www.ftc.gov/system/files/documents/cases/161003mshatestimony.pdf (testifying that that FTC staff was "aware of no analysis comparing the impact this merger would have on residents of Southwest Virginia to other possible mergers or affiliations that likely are available").

On other occasions, the Commission argues that a joint venture, instead of a merger, will accomplish the same efficiencies. But the ability of a joint venture to achieve all the efficiencies that a single firm can achieve is dubious at best.[34] And in view of recent enforcement activities by some state antitrust authorities, selection of a joint venture model—instead of a merger or outright acquisition—can expose hospitals to costly litigation on claims they are price fixing or otherwise violating Section 1 of the Sherman Act.[35] In these circumstances, it often is unrealistic for the Commission to argue that some other deal—a different merger or a joint venture short of merger—is available by which the same benefits can be obtained.

- Verifiability presents another hurdle which, if set too high, will cause merging hospitals to consider a COPA process to avoid unduly narrow antitrust review. While efficiencies should be verifiable to be cognizable, the evidence the agencies identify as most convincing, such as ordinary course documents, often is not readily at hand. Moreover, as noted in a recent article examining the treatment of efficiencies in merger review, agencies "assessing claimed efficiencies may be skeptical of efficiencies determined 'outside of the usual business planning process,'"—yet "merging parties often use consultants and economic experts to assess and present the efficiencies to the antitrust agency or court."[36] It is not unusual in hospital mergers, especially involving not-for-profit organizations, for the leaders to determine to merge based on their knowledge that the merger will benefit their communities without quantifying those benefits. When it comes time to present their mergers to the Commission, it should not be surprising that the hospitals employ consultants to quantify these benefits for them. These efficiencies are not identified in ordinary course documents, but that makes them no less real.

- The admonition that efficiencies, to be credited, should not arise from an "anticompetitive" reduction in output or service seems uncontroversial, but the Commission sometimes

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[34] As Oliver Williamson wrote long ago, in *The Vertical Integration of Production: Market Failure Considerations*, 61 AM. ECON. REV. 112, 113–14 (May 1971) "the most distinctive advantage of the firm … is the wider variety and greater sensitivity of control instruments that are available for enforcing intrafirm in comparison with interfirm activities." Even more succinctly, "fiat is frequently a more efficient way to settle minor conflicts … than is haggling." *Id.*

[35] Three years ago, CHI Franciscan and a physician clinic on the Kitsap Peninsula in Washington State entered into series of agreements that tightly aligned the clinic with CHI but fell short of an actual merger or acquisition. CHI purchased all the clinic's assets and assumed all the clinic's leases. The clinic entered into a professional services agreement by which its doctors worked exclusively for CHI patients. All revenues were CHI revenues and CHI agreed to pay the clinic on a formula based on the physicians' work and to pay the expenses of the clinic. In 2017, almost a year after the transaction closed, the Attorney General for the State of Washington sued CHI and the Clinic arguing they were engaged in per se illegal price fixing. CHI and the clinic countered that this wasn't possible: either they were a single entity for antitrust purposes (and so incapable of price fixing) or they were at the very least engaged in a legitimate joint venture to which the rule of reason (not the per se rule) should apply. The Attorney General strenuously objected to both arguments and continued to insist—right up until the case settled, earlier this year—that the parties were engaged in per se price fixing. *See State of Washington v. Franciscan Health System et al.*, No. 3:17-cv-05690-BHS, ECF Nos. 1 (complaint); 88, 89 (answers of Franciscan Health and The Doctors Clinic); 249 (Defendants' Trial Brief); 256-1 (State's Trial Brief); and 286 (consent decree).

[36] Erin L. Shencopp & Nathaniel J. Harris, *Using Efficiencies To Defend Mergers: The Current Legal Landscape*, THE ANTITRUST SOURCE, Apr. 2019, at 5 (quoting Horizontal Merger Guidelines §10), https://www.americanbar.org/content/dam/aba/publishing/antitrust_source/2018-2019/atsource-april2019/apr19_full_source.pdf.

> characterizes the elimination of duplicative services and equipment—which produces undeniable savings—as the elimination of competition and so not a cognizable efficiency. While patients understandably appreciate having hospital services as close by as possible, substantial savings sometimes can be accomplished by eliminating unnecessary duplication—as the Montana Department of Justice appreciated, when it granted a COPA to the two hospitals in Great Falls. Similarly, one of the motivations for the Wellmont/ Mountain States merger was to lessen unnecessary duplication of resources.[37] The Commission disparaged the claim, stating that eliminating duplication was tantamount to eliminating competition and, thus, would lead to "less productive allocation of resources and thereby deny consumers these benefits."[38] "Consolidation of clinical services," argued the Commission, "including reduced facility and equipment investments . . . could result in reduced patient choice and access to healthcare services." The Tennessee Department of Health agreed with the hospitals, however, finding there was significant duplication of scarce resources in the hospitals' service area and the merger promised efficiencies by providing a mechanism by which this duplication could be eliminated.[39]

Finally, there is the well-recognized problem of asymmetrical burdens: under Section 7 of the Clayton Act, a plaintiff must show that the effect of a merger or acquisition "may be substantially to lessen competition."[40] While this language, "makes no reference either to a threshold of probability for a finding of anticompetitive effects or to any possibility of an efficiencies defense,"[41] the Guidelines "require only 'reliable' evidence about the 'likely effects of a merger'," while simultaneously imposing a much more substantial burden of proof on merging parties who rely on efficiencies to justify their merger.[42] Some courts take the same approach: "When it comes to determining anticompetitive effects, courts focus on 'probabilities, not certainties or possibilities.' Yet when dealing with efficiencies, courts seem to require more."[43] But whether the agencies are simply following the lead of the courts, or displaying more skepticism than required by a faithful adherence to precedent, the reality is that faced with

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[37] Wellmont Health System & Mountain States Health Alliance, *Better Together: Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report*, 7 (Jan. 2016), http://becomingbettertogether.org/report/#sthash.MRGC9LZ1.dpuf; Mountain States Health Alliance & Wellmont Health System, Application for a Certificate of Public Advantage for State of Tennessee, 5-6 (Feb. 16, 2016), https://www.tn.gov/content/dam/tn/health/documents/copa/APP_%20COPA_application.pdf.

[38] FTC Staff Submission to the Tennessee Department of Health Regarding the Certificate of Public Advantage Application of Mountain States Health Alliance and Wellmont Health System, 47 (Nov. 21, 2016) https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-submission-tennessee-department-health-regarding-certificate-public-advantage-application/161122wellmontcommenttenn.pdf.

[39] Tenn. Dep't of Health, Terms of Certification, 27-29 (Jan. 31, 2018), https://www.tn.gov/content/dam/tn/health/documents/copa/TOC%20-%20Ballad%20Health%20-%20FINAL%20SIGNED%20Version%201.31.18.pdf.

[40] 15 U.S.C. § 18.

[41] Crane, *supra*, note 27, at 355.

[42] *Id.* at 357 (quoting Horizontal Merger Guidelines §2.2.1).

[43] Shencopp & Harris, *supra* note 36, at 6. As the authors of the article point out, a group of law professors and economists as amici in the government's challenge to the Anthem/Cigna merger, "raised precisely this concern, that 'the merger-specificity and verifiability requirements . . . place an asymmetric burden on merging parties that could doom beneficial mergers'" but the Court rejected that concern. *Id.* at 6 n.53 (quoting *United States v. Anthem, Inc.*, 855 F.3d 345, 356 (D.C. Cir. 2017)).

this skepticism, hospitals understandably turn to COPA laws to assure themselves of a forum that will provide a more holistic review of their mergers.

IV. CONCLUSION

The AHA expresses no view on the ultimate question of whether COPA laws represent good policy choices. The Commission has made no secret of its view that COPA laws are a poor policy choice and there is no legitimate aim a COPA law seeks to advance that cannot be accommodated by the antitrust laws. But many merging hospitals have a different view. They believe the Commission views claims of efficiencies in hospital mergers with unwarranted skepticism and subjects these claims to a high standard of proof that legitimate and genuine efficiencies often fail to meet. It should be no surprise, then, that some hospitals turn to the COPA process, where the benefits their mergers will bring to the community are given greater weight. If the Commission were to give more weight to efficiencies in the competitive balance, it is likely the attraction of a COPA (which comes at the price of ongoing regulation) would diminish substantially.

Sincerely,

/s/

Melinda Reid Hatton
General Counsel