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Effective Defenses of Hospital Mergers in Concentrated Markets

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THE HOSPITAL SECTOR HAS generated more litigated antitrust merger cases than any other segment of our economy,[1] and hospital merger activity appears likely to continue unabated in the foreseeable future.[2] According to some health care commentators, the Federal Trade Commission's recent success in litigating to block proposed hospital mergers does nothing more than obstruct legitimate efforts by hospital systems to achieve the laudable goals of national health care reform. According to these critics, the FTC is frustrating the ongoing efforts of hospital systems to better contain costs and improve communication and collaboration among providers. Thus, many hospital executives seeking to merge claim that they are caught between competing arms of the federal government, with one pushing for a new era of integration and coordination of care, and the other clinging to outdated views of competition among providers. And worse yet, according to these commentators, FTC staff is unreceptive to defenses of proposed hospital mergers, leading to an overly aggressive enforcement agenda premised on the simplistic view that any hospital merger that triggers certain market concentration thresholds must be stopped.

We believe that these views reflect misunderstandings or misconceptions regarding antitrust enforcement in hospital markets. In this article, we briefly describe the arguments commonly asserted to defend hospital acquisitions in concentrated markets and outline the factual predicates that we believe would make these defenses compelling. Our unifying theme is that, in appropriate cases, these defenses deserve and receive serious consideration from FTC staff. In addition, we assert that the goals of health care reform generally are consistent with preserving the benefits of hospital competition.

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Quality of Care Defenses

Seasoned antitrust practitioners and their clients almost always claim that a proposed hospital merger will improve quality of care at one (or both) of the involved hospitals. When substantiated—meaning that the evidence supports the notion that a hospital merger will improve the quality of care at the affected hospitals—such claims may well carry the day, overcoming high market concentration levels, "hot documents," health plan concerns about a merger, and other factors that weigh in favor of enforcement.

A useful starting point in understanding how FTC staff will assess such claims is to consider the role of expert witness analysis and testimony relating to quality of care. The empirical literature relating to the impact of hospital mergers on quality does not provide a universal answer regarding whether mergers are likely to have a positive (or negative) effect on quality of care. Put differently, empirical literature does not support the argument that hospital mergers always, or even generally, improve quality. In reality, the evidence is mixed, with some studies concluding that mergers actually *decrease* quality.[3]

Quality claims, therefore, must be assessed in much the same way as other merger defenses, by analyzing the case-specific facts and evidence. And though quality of care experts may play an important role in hospital merger cases, their role generally is limited to reviewing the case-specific evidence and explaining its implications to the judge; testimony that hospital mergers (or some subset thereof) generally have a positive or negative impact on quality is suspect. Thus, just as with other defenses, quality-related claims in hospital merger matters often turn on ordinary course documents, executive testimony, and other case-specific evidence.

One complicating issue is how to assess such quality-related issues in light of the inevitable variability of quality scores across metrics and service lines. As a starting point, hospital executives and their counsel should expect that an unsubstantiated "rising tide" argument—i.e., a claim that the merged entity will somehow achieve the higher of the two merging hospitals' quality scores across each metric or service line—is rarely given much weight. The key to a successful argument on this point is substantiation. If, for example, counsel demonstrates that the acquirer's prior hospital acquisitions led to quality enhancements at the acquired facilities, such arguments can be extremely compelling. But if the acquiring system has been unable to achieve relatively uniform and high-quality of care across its current hospitals, it should not expect FTC staff to look favorably upon an argument that its acquisition of (another) low-quality hospital will inevitably improve quality outcomes. In addition, the existence of an implementation plan, particularly

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one created and adopted as part of the deal analysis (as opposed to one prepared specifically in preparation for an antitrust defense) further buttresses quality claims.

Another important question is *which* measures of quality are most relevant. This is a difficult issue, but not one without a logical answer. In most cases, the clearest and most sound solution is to assess the available evidence to identify the specific quality metrics the hospital executives and physician leaders evaluate in the ordinary course of business and which metrics were considered as part of the deal analysis. In other words, we advocate relying on the merging parties' analyses to determine which metrics to consider, and what the merger's likely impact on those measures will be, rather than substituting the views of the FTC staff or hired expert.

There are two important takeaways here. First, asserting quality-related defenses to proposed hospital mergers is time and money well spent, as such claims are given serious consideration. And doing so early in the process increases the likelihood that such arguments will carry the day. In several cases, merging parties have effectively substantiated assertions that the acquired hospital's quality is subpar through ordinary course of business documents and by affording FTC staff an early opportunity to tour the facility and see firsthand where quality may be lacking. Buttressed with evidence that such gaps are likely only to be addressed through the proposed merger, FTC staff give such claims serious weight.

Of course, if the evidence suggests that the acquired hospital has other commercially reasonable means at its disposal to achieve the same quality improvements, such arguments are appropriately discounted. In addition to the presence of other viable acquirers that are capable of achieving comparable quality improvements, the most common alternative scenarios evaluated as part of this merger-specificity analysis are the possibilities for the acquired hospital to improve its own quality through the use of industry consultants and other ordinary-course tools.

Second, although expert witnesses may be adept at analyzing and conveying such information on behalf of merging parties, the best path to success with a quality-related defense is to offer ordinary-course and deal-related evidence demonstrating that the executives (not their lawyers or retained experts) believed that the proposed merger would increase quality of care. It is effective for hospital executives themselves to meet with FTC staff and explain how they assess quality in the ordinary course of business and how quality considerations weigh in the analysis of the proposed merger. When supported with appropriate evidence, such arguments are compelling. Indeed, this may be the most effective way to avoid an FTC challenge to a potentially problematic hospital merger.

Defenses Relating to the Financial Condition of the Acquired Hospital

With rare exception, the failing and flailing firm defenses are unsuccessful in court. The "pure" failing firm defense has such strict criteria in the Horizontal Merger Guidelines[4] and case law that it is rarely applicable. And the somewhat more flexible "flailing firm defense" is highly disfavored by courts and rarely successful at saving otherwise unlawful transactions. Indeed, at least one court has expressed the view that "financial weakness . . . is probably the weakest ground of all for justifying a merger . . . . [It] certainly cannot be the primary justification of a merger."[5] In *Chicago Bridge*, FTC Administrative Law Judge Chappell made clear that the financial weakness defense is credited "only in rare cases."[6] He was right, and for good reason. As the Ninth Circuit held in *FTC v. Warner Communications, Inc.*, this "would expand the failing company doctrine, a defense which has strict limits."[7] And cases, such as *Arch Coal* and *University Health*, stand for the proposition that a flailing firm defense only saves a transaction in the rare scenario in which the acquired firm is so weak that its market share would soon decline and bring the merger below the Merger Guidelines and case law concentration thresholds.[8] This is a high bar for defendants.

Despite the case law, there is value in asserting to FTC staff an argument premised on the weak financial condition of the to-be-acquired hospital. Although staff will rely fully on the relevant case law during trial, a more flexible analytical process typically prevails at the investigation stage. At that relatively early stage, FTC staff are not merely seeking to resolve whether the merging parties can meet the strict legal requirements of these defenses, but rather will assess whether the acquired hospital's financial condition evidences a declining competitive significance such that challenging the transaction is not the best use of finite Commission resources. The mere fact that FTC staff could likely overcome an asserted financial weakness defense in court does not mean that FTC staff do not take such arguments into account as part of staff's prosecutorial discretion in its determination as to whether to recommend challenging a transaction. And, particularly in cases that otherwise may be marginal (i.e., lukewarm health plan support for challenging the merger, marginal documentary evidence, lack of interest from the state Attorney

General), such arguments may even prove dispositive, regardless of whether the strict requirements of such a defense are met.

Often a driving factor in staff's evaluation of financial condition is the *trend* of certain financial measures, including cost coverage ratios and cash reserves. The purpose of evaluating such metrics is to determine whether such objective measures support an assertion that the acquired facility's market share overstates its future competitive significance. More specifically, these measures enable an assessment of whether the acquired facility is unlikely to be able to maintain its current breadth or quality of services on a standalone basis going forward. Often counsel's arguments are undermined by ordinary-course documents in which the acquired hospital boasts about its improving financial condition and opportunities to become a stronger independent competitor in the future. In other cases, however, this type of analysis has led FTC staff to recommend closing hospital merger investigations, including some that would create market concentration levels far in excess of the thresholds for presumptive illegality. Thus, when such arguments are substantiated by the evidence, merging parties should raise these issues with FTC staff, and do so early. Indeed, if parties wait to raise these issues with a judge, it may be too late.

Efficiencies Defenses

There is nothing unique about the assessment of efficiencies in hospital cases relative to merger matters in any other industry. The weight these claims receive depends almost entirely on merger specificity (whether the cost savings could be achieved by another reasonably available means) and verifiability (does the evidence indicate that the cost savings are quantifiable and likely to occur). And, of course, an acquisition that threatens substantial competitive harm can only be saved by correspondingly significant efficiencies.

The merger specificity filter requires assessing whether the hospitals could achieve asserted cost savings as independent entities, for example, by hiring a consultant to implement a more efficient staffing schedule or outsourcing an IT platform to reduce costs. As with other defenses, counsel's efficiencies claims may be undermined by ordinary-course documents in which the acquired hospital projects lowering its own costs going forward, or by hospital executives who describe a continuing ability to reduce their own costs going forward if the transaction does not proceed.

Pursuant to the Merger Guidelines, merger specificity also requires not crediting efficiencies that likely would be achievable through an alternative transaction that is "practical in the business situation" and does not present the same competitive problems.[9] For example, if the target hospital had alternative bid(s) from hospital system(s) not currently participating in the same market(s) as the target hospital, and each believed that it would achieve similar cost savings from reduced general and administrative expenses, these savings generally would not be considered merger specific. Whether an alternative transaction is reasonably achievable is a fact-intensive question, but the agency's investigative tools—obtaining documents and testimony from alternative transaction partners—are well-suited to this task.

Verifiability is often more difficult to assess. In our experience, cost savings claims are taken very seriously, at least when they are supported by evidence that was not merely created for the merger review process. As is the case with quality-improvement claims, FTC staff place great weight on evidence that executives evaluated the likely cost savings as part of their deal analysis and did so identifying the sources of cost savings in a concrete, specific way.

A final issue worth noting is that asserted cost savings in hospital merger matters often derive from consolidating services. For example, if two hospitals each have a CT scanner that runs at 40 percent utilization, a logical post-merger integration plan might be to go to a single scanner at one location or the other. Although it is perhaps obvious, when it comes to the availability of services post-merger, the word "consolidating" can often be used interchangeably with "eliminating" services at one or more locations. And because patient access and convenience matter in health care services, the post-merger elimination of services at particular locations may have meaningful negative consequences for patients.

We advocate a common sense approach to resolving this tension between cost savings and access often inherent in hospital merger efficiencies analysis. If the hospitals are located close together and both have grossly underutilized service lines, the cost savings benefit to consumers likely will outweigh any harm due to loss of access, and the efficiency should be credited. But, if access will be materially impacted, this should reduce the weight given to the asserted cost savings from closing a service line. Although the court's opinion did not address the issue directly, FTC staff took this position in the recent *ProMedica* matter.[10]

The "But We Are Not-for-Profit" Defenses

The first articulation of this defense is a claim that a not-for-profit (NFP) hospital's charitable mission, in combination with governance by a board comprised of community members, prevents an NFP hospital from charging supracompetitive prices and exercising whatever market power it might obtain by merging with a rival. Although this argument was credited by the district court in *FTC v. Butterworth Health Corp.*,[11] the general claim that NFP hospitals do not fully exercise market power has been rejected empirically by a voluminous body of economic research.[12] Our general experience is that many NFP hospitals are large, complex organizations whose boards, which indeed often include numerous community business leaders, may play no role in overseeing contract negotiations with health plans.

Moreover, we have seen NFP hospital leaders apply a "no margin, no mission" philosophy, reflecting the view that they should obtain the highest prices that they can negotiate from health plans to ensure the organization can provide high

levels of charity care, expand the services offered by the hospital, compensate employees and managers more generously, and upgrade facilities for patients and staff. We have heard more times than we can count that NFP hospitals negotiate rates with health plans just as aggressively as for-profit hospitals. And as the FTC staff routinely argues in hospital cases, higher rates ultimately are borne by employers and patients in the local community, not by commercial health plans.

If, however, there were both reliable evidence demonstrating that a particular NFP hospital in fact declined to exercise whatever market power it possessed *and* sound reason to conclude that such behavior would continue, this would unquestionably affect the analysis of a proposed acquisition of a rival by that NFP hospital. Notwithstanding the interesting theoretical question of whether antitrust enforcement should stand down in such a situation given that the acquiring hospital's not-profit-maximizing behavior could change in the future, two more practical evidentiary challenges would arise.

First, the FTC would have no hot documents, which—although not necessary—often form the backbone of its cases. For example, if an NFP hospital was clearly and intentionally not charging as much as it could, its documents would be devoid of any indication that additional "leverage" with health plans or an ability to negotiate higher rates motivated the proposed acquisition.

Second, health plans would presumably perceive that the hospital was charging them significantly lower prices than it otherwise could, and would either have no concerns about the acquisition or be affirmatively positive about such an organization acquiring a nearby rival. The absence of hot documents and customer concern, taken together, would weigh heavily against seeking to challenge a proposed merger.

The second version of the NFP defense acknowledges that a NFP hospital charges the highest prices it can negotiate with health plans, but asserts that the NFP structure causes the hospital to reinvest these supracompetitive profits in initiatives that enhance community health services, rendering the high prices benign, at least on a net-net basis to the community. It is settled law that NFP hospitals are not exempt from the antitrust laws, and however packaged, that is the distillation of this claim. In any event, NFP hospitals may not, as a practical matter, invest supracompetitive profits as efficiently as the individuals and businesses that would be overcharged for hospital services in the first place due to the possibility that profits can "leak" away from the most beneficial investment opportunities to employee salaries, more luxurious offices, and the like.

The "Health Care Reform Changes Everything" Defense

The boldest version of this defense is that federal health care reform is a blanket endorsement of providers working together, implying that rival hospitals—as providers—should be allowed to merge and work together. Health care reform is not baseball, and no such antitrust exemption exists. Indeed, the regulations implementing key components of health care reform explicitly acknowledge the desirability of competition among providers.[13]

The second argument is that health care reform is substantially about accountable care organizations (ACOs), and scale that is available only via a merger or acquisition is needed to create a viable ACO. This defense may have merit, but turns on merger-specificity—is it true that ACO participation or creation is not possible absent a merger? In many situations, ACOs can be established through means less restrictive than mergers, and the most beneficial collaboration usually stems from coordination among providers of *complementary* components of care (i.e., a hospital collaborating with a rehabilitation facility or outpatient clinic), rather than coordination or merger between nearby rival hospitals.[14]

A third health care reform defense is that a competition-reducing merger should be allowed because: (1) health care reform will mean reduced reimbursement from government payers; (2) government payers account for a majority of the merging hospitals' revenues; and thus (3) the added revenues/profits resulting from enhanced bargaining power vis-à-vis payers (and maybe some cost savings too) are essential to allow the hospitals to survive in a world of lower government reimbursement. Colloquially, this is a claim that "Sure, we're not failing now, but once health care reform is implemented, we will be unless we can merge with this rival."

As a preliminary point, the premise of this argument is questionable. In reality, some facets of health care reform, such as reducing the number of people without health insurance, will benefit the financial situation of hospitals. In contrast, other facets, including reduced reimbursement for certain services, will harm the finances of hospitals. The net effect of such provisions is ambiguous generally, and likely varies across hospitals. Our view is that this claim needs to be addressed through a *General Dynamics*-type analysis, pursuant to which current market share evidence is given less weight if other evidence convincingly indicates that a firm will be less competitively significant in the future,[15] or the failing/flailing firm doctrines, depending on whether the hospitals are asserting that health care reform will cause diminished competitive significance or outright failure. In either case, the analysis likely turns on whether the evidence—particularly the ordinary course of business projections created and relied on by hospital executives—demonstrates that health care reform will have the impact the merging hospitals assert.

Conclusion

In any merger review, regardless of industry, the fundamental question remains whether the proposed consolidation may substantially lessen competition. Assessing defenses relating to quality of care, efficiencies, financial condition, and health care reform is unquestionably a critical step in answering this question in hospital merger matters, irrespective of concentration levels. These defenses are given serious con-

sideration by FTC staff in the course of their investigations, and, in appropriate circumstances, such arguments may well allow proposed hospital mergers that raise significant antitrust issues, including mergers in highly concentrated markets, to survive antitrust scrutiny. ■

[1] By our count, there have been at least fifteen litigated hospital mergers involving state or federal enforcement actions that resulted in judicial rulings since 1986. FTC v. Phoebe Putney Health Sys., Inc., No 11-12906 (11th Cir. 2011), *rev'd and remanded*, No. 11-1160 (U.S. Feb. 19, 2013), *available at* http://www.supremecourt.gov/opinions/12pdf/11-1160_1824.pdf; Ukiah Adventist Hosp. v. FTC, 981 F.2d 543 (D.C. Cir. 1992); FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069 (N.D. Ill. 2012); California v. Sutter Health Sys., 84 F. Supp. 2d 1057 (N.D. Cal.), *aff'd mem.*, 2000-1 Trade Cas. (CCH) ¶ 72,896 (9th Cir. May 2, 2000), *revised*, 130 F. Supp. 2d 1109 (N.D. Cal. 2001); FTC v. Tenet Healthcare Corp., 17 F. Supp. 2d 937 (E.D. Mo. 1998), *rev'd*, 186 F.3d 1045 (8th Cir. 1999); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997); FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997); FTC v. Freeman Hosp., 911 F. Supp. 1213 (W.D. Mo.), aff'd, 69 F.3d 260 (8th Cir. 1995); United States v. Mercy Health Servs., 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997); FTC v. Univ. Health, Inc., No. CV-191-052, 1991 WL 117432 (S.D. Ga.), *rev'd*, 938 F.2d 1206 (11th Cir. 1991); United States v. Carilion Health Sys., 707 F. Supp. 840 (W.D. Va.), *aff'd per curiam*, 892 F.2d 1042 (4th Cir. 1989); United States v. Rockford Mem'l Corp., 717 F. Supp. 1251 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990); ProMedica Health Sys., Inc., FTC Docket No. 9346 (Mar. 28, 2012), *available at* http://www.ftc.gov/os/adjpro/d9346/120328promedicabrillopinion.pdf; Evanston Nw. Healthcare Corp., FTC Docket No. 9315, 2005 WL 2845790 (Oct. 20, 2005), *aff'd*, No. 9315, 2007 WL 2286196 (Aug. 6, 2007); Hospital Corp. of Am., 106 F.T.C. 361 (1985), *aff'd sub nom.* Hospital Corp. of Am. v. FTC, 807 F.2d 1381 (7th Cir. 1986).

[2] Irving Levin Associates reported that the number of hospital mergers increased in each of 2011 and 2010 from the prior year. *See* Press Release, Irving Levin Assocs. Inc., Decade in Review: Hospital M&A Deal Volume Increases (Feb. 28, 2012), *available at* http://www.levinassociates.com/pr2012/pr1202hospital. Two very large proposed hospital mergers announced in recent months—the Henry Ford/Beaumont Health System and Scott & White/Baylor Health Care System transactions—highlight the current high level of hospital transaction activity. *See* Press Release, Henry Ford Health Sys. Press, Henry Ford, Beaumont Sign Letter of Intent to Combine Operations (Oct. 31, 2012), *available at* http://www.henryford.com/body.cfm?id=46335&action=detail&ref=1763; Press Release, Scott & White Healthcare, Baylor, Scott & White to Create New Health System (Dec. 14, 2012), *available at* http://news.sw.org/2012/12/baylor-scott-white-to-create-new-health-system/.

[3] Two prominent health economists reviewed the empirical literature examining the effect of hospital mergers on quality and concluded that "[a]lthough the results of the literature are mixed, a narrow balance of the evidence and the evidence from the best studies indicates that hospital consolidation more likely decreases quality than increases it." William B. Vogt & Robert J. Town, Robert Wood Johnson Found., Research Synthesis Report No. 9, How Has Hospital Consolidation Affected the Price and Quality of Hospital Care? 11 (2006); *see also* Katherine A. Ambrogi, *Clinical Quality Analysis in Merger Enforcement: Lessons from* FTC v. OSF Healthcare, ABA Antitrust Health Care Chron., Sept. 2012.

[4] U.S. Dep't of Justice & Federal Trade Comm'n, Horizontal Merger Guidelines § 11 (2010) [hereinafter Merger Guidelines], *available at* http://ftc.gov/os/2010/08/100819hmg.pdf.

[5] Kaiser Alum. & Chem. Corp. v. FTC, 1339 F.2d 1324 (7th Cir. 1981).

[6] Chicago Bridge & Iron Co., N.V., FTC Docket No. 9300, slip op. at 109 (June 19, 2003) (quoting FTC v. Univiversity Health, Inc., 938 F.2d 1206, 1221 (11th Cir. 1991)) (internal quotation marks omitted), *available at* http://www.ftc.gov/os/2003/06/cbiid.pdf (initial decision).

[7] 742 F.2d 1156, 1164 (9th Cir. 1984).

[8] FTC v. Arch Coal Inc., 329 F. Supp. 2d 109, 154 (D.D.C. 2004); *University Health, Inc.*, 938 F.2d at 1221.

[9] Merger Guidelines, *supra* note 4, § 10.

[10] *See* Complaint Counsel's Post-Trial Findings of Facts and Conclusions of Law, ProMedica Health Sys., Inc., FTC Docket No. 9346, ¶¶ 823–33 (Sept. 20, 2011) *available at* http://www.ftc.gov/os/adjpro/d9346/110920ccposttrialfofandcoflaw.pdf .

[11] 946 F. Supp. 1285, 1296–97 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997).

[12] An article by Dr. William Lynk cited by the district court in *Butterworth* found no evidence of a link between price increases and higher market concentration. *See Butterworth*, 946 F. Supp. at 1297 (citing William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & Econ. 437 (1995)). However, re-examination of Dr. Lynk's analysis and a significant body of subsequent research has found that non-profit hospitals with greater market power charge higher prices. *See* Emmett B. Keeler, Glenn Melnick & Jack Zwanziger, *The Changing Effects of Competition on Non-Profit and For-Profit Hospital Behavior*, 18 J. Health Econ. 69 (1999); David Dranove & Richard Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis*, 18 J. Health Econ. 87 (1999); Robert A. Connor, Roger D. Feldman & Bryan E. Dowd, *The Effects of Market Concentration and Horizontal Mergers on Hospital Costs and Prices*, 5 Int'l J. Econ. Bus. 159, 177 (1998) (discussing preliminary findings that "post-merger price reductions [are] smaller in less-competitive market areas"); John M. Brooks, Avi Dor & Herbert S. Wong, *Hospital-Insurer Bargaining: An Empirical Investigation of Appendectomy Pricing*, 16 J. Health Econ. 417, 431 (1997) ("[T]he growth of managed care organizations in a market may lead to market segmentation and price discrimination."); Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. Indus. Econ. 63 (2001); Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, 23 Health Aff. 175 (2004); Leemore S. Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*, 52 J.L. & Econ. 523 (2009).

[13] *See* Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule, 76 Fed. Reg., 67,802, 67,841 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425), *available at* http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf ("[C]ompetition in the marketplace benefits Medicare and the Shared Savings Program because it promotes quality of care for Medicare beneficiaries and protects beneficiary access to care . . . . Competition among ACOs can accelerate advancements in quality and efficiency. All of these benefits to Medicare patients would be reduced or eliminated if we were to allow ACOs to participate in the Shared Savings Program when their formation and participation would create market power.").

[14] *See, e.g.*, David Dranove, *ACOs and the Looming Antitrust Crisis*, The Health Care Blog, Oct. 14, 2010, http://thehealthcareblog.com/blog/2010/10/14/acos-and-the-looming-antitrust-crisis/#more-20251 ("The AHA wants us to believe that all hospital mergers are just part of the effort to create ACOs. But ACOs are more about vertical integration between doctors and hospitals than they are about horizontal hospital mergers, and there is no obvious reason why hospitals have to merge for ACOs to work."); *Health Care Reform: ACOs and Developments in Coordinated Care Delivery, Shared Savings and Bundled Payments*, McDermott Will & Emery (Apr. 14, 2010), http://www.mwe.com/publications/uniEntity.aspx?xpST=PublicationDetail&pub=5604 ("[A]chieving the ideal level of care coordination and quality goals envisioned by the ACO model will require an organization that includes providers across the vertically integrated spectrum of care, from primary care through acute care through long-term and palliative care.").

[15] *See* United States v. Gen. Dynamics Corp., 415 U.S. 486, 501–03 (1974). In addition, Section 5.2 of the Merger Guidelines states that "[t]he Agency will consider reasonably predictable effects of recent or ongoing changes in market conditions in interpreting market concentration and market share data." Merger Guidelines, *supra* note 4, § 5.2.