HEALTHCARE MERGERS

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Expectations for Healthcare Mergers During the Pandemic

Comments on the January 2020 Vertical Merger Guidelines and the Healthcare Sector

CORNERSTONE RESEARCH
Economic and Financial Consulting and Expert Testimony

Expectations for Healthcare Mergers During the Pandemic

By Andrew Elzinga, Avigail Kifer, and Arthur Corea-Smith[1]

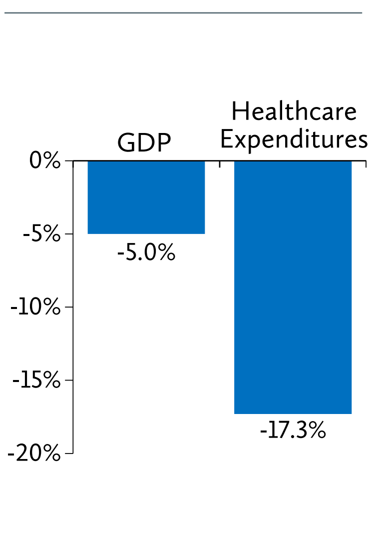
Trends in merger investigations related to the current COVID-19-induced downturn may be too new to fully assess, yet it seems likely that antitrust economists and counsel will reprise several of the challenges faced during the Great Recession. Looking to that period for guidance, this article considers likely developments in healthcare mergers as well as challenges particular to the current pandemic.

Potential Increase in M&A Activity Involving Distressed Firms

Given the toll of the COVID-19 pandemic on economic activity, observers have speculated that the increased number of struggling firms may lead to an increase in merger activity invoking the failing firm defense.[2] Transactions relying on the failing firm defense require the merging parties to demonstrate that the allegedly failing firm:

- Is in danger of failing to meet its imminent financial obligations
- Is unable to reorganize through bankruptcy
- Has made unsuccessful good-faith attempts to find alternative purchasers.

However, the failing firm defense has a notoriously high burden of proof and the DOJ and FTC (collectively "the agencies") have stated that they will continue to hold failing firm defenses to a high standard throughout the pandemic.[3]



Although the pandemic has increased the likelihood of failing firms across industries, the healthcare sector may be particularly prone to such struggles, despite the monetary relief offered by the CARES Act and the Paycheck Protection Program and Health Care Enhancement Act.[4] Between Q4 2019 and Q1 2020, when U.S. gross domestic product declined by 5.0 percent, healthcare expenditures declined by 17.3 percent.[5] This outsized decline in healthcare expenditures coincided with substantial reductions in patient volumes across healthcare providers: inpatient admissions declined by 30 percent, emergency room visits fell by 40 percent, and outpatient surgery visits dropped by over 70 percent.[6]

JANUARY–APRIL 2020

Inpatient Admissions
-30%

Emergency Room Visits
-40%

Outpatient Surgery Visits
-70%

During the initial stages of the pandemic, hospitals experienced a decline in revenue of over $1.4 billion *per day* between March 1, 2020, and April 15, 2020, and laid off 135,000 employees over a similar time period.[7] Beyond hospitals, providers across the healthcare sector are suffering, as evidenced by the reduction of 1.4 million jobs in the healthcare industry between March and April 2020.[8] An effect on insurers may follow the effect on providers, despite the reduction in costs due to reductions in health claims, as layoffs lead to reduced premium revenues and drive individuals to health plans that are less profitable for insurers. Ratings agencies have issued negative or stable outlooks for the industry.[9]

One important driver of the reductions in volume and revenue is the many state-imposed delays in elective procedures,[10] which tend to be more profitable services for healthcare providers. Elective procedures account for, on average, over one-third of hospital admission spending.[11] In rural areas, where there may be a single hospital serving an entire community, the ongoing pandemic has only exacerbated the existing financial strain. Prior to the pandemic, 25 percent of rural hospitals were at "high risk of closing" (44 percent of rural hospitals were unprofitable); the reduction in outpatient services—which comprise 76 percent of total hospital revenues—may increase their financial vulnerability.[12] Although hospitals and other healthcare providers in these communities may be seen as having market power, cash infusions through mergers with other health systems may be required to ensure their future longevity.

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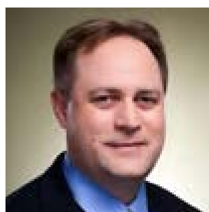

Greg Eastman is a senior vice president of Cornerstone Research. He has been retained by both the agencies and the merging parties to perform profitability analyses and assess whether firms are failing in matters across industries, including healthcare, biotech, and high-tech.

On behalf of the DOJ in the EnergySolutions/WCS proposed merger, Dr. Eastman provided testimony on failing firm and efficiency analyses. He has also worked with the State of Washington AG's office on failing firm issues in the CHI Franciscan Health/The Doctors Clinic/WestSound Orthopaedics retrospective review. Dr. Eastman's expertise also includes assessing merger-specificity and verifiability of claimed efficiencies.

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Even in light of the economic downturn, however, healthcare mergers involving a financially distressed firm will not skirt the agencies' review simply by invoking the failing firm defense.[13] Expert analysis will likely be necessary to analyze the impact of the pandemic on the financial viability of the merging parties, whether the struggling firm could successfully reorganize, and whether there were good-faith attempts to find alternative purchasers in light of the current economic conditions. Expert analysis can help attorneys answer questions such as: What is the appropriate way to project provider or insurer financials, given the effect of the pandemic on employment and, as a likely result, Medicaid enrollment? Are revenues from elective procedures lost or simply deferred? What is the relevant market for potentially failing assets and how might it change given the rapidly evolving economic conditions?

Potential Increase in Canceled Mergers

The Great Recession saw a dramatic reduction in M&A activity, including a record number of merger cancellations in 2008.[14] Initial evidence suggests that a similar trend may play out in the COVID-19 crisis. For example, Xerox recently dropped its $34 billion bid for HP, citing the pandemic, and Bed Bath & Beyond commenced litigation against 1-800-Flowers over crisis-related delays in the sale of one of the home goods retailer's divisions.[15] Acquisitions in the healthcare sector are also being impacted: Beaumont Health delayed its acquisition of Summa Health, UMass Memorial Health Care's acquisition of Harrington HealthCare was pushed back, and Jefferson Health called off its purchase of the Fox Chase Cancer Center.[16] In 2019, there were ninety-two announced transactions among hospitals and health systems, and some of these transactions may face cancellations or delays given the hardships that healthcare providers are experiencing.[17]

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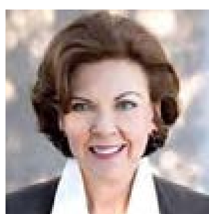

Christine M. Hammer is a certified public accountant and senior advisor at Cornerstone Research. She has provided expert analysis of failing firm assessments and on claimed efficiencies in the healthcare and pharmaceutical industries. She has been retained by both the agencies and the merging parties.

Ms. Hammer assisted the FTC in its review of the 2017 acquisition of Freedom Innovations by Otto Bock HealthCare North America Inc. Through her experience, Ms. Hammer has developed insight into the agencies' approach toward the failing firm defense.

In 2019, there were 92 announced transactions among hospitals and health systems, and some of these transactions may face cancellations or delays given the hardships that healthcare providers are experiencing.

Matters relating to canceled or delayed mergers—such as breach of contract, reverse termination fee disputes, and alleged violations of "best efforts" obligations—may require expert analysis to evaluate the economic, financial, and regulatory risks of the merger. Experts may also evaluate how conduct by the parties following the merger agreement may have introduced new risks to the merger that were not present as of the agreement—an analysis that may be particularly relevant for healthcare mergers in light of the ongoing pandemic. These analyses can help inform courts as to whether material adverse changes in business conditions constitute sufficient grounds for waiving termination fees or whether the conduct of one party warrants assigning damages.

Potential for Heightened Scrutiny of Competitive Effects

Another Great Recession trend that some observers predict will reoccur during the COVID-19 pandemic is a decline in merger activity. Notably, however, despite the substantial decline in merger activity following the Great Recession, the absolute number of second requests and merger challenges remained stable relative to 2008.[19]

To the extent that the number of second requests and merger challenges during this downturn remains stable, or falls by less than the anticipated decline in merger activity, those mergers that are pursued may be seen as facing increased challenges. Observers have speculated, for example, that the current economic downturn may accelerate a pre-crisis trend towards heightened scrutiny of mergers not traditionally viewed as problematic, including vertical mergers, mergers potentially building monopsony power, and consummated and potential acquisitions that fall below the HSR threshold.[20]

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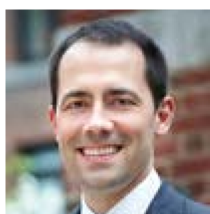

C. Scott Hemphill of New York University provides expert testimony on merger effects, monopsony, industry regulation, vertical restraints, and exclusionary conduct. His research has been cited in federal and state courts, including the U.S. Supreme Court and the California Supreme Court, and has formed the basis for congressional testimony on matters of regulatory policy.

Recently, Professor Hemphill was retained by the seller in a large canceled healthcare merger to provide expert analysis relating to the buyer's merger antitrust defense and to the merits of the buyer's proposed efficiencies argument.

Part of this may be due to difficulties in predicting whether current market competition is a sufficient proxy for future competition, given the evolving economic environment. The complexity of healthcare markets, furthermore, requires a nuanced analysis of competitive effects in these historically less scrutinized mergers, given the defining features of the industry, including moral hazard, information asymmetries, complex reimbursement schemes, price negotiations, and potential applications of two-sided market theories.

For example, increased scrutiny of vertical healthcare mergers may mean that the agencies' review of insurer/provider or provider/device manufacturer mergers will involve analyses related to foreclosure and raising rivals' costs, as discussed in the recently released Draft Vertical Merger Guidelines.[21] Effective merger analysis in the healthcare context will need to balance potential anticompetitive changes in patient choice resulting from changes in physician referral patterns, pharmacy steering patterns, or coverage policies, with potential improvements in care coordination, quality, and costs. In addition, vertical mergers, or mergers of complements more broadly, in healthcare could strengthen incentives to reduce total healthcare costs. For example, the merging parties may be better suited to promote preventive care or facilitate information sharing to improve formularies and design stronger incentives for medication adherence.

Vertical merger analyses may also need to more broadly incorporate trade-offs between higher prices and supply chain stability. As the healthcare system regroups from the immediate effects of the pandemic and reassesses its preparedness levels for future health crises, firms are likely to reconsider the riskiness of a supply chain that is heavily dependent on foreign firms. As the number of COVID-19 infections rose in early 2020, the United States encountered increasing difficulties in importing sufficient quantities of key equipment (ventilators, personal protective equipment, etc.) from countries such as China, which produces over half of the world's face masks.[22]

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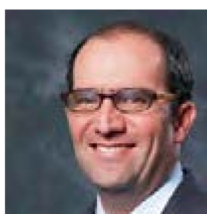

Aviv Nevo is a former chief economist at the Antitrust Division at the DOJ, where he advised on merger, as well as civil and criminal, investigations. He has been retained as an expert by the DOJ, the FTC, and private firms in cases related to antitrust merger review, conduct investigations of dominant firms, and antitrust and other litigation matters.

Professor Nevo testified as the U.S. government's economic expert in the proposed $37 billion merger between health insurers Aetna and Humana in 2016. He has analyzed competitive effects for merging parties in numerous matters, including Cigna/Express Scripts, Walt Disney/21st Century Fox, Big Tex Trailers/American Trailer Works, and Commercial Metals Company/Gerdau S.A.

Reducing the risk of future shortages may mean on-shoring production facilities and distributions systems or expanding existing capacity through, for example, vertical integrations with medical supply manufacturers.[23] Integrating with domestic producers—whose costs of production are higher—may lead to increased healthcare prices. At the same time, a refocus on domestic producers could mean the upstream market for healthcare equipment shrinks from a global market to a national one, and could lead to higher barriers to entry (as U.S. standards may be more stringent). Such concerns may increase fears of foreclosure and other anticompetitive effects. Expert analysis of these vertical integrations may be necessary to disentangle indicators of potential anticompetitive behavior from higher prices due to anticipated increases in input costs.

Mergers allegedly building monopsony power in input markets, such as mergers between insurers (as purchasers of healthcare services) or healthcare providers (as purchasers of labor), could also draw enhanced interest.[24] Evaluating the effects of monopsony power in healthcare, too, raises important questions and considerations such as whether the alleged monopsony power is sufficient to generate anticompetitive conduct; the types of efficiencies that may be created through the increase in bargaining power; and whether the merging parties have an incentive to pass through cost savings to consumers.

The DOJ and FTC recently issued a joint statement on COVID-19 and protecting competition in labor markets for frontline workers. The agencies recognized the necessity of increased cooperation among private businesses and other entities, but also the potential for anticompetitive practices.[25] Assessing the likelihood and degree of anticompetitive effects against potential efficiencies requires a deep understanding of the mechanics of the healthcare sector.

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Gautam Gowrisankaran of Columbia University has focused his academic research on the effects of hospital mergers on pricing and bargaining leverage, the effect of competition on hospital quality, and complementarities in hospital mergers. His testifying experience involves analyzing the competitive effects of mergers in the healthcare industry, including testimony to the FTC regarding the merger of West Virginia hospitals Cabell Huntington Hospital and St. Mary's Medical Center. His paper, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," coauthored with Aviv Nevo and Robert Town, was the 2016 winner of the Antitrust Writing Award for best academic paper on mergers.

Finally, the pandemic may reinvigorate reviews of consummated mergers (or proposed mergers) that had been (or are) too small to trigger HSR filing requirements, but today may attract greater antitrust scrutiny. Such investigations are already occurring in the healthcare, pharmaceuticals, and technology sectors,[26] but may expand more broadly in the healthcare sector given the pandemic. For example, by the time the FTC challenged prosthetics manufacturer Otto Bock's 2017 acquisition of rival Freedom Innovations, which was not subject to HSR premerger notification requirements, the deal had already been completed.[27] More recently, the medical device manufacturer Covidien's 2012 purchase of Newport Medical Instruments, a ventilator manufacturer, was characterized as a "killer acquisition" that may have "contributed to the current shortage of ventilators."[28] Days later, FTC Commissioner Slaughter called for a retrospective review of the acquisition.[29]

Evaluating the merits of a challenge to a consummated healthcare merger could involve economic analyses of market structure, market power, competition, and entry, grounded in the facts and realities of the complex relationships of the healthcare sector. How closely did the two firms compete? How likely were patients—whose decisions may be driven by physician recommendations and insurance coverage—to substitute between products? For hospital mergers, when is it appropriate to define product markets as a cluster of inpatient services, versus singling out a single service, as the FTC did in its challenge to ProMedica Health System's consummated acquisition of St. Luke's Hospital?[30] Understanding the economics of the continuously evolving healthcare sector and the nature of relationships between market participants in the healthcare space can help to assess the potential of a future challenge to a non-reportable merger.

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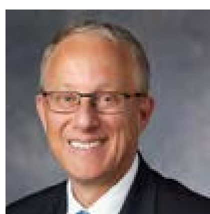

Daniel Kessler of Stanford University has consulted and testified on behalf of hospitals, physician groups, integrated delivery systems, insurers, and pharmaceutical manufacturers. His recent research uses health insurance claims data to investigate how competition among hospitals and vertical integration between hospitals and physicians affect the cost and quality of care.

In a recent matter, Professor Kessler provided expert analysis of the competitive impact of an integration between a health system and physician group, as well as an assessment of the efficiencies derived from such an integration.

Comments on the January 2020 Vertical Merger Guidelines and the Healthcare Sector

By Gautam Gowrisankaran, Avigail Kifer, Dina Older Aguilar, and Andrew Sfekas[31]

With the Draft Vertical Merger Guidelines ("Guidelines") released on January 10, 2020, the DOJ and FTC (collectively "the agencies") offered long-awaited and expanded guidance on an important, but narrowly defined, set of business combinations. The Guidelines illustrate how competitive harm and pro-competitive benefits may occur from mergers between firms "at different stages of the same supply chain." The examples focus on traditional industrial relationships such as input suppliers and manufacturers, and manufacturers and distributors. They add substantial value and insight into how to consider these types of business combinations.

The Guidelines do not, however, directly address healthcare markets, despite their economic importance and the sustained merger activity in the space.[32] Mergers in healthcare markets are frequently non-horizontal, but not strictly vertical, such as the mergers between complements like hospitals and physician groups. Regardless, analyses of non-horizontal mergers benefit from the same tools as do analyses of vertical mergers (particularly with respect to analyses of foreclosure, raising rivals' costs, and elimination of double marginalization). Equally important, healthcare markets are characterized by a number of key features that distinguish them from the settings examined in the Guidelines:

Mergers in healthcare markets are frequently non-horizontal, but not strictly vertical, such as the mergers between complements like hospitals and physician groups. Regardless, analyses of non-horizontal mergers benefit from the same tools as do analyses of vertical mergers.

- **Moral Hazard**: Patients with health insurance do not typically bear the full marginal cost of the healthcare services they receive. Insurance adds protection against financial risk, which creates value. However, it may also lead patients to consume healthcare with low or no marginal value.
- **Information Asymmetry**: Patients have limited information on the price and value of different treatments and may rely on guidance from medical professionals, who are generally not the payers.
- **Complex Reimbursement Schemes**: Provider payment schemes increasingly employ complex mechanisms to ensure quality and control costs, including (i) bundled payments; (ii) rebates based on cost savings achieved (e.g., Medicare Shared Savings Accountable Care Organization, "ACOs"); and (iii) higher reimbursements conditioned on meeting quality metrics (e.g., Medicare merit-based Incentive Payments).[33]

- **Bargaining and Two-Stage Competition**: Competition between healthcare providers takes place in two stages. In the first stage, providers compete to be included in insurer networks and, for private payers, negotiate reimbursement rates. In the second stage, providers compete for patients given their network status. Price setting differs from simpler traditional models, where sellers unilaterally set prices given a residual demand curve (i.e., Bertrand competition).

Healthcare mergers also illuminate the importance of even more broadly applicable considerations, such as the potential necessity of weighting the likelihood of foreclosure, the role of industry regulations, and issues relating to the coincident substitutability and complementarity between products.

These particular characteristics complicate the analysis of vertical and related mergers in healthcare. For instance, moral hazard may encourage providers to over-prescribe care. This possibility may be reduced through a provider and insurer merger that allows the provider to share in cost savings. Information asymmetries and patients' resulting reliance on provider referrals may allow a merger between provider types—such as a physician group and a hospital system—to foreclose competition by directing patients away from competitors (e.g., other hospitals). However, this could also allow such a merger to create the possibility for improved patient care, if referrals within the merged entity lead to better continuity of care and less duplication of services. Complex reimbursement schemes, such as those where payment is based on value rather than service volume, may be facilitated by a merger, and may increase incentives for cost-savings and efficiencies. Analyzing mergers in healthcare and other industries where prices are set through bargaining is similarly complex. The agencies have used sophisticated bargaining models in merger analyses to quantify theories of vertical harm, such as in the recent AT&T/Time Warner merger.[34] Standard merger simulations may over- or understate price effects.

Healthcare mergers also illuminate the importance of even more broadly applicable considerations, such as the potential necessity of weighting the likelihood of foreclosure, the role of industry regulations, and issues relating to the coincident substitutability and complementarity between products, which can influence predictions of competitive effects. These considerations were neglected in the draft Guidelines.

The Guidelines recommend applying the "principles and analytical frameworks used to assess horizontal mergers" to the analysis of vertical mergers, but acknowledge that vertical mergers raise "distinct considerations."

Consider, for example, the potential foreclosure concerns in an acquisition of an outpatient clinic by a physician group. Such a merger could be anticompetitive if, for example, the physician group diverted patients to its affiliated clinic, which then caused competing clinics to exit. A model of the merger's effect would have to estimate first the changes in optimal referral patterns and the likelihood of foreclosure, then the effect on the exit of competing clinics, and then the ultimate effect on clinic prices. A merger may have a small probability of foreclosure, but a significant effect on prices if foreclosure occurs. Alternatively, the merger may engender a high likelihood of foreclosure, but a small price effect. Depending on the specifics of any given merger, these concerns may or may not be offset by potential pro-competitive gains from integration, such as improved coordination of care, reductions in duplicated services, and lower patient costs.

Next, consider the effects of explicit restrictions on and external monitoring of firm behavior. Healthcare markets and the entities operating within them are heavily regulated. Analyses need to consider whether and how regulatory limits may constrain the merged entity's behavior.

Finally, note that in healthcare, two firms may produce both substitute and complementary products. The same two products may function more as substitutes in some settings and more as complements in others, and the degree of complementarity between products can differ. For example, physicians from different specialties may be substitutes for some patients and complements for others. A children's hospital and a general acute care facility may be complements, but a physician group and a hospital may be stronger complements. At what point do the strengths of the complementarities (and resultant competitive effects) outweigh the reduction of substitution in the market?

In summary, the Guidelines recommend applying the "principles and analytical frameworks used to assess horizontal mergers" to the analysis of vertical mergers, but acknowledge that vertical mergers raise "distinct considerations." We agree. We believe that considering mergers of complements, recognizing the distinct sources of efficiencies and potential inefficiencies for these mergers, and applying the agencies' guidance to healthcare examples would provide insight for industries with similar distinctive features such as moral hazard, information asymmetries, complex payment schemes, network formation, and price setting through bargaining.[35] This is particularly important in light of developing academic and legal theories related to two-sided markets and cross-market mergers.

The full commentary is available on the **FTC's website**.

Endnotes

1. Andrew Elzinga is a manager in Cornerstone Research's Boston office. Avigail Kifer is a manager in Cornerstone Research's New York office. Arthur Corea-Smith is an associate in Cornerstone Research's New York Office. The authors are grateful to Ross Askanazi, Ceren Canal Aruoba, Stephanie Chapman Weishaar, Ilene Friedland, Kostis Hatzitaskos, Jeff Kong, Bob Majure, Dina Older Aguilar, Andrew Sfekas, and Charlotte Witherspoon for assistance, comments, and suggestions.
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6. The decline in provider volume is measured as the change between January 2020 and April 2020. See "Hospital Volumes Hit Unprecedented Lows," Crowe, May 2020.
7. Note that the 135,000 employees statistic is based on employment changes between March 2020 and April 2020. See "Hospital Volumes Hit Unprecedented Lows," Crowe, May 2020; "Current Employment Statistics – CES (National): Employment and Earnings Table B-1a," U.S. Bureau of Labor Statistics, April 2020, https://www.bls.gov/web/empsit/ceseeb1a.htm.
8. "Current Employment Statistics – CES (National): Employment and Earnings Table B-1a," U.S. Bureau of Labor Statistics, April 2020, https://www.bls.gov/web/empsit/ceseeb1a.htm.
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11. Numbers are based on spending by large employer plans for non-elderly enrollees. Cynthia Cox et al., "How Health Costs Might Change with COVID-19," Peterson-KFF Health System Tracker, April 15, 2020.
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23. For example, Premier Inc. recently announced a new initiative to invest in domestic manufacturers to "ensure a robust and resilient supply chain for essential medical products," and subsequently joined fifteen health systems to acquire a minority stake in Prestige Ameritech, the largest U.S. manufacturer of face masks. See "Premier Inc. Launches New Program to Invest in Domestic and Diverse Manufacturing Capabilities," Premier Inc., May 19, 2020; Fred Pennic, "Premier & 15 Health Systems Acquires Minority Stake in PPE Company to Address Shortage from COVID-19," *HIT Consultant*, May 27, 2020.
24. Note that the DOJ held a public workshop on competition in labor markets in late 2019, which included the topic of "labor monopsony in merger enforcement." See "Public Workshop on Competition in Labor Markets," U.S. Department of Justice, November 18, 2019.
25. "Justice Department and Federal Trade Commission Jointly Issue Statement on COVID-19 and Competition in U.S. Labor Markets," U.S. Department of Justice, April 13, 2020.
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31. Gautam Gowrisankaran is the Peter and Nancy Salter Chair in Healthcare Management and Professor of Economics at the University of Arizona, an affiliated professor at HEC Montreal, a research associate at the National Bureau of Economic Research, and a senior advisor at Cornerstone Research. Avigail Kifer is a manager in Cornerstone Research's New York office. Dina Older Aguilar is a vice president in Cornerstone Research's San Francisco office. Andrew Sfekas is a senior economist in Cornerstone Research's Washington, D.C. office.

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32. The guidelines do include, in Example 5, an illustration of foreclosure and raising rivals' costs based on a hypothetical acquisition by a pharmaceutical company of the sole supplier of an active ingredient to one of its products.
33. Tim Doran et al., "Impact of Provider Incentives on Quality and Value of Health Care," *Annual Review of Public Health* 38 (2017): 449–465, https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-032315-021457 ("ACOs consist of physician groups, hospitals, and other health care providers that collectively agree to be accountable for the quality and spending for their patient population.... Beginning in 2019, all clinicians who bill Medicare (e.g., physicians and nurse practitioners) must participate in either the alternative payment model (APM) or the merit-based incentive payment system (MIPS), both of which are value-based payment models. Bundled payment models and the Pioneer ACO model are examples of advanced APMs."). See also Matthew Press et al., "Medicare's New Bundled Payments: Design, Strategy, and Evolution," *Journal of the American Medical Association* 315, no. 2 (2016): 131–132.
34. Expert Report of Carl Shapiro, U.S. v. AT&T Inc., DirecTV Group Holdings LLC, and Time Warner Inc., February 2, 2018.
35. For instance, telecommunication markets include a first stage of competition with negotiation over a network of providers and prices; insurance markets generally create opportunities for moral hazard; and financial services markets include informational asymmetries and consumer reliance on expert recommendations.

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