Southwest Virginia Health Authority and Federal Trade Commission

Board Meeting

October 26, 2016 at 3:00 PM

Southwest Virginia Higher Education Center,

Room 240

Abingdon, Virginia

I. Call to Order.

Chairman Kilgore called the meeting to order at 3:00 PM.

II. Roll Call.

Ms. McFadden called roll. Ms. Copeland, Mr. Eaton, Mr. Mosley, Dr. Cantrell, Senator Carrico (five minutes late), Dr. Welch, Mr. Leonard, Mr. Givens, Delegate Kilgore, Mr. Horn, Ms. Ward, Dr. Tooke-Rawlins, Mr. Vanover, Dr. Counts, Mr. Prewitt, Mr. Clark, Mr. Neese and Ms. Brillhart were present.

Dr. Henry and Dr. Rheuban were present by telephone.

Ms. O'Dell, Delegate Morefield, Dr. Mayhew, Mr. Perdue, Ms. Baker, Dr. Weiting, Senator Chafin, Dr. Means and Mr. Mulkey were absent.

III. Declaration of Quorum.

Chairman Kilgore declared a quorum.

IV. Public Comment

Mr. David Hollands from Chillhowie asked, "Explain to me how one major entity will not be a monopoly? It is better to have two strong entities for competition sake."

Mr. Hollands stated that he spoke to Senator Carrico and others and he didn't know if they agree with what he says or not. He suggested it is not in the community's best interest to have one major entity controlling all of the health care in this region. He continued, "In fact, that is in violation of the Sherman Anti-Trust Act; since you are a republican, that was Theodore Roosevelt; for a history lesson."

Ms. Sharon Smith, a provider and patient in the area, spoke next. She said,

> "Just based on knowing the health care system for the past twenty years, when you have a health system that has considerable debt merging with a health system that does not have that same amount of debt; and in the event those debts are called in, that will take away the entire availability of healthcare for our region; which means you go to Roanoke or go to Knoxville. There will be no Level 1 trauma centers and there will be

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nothing. Currently, my concerns are from a patient standpoint, I try often to get patients in for testing and if they have any amount of debt to one of the facilities, then I can't get their tests done. Now, they have to the option to go to another facility to be able to get healthcare. As we know with Obama Care, everybody has higher deductibles. They have higher deductibles, less income and less resources from a financial standpoint of being able to afford their healthcare. That is a concern not just from me, but all of the providers pretty much in the area. So, I don't understand how you can address when two health systems of this size merge. You can't tell me that they are not going to cut down on duplication of services; which means people that come out of the coalfields in Grundy and Tazewell; which many of them do come to this area for healthcare – are going to close facilities that are closest to them in order to keep some of the other facilities open. There are already hospitals struggling right now, Smyth County averages two patients to five patients a day as far as their census. You can't tell me they are not going to close that facility for those fewer patients, so it is going to be detrimental for urgent cares for patients coming out of those areas. They need access to the ERs. They need overnight access. It is going to make people drive further and it is going to affect quality of health care in our region. There is no way to eliminate that by merging two facilities the size they are."

Mr. Holland asked if he could add something else. He continued by saying that:

"They both got themselves in a bind because they were promised the world by Obama Care. Wellmont, the person over HR was backdooring money to these health organizations that they weren't allowed to per Mr. Holland. Now, they got caught; no more money is coming out. Now, they got themselves in a financial fix by what they dished out. When Obama Care kicked in, there were maybe 68 patients or more kicked out down there at Wellmont hospital, my mother being one of them and her with pneumonia. She died a few days later. She was one of the people that suffered from Obama Care; they only allowed so many days and after that, they kicked them out. Now, if we had it done all over again, we would have sued for malpractice and maybe even tried for manslaughter, because that was a death nail to her."

Chairman Kilgore thanked Mr. Holland for speaking.

There was no other public comment.

V. <u>FTC Presentation – Mark Seidman</u>

Chairman Kilgore introduced the staff of the Federal Trade Commission. Mr. Mark Seidman is the Deputy Assistant Director for Region 4 Sector of the FTC, who introduced his colleagues. He began his presentation by introducing his colleagues. Goldie Walker – Attorney for the FTC, Eileen Thompson – an economist with the FTC and the Assistant Director of the Anti-Trust 2 Division, Stephanie Wilkinson – an attorney in our office of policy and planning, as well as Tina Dickenson – an attorney in Region 4.

Mr. Seidman expressed his appreciation meeting with the Authority. He said,

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"While we might be a little bit constrained in what we can say today because of some confidentiality issues, or regarding legal issues, we still hope that we will be able to answer any questions that the Authority has and if there is anything we are not prepared to answer today, we are happy to follow up as soon as we can. There are several caveats. One is that while the Commission has authorized us to participate in this process, our remarks today are our own and do not necessarily represent the views of the Commission or our individual Commissioner. The other caveat is that we are going to be talking about a lot of things today that may involve remedies for potentially uncompetitive effects from a merger and I don't want any of our comments to be taken as an endorsement of any particular plan and don't want our comments held against us in the future. But we do want to engage the Authority on what they are thinking about and the routes they are getting ready to take. I just don't want the big picture to get lost there."

Mr. Seidman said that FTC staff reviewed the Applicants' response to our public comment, and they really appreciate this opportunity to address some of the criticisms the Applicants raised. He said that staff will give a short presentation and will pull out some of the key points from the public comment as well as address some of the issues raised in the Applicant's response. Mr. Seidman said:

"As we noted previously, the FTC's mission is to maintain competition while protecting consumers. We take seriously our role in protecting the consumers in this region which is why we have submitted a lengthy public comment and sought to participate in this state review process. I want to frame our discussion and public comment and make it clear on what we are not discussing. First, we are not discussing or questioning the policy choices that made were made by the Virginia Legislatures in passing the Cooperative Anti-Agreement legislation. We respect that choice and we endeavor to evaluate the Applicant's Cooperative Agreement application laid out in that legislation. Indeed, we structure the analysis in our public comment to track statutory factors laid out in the Cooperative Agreement legislation.

Second, we are not prosecuting an Anti-Trust case against the merger through our public comment or our discussion today. Our role has been to apply our extensive experience in reviewing and investigating hospital and other healthcare transactions to help the Authority understand the nature and the risks posed by the elimination of competition and to identify the challenges, ambiguity and potential shortcomings in the Applicant's claims and commitments."

Mr. Seidman went on to explain that ultimately MSHA and Wellmont are making an extraordinary request from the Authority and the Department of Health to approve a merger that would create a virtual hospital monopoly in Southwest Virginia. He said that the burden is on the hospitals to fully describe the benefits from the merger and clearly explain how their commitments will mitigate any harm from the merger. He said that in the Cooperative Agreement legislation they must ultimately demonstrate that the benefits likely to result from the COPA outweigh the disadvantages likely to result from the reduction in competition. He further explained,

"Because of the statutory factors, the Authority and the Department of Health must

consider are very similar to the factors considered in our standard merger guidelines analysis. We refer consistently to those guidelines in our public comment. Indeed, our merger guidelines instruct us to consider many of the same factors that the COPA law instructs the Authority and DOH to consider including the impact of the merger on quality and care and the potential for cost savings. Indeed, the healthcare regulations recognize our expertise in this area and expressly allowed for consultation with the FTC. Lastly, I want to note that we are well aware of the economic and healthcare challenges in this region. The Applicants have discussed their concerns at length in their application and in their response to our comments. Contrary to the Applicant's statement, we are not blind to these realities. The question or us and more importantly, the question for the Authority is whether this merger is the only way to address the issues at the cost of displacing virtually all hospital competition in the area, and the Applicants are asking the Authority and the DOH to make this decision on virtually no concrete information on alternative arrangements available to the Applicants.

In essence, the Applicants are asking this community to take on a tremendous risk that their monopoly power to be effectively constrained by government regulation and counterbalances by promises that may be difficult to enforce and will take years to materialize in some cases. In which the Authority and DOH may have limited ability to remedy if the parties fail to fulfill their promises. As a brief outline for our presentation today, I am going to turn it over to Goldie and she will discuss some of the dynamics of hospital competition both generally and specifically with these hospitals. Eileen is going to talk about the economic analysis that has been done and the potential for less restrictive alternatives as well as the economic literature regarding the impact of an out of market acquisition raised by the Applicants."

Mr. Seidman said that Ms. Wilkinson would discuss some of the commitments made by the Applicants, and he would discuss the plan of separation and enforcement mechanisms or lack thereof affordable to the DOH. He said, "So, with that, I will turn it over to Goldie."

Mr. Seidman then introduced Ms. Goldie Walker, who is an attorney at the FTC discussed three topics. First, she discussed the relevance of hospital competition and the review about the Cooperative Agreement, and the hospital competition in general and how it affects patients and employers here in Southwest Virginia. Second, she discussed the loss of competition that will result from the cooperative agreement. Lastly, she provided a quick overview of evaluation on the proposed merger and the benefits of that agreement whether they outweigh or harm the loss of competition.

"Why is hospital competition relevant in your review of the cooperative agreement?" asked Ms. Walker.

Ms. Walker said that it is relevant because the Virginia Cooperative Agreement statute expressively states that the Authority and the Health Department much consider if there is harm resulting from the elimination of competition. She said that the Authority shall make a recommendation to the Commissioner based on a review of the reduction in competition. Also, worthy to note, all four of the statutes disadvantages which the Authority must evaluate relate to competition. The factors include negotiation with health insurer's competition among healthcare providers, the adverse impact on price, the quality of healthcare and the availability of less restrictive alternatives to competition. The

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Applicants have questioned the value of competition in this market, and its relevance to the Cooperative Agreement analysis, but based on the statute it is inaccurate to say that competition and competition analysis is not relevant to the review of the COPA. As they explained in stats in recent public comments, hospital competition occurs in basically two stages.

She said,

> "I should note that I am going to refer mostly to hospital competition, but the same dynamic refers to competition in out-patient services and physician services. In the first stage, hospitals can pay for inclusions and health insurer's networks. To be included in the network, the hospital negotiates prices with the health insurer. These negotiated prices largely depend on each side's bargaining leverages during these negotiations. For example, a hospital will have a lot of leverage if there are few viable alternatives to the hospital. Because the hospital's network with be less attractive to its members without that hospital. As a result, health insurers will be willing to paying a higher price to keep that hospital within its network. In contrast, when there are viable alternatives to the hospital, the hospital will have less leverage to demand higher prices, because the insurer could have an attractive network without that hospital. In this way, competition enables the insurer to restrain a hospital's price increase; at least compared to a market with little or no competition."

Ms. Walker suggested that the bargaining leverage of MSHA or Wellmont is limited by the availability of the other system as an alternative. Wellmont and MSHA are close competitors. She said that their proposed merger is likely to increase their bargaining leverage of the proposed merged system because it eliminates the significant constraint that each system has on the other in the negotiations with health insurers. The FTC and the Courts have sought and considered evidence from insurers regarding the likely effects from the hospital mergers. She said their role is not necessarily to protect their insurers, it is important to remember that insurers are often a proxy for employers and for patients. So, when prices go up for insurers, insurers often pass on those higher prices to their customers. Here, this would be the local employers and the residents in Southwest Virginia. Employers typically pass on these higher prices to their employee in the form of higher premiums, copayments, upping the deductibles and other out-of-pocket expenses. Self-insured employers feel the brunt of any price increases immediately. The Cooperative Agreement statute recognizes this dynamic and requires the Authority to consider the adverse impact that the Cooperative Agreement may have on payers and the ability to negotiate rates with the insurer.

Ms. Walker explained to the Authority that in the second stage of competition, hospitals compete to attract patients and physician referrals to their respective hospitals. She said this competition between hospitals is based upon providing better quality, innovation, access and availability of health care services. A hospital merger may lessen or eliminate this competitive incentive to maintain or improve quality where few adequate alternatives remain. By combining the two hospitals, there incentive to keep up quality levels; to innovate; to provide access to all services is diminished. Ms. Walker said it is important to note that in this second stage of competition it affects all patients – not just commercially insured patients. Meaning that, if the merger results in a reduction in quality, it also hurts Medicaid and Medicare patients as well as the uninsured.

Ms. Walker continued,

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"Now to my second point regarding the loss of competition that will result here from the cooperative agreement; the evidence is overwhelming that MSHA and Wellmont vigorously compete against each other, and that they are each other's closest competitors and there are few meaningful competitors to these competitors for local consumers. Economic studies, litigated cases and our own extensive experience show that the merger is highly likely to lead to higher prices and lower quality for employers and residents from Southwest Virginia. Putting aside their claims about the commitments, the parties do not meaningfully dispute this conclusion. Instead of directly rebutting the evidence demonstrating the tremendous loss in competition from this merger, the parties argue that the Legislature's goal was to displace competition, and therefore, consideration of competition is irrelevant. As shown earlier, the loss of competition must be considered.

Ms. Walker continued,

"Now as Mr. Seidman mentioned, the Health Commissioner's regulations seem to recognize that the insight of the FTC can provide by stating that we may be consulting during the review of the Cooperative Agreement and the application, and we do believe that we can be helpful because this analysis is very similar to the factors in the Authorities review process."

She finished by discussing the benefits of the analysis of the Cooperative Agreement. The staff reviewed numerous hospital mergers and analyzed the potential benefits and harm from the reduction of competition. This type of analysis is well known to the staff and similar to what the Authority will access. The statute spells out that the benefits to the consumer. The benefits should include the enhancement of quality of care, the preservation of hospital facilities and the enhancement of population health. Ms. Walker said that staff examined each of these statutory factors extensively in our written comments.

Ms. Walker explained that from staff's evaluation of the application and the supplemental materials, the Applicants have not shown that meaningful benefits outweigh the harm. In their comments, staff focused on whether the parties demonstrated that their claimed benefits were substantiated and could be achieved through this merger. In fact, the statute specifically requires the consideration of least restrictive alternatives to achieve claimed benefits or a better balance of benefits over disadvantages. Ms. Walker said that Eileen Thompson would discuss that next in her presentation, the Authority and the DOH, should consider whether this merger is the only way to achieve a given benefit. She said that it is only logical to hold the Applicants to a high standard for substantiating their claims. If the Authority and the DOH are going to grant the Applicant's extraordinary request to approve this merger to near monopoly, the Applicants should be very clear about the benefits they claim.

Ms. Walker said the Applicants have not shown that most of their claimed benefits can only be achieved by this merger and not by other means having the same or lesser anti-competitive effects. The staff identified several benefits that lacked merger specificity such as those including the projected cost efficiencies of services provided by the hospitals. She said that many of the Applicants claimed benefits lack sufficient detail to verify them such as the Applicant's quality claims and beneficial consolidation benefits. In weighing these potential benefits against the unquestioned elimination of competition, the

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Authority should hold the Applicants to a higher standard of specificity for their claimed benefits.

Ms. Walker explained,

> "Now, we acknowledge that there may be some benefits, but they would likely be costly and difficult to achieve. For example, the introduction of the potential IT platforms and the EMR would be beneficial, but it would also be costly and time consuming to make such a transition. Importantly, the Applicants have not described what the incremental improvement of a combined EMR system would be over what they have today; especially considering the availability of a region-wide health information exchange currently in operation. As mentioned earlier, there will be significant harm from the result of the loss of competition. Given the questions about the magnitude, the timing and the likelihood of achieving the claimed benefits, we do not believe the parties have shown that the benefits of the Cooperative Agreement outweigh the harm. Or that the Authority should take the significant risk that these benefits will actually be achieved."

Ms. Walker introduced Dr. Eileen Thompson, who is the economist that discussed the economic analysis that we have conducted. Dr. Thompson began by discussing the analysis that the Bureau of Economics performed of the impact of the Cooperative Agreement on competition. She said,

> "In particular, I would like to focus on the analysis we did based on the in-patient discharge data collected by the states of Tennessee and Virginia. A useful way to describe the data visually is through what we refer to as "Pac-Man maps" due to the similarity of Pac-Man video games. Each circle on this map represents the shares by hospital systems for the patients living in those counties. So, for example, in Washington County, the circle here represents the shares of the hospital systems for patients living in Washington County; the red is MSHA share and the blue is Wellmont and the little yellow sliver is the share accounted for by all of the other hospitals other than Wellmont and MSHA. So, the big take away from this picture is that there is a lot of red and blue on the map particularly in the central regions. Some patients from this area do seek care from other hospitals, but generally those numbers are very small as is evidenced by the small amount of yellow on the map of other hospitals."

In order to further analyze the impact of the cooperative agreement on competition, she continued to the next slide that describes the data where people actually went for care in 2014 from these areas. She said that staff tried to measure the current degree of competition between Wellmont and MSHA. They estimated what they call a patient choice model that allows staff to predict where patients would have gone if there first choice hospital was not available. Dr. Thompson said,

> "So, for example, if there first choice hospital was not included in the insurance network; where would they go? So, to do this, we utilized the patient level data that is collected by the states and we predict how patient's make choices by looking at factors such as distance they travel; their diagnosis and other characteristics of the patient and hospitals. So, we were better able to predict where patients will go for care based on various patient characteristics and characteristics of the hospital. So, then what we do is look at the Wellmont patients for example and we say; suppose Wellmont patients

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can't go to this hospital based on the characteristics of people that currently go to that hospitals, then where would they likely go as their second choice? We find in our results that Wellmont and MSHA are extremely close competitors which is probably not surprising to many in the room. What we find is about 85% of Wellmont patients would choose MSHA as their second choice, and similarly MSHA patients would choose Wellmont as their second choice. In other words, about 85% of the patients that are admitted to either a Wellmont or MSHA hospital are choosing between these two systems. That is a very high degree of competition between the two systems and to get an idea of the magnitude of harm for the merger, our internal analysis suggests that a merger of such close competitors could lead to price increases upwards of a 100%; which we recognize is a very large number, but it is broadly consistent with economic analysis of past mergers that have taken place."

Dr. Thompson explained that economic studies generally find that mergers between competing hospitals in concentrated markets lead to significant price increases; often more than 20%. She said,

> "For example, an economic study of the merger between La Sadra and Summit hospitals in California found price increases ranging from about 20-44% depending on the payer. Our numbers here are higher and that is not surprising given the very substantial amount of competition here. Anticipating your next question, we do recognize that the Applicants have agreed to limit price increases by imposing price caps, but we still feel that our analysis and our estimates are very informative because they provide a measure of the amount of additional market power that could arise as a result of the cooperative agreement.
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> Stephanie will talk in a few minutes, we do have serious concerns about the effectiveness of the price caps, but even if the price caps are effective, this market power may manifest itself in other ways; for example, a decrease incentive to invest in quality of care initiatives. So, given the large amount of market power that we believe could result from this merger, it is important to consider whether or not there are other alternatives that are less restrictive for competition that could achieve the same benefits. In fact, one of the statutory factors asks that the Authority ask that exact same question. As we detailed in our public comment, we believe that many of the benefits that the Applicants hope to achieve through their cooperative agreement, could be achieved through other means either by the Applicants independently or through some other form of collaboration that wouldn't involve a full merger. For example, the latter would include joint ventures or other contractual arrangements; to coordinate on clinical care and elimination of services. So, the FTC has issued extensive guidance that is available on our website on the types of collaborations to improve patient care that would not run afoul of the anti-trust laws.

Dr. Thompson said that the staff was not aware of efforts on the part of the Applicants to investigate these other types of collaboration that would be short of a merger or would not impose such a large effect on competition. She suggested that another way that some of these benefits may be achieved is through an alternative merger that does not involve mergers of two close competitors. These

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mergers are often referred to as “out of market” mergers because they don’t involve mergers between two competitors in the same market. She said that the Applicants have raised concern that an out of market merger may lead to substantial price increases and to support their concern, they point to an economic site that finds that prices increased approximately 17% on average when independent stand-alone hospitals were acquired by out of market systems.

Dr. Thompson said that it was important to note, however, that MSHA and Wellmont are not small independent stand-alone hospitals. She said the results of this study do not apply directly to them, and, in fact, the study finds that the results of the price increases are particularly strong when acquired hospitals are small; and their benchmark for small is the bottom 1/3 of their sample in term of bed size was 58 beds. The Wellmont and MSHA hospitals are significantly larger than a 58-bed hospital. Suggesting that this particular study does not relate directly to the Applicants. She said,

> “It is also important to note that the economic study of out of market mergers is relatively recent and the mechanisms through which these price increases may occur are not well understood. The study that the Applicant site suggests that one hospital mechanism is that hospitals gain additional bargaining ability; so, they are able to become better bargainers when they become part of the system because they can draw on the free sources of larger systems in order to develop skilled negotiating teams. Again, MSHA and Wellmont are relatively large systems, and they are likely to have sophisticated negotiators already. So, it appears that is it not very likely that an out of market merger would impact their ability to negotiate; particularly when compared to the loss of competition that would arise from the cooperative agreement.”

Dr. Thompson continued,

> “The Applicants have also raised concerns that an out of pocket merger would lead to more job losses and facility closures than the proposed cooperative agreement. There is no reason priory to believe this would be the case. Another merger that maintains competition between the Applicants continues to face the same incentives just as the Applicants currently face to maintain both facilities. We view the concerns right now by an out of market to be very speculative. We understand that Wellmont has received a number of other offers, but the detail of those offers and the business plans of the alternative participants are not public. So, we would encourage that the Authority to request that the Applicants provide the information necessary to fully evaluate these other alternatives before they reach the final conclusion.”

Mr. Barry asked, “Would you please go back to the slide with the ‘Pac-Man map.’ Has the FTC taken a position on what ‘THE’ market is for purposes of an Anti-Trust analysis?”

Dr. Thompson replied, “No, we haven’t. We just looked at the 21 counties that the Applicants identified in their application.”

Mr. Barry asked, “Do you agree that the market extends across the state line of Tennessee and Virginia?

Dr. Thompson replied,

> "We haven't taken a position on that. For us, the definition of a relevant geographic market takes a very specific form and it is basically the market in which the hospitals could raise prices. So, looking at the map, we have not done that type of analysis. It is possible that there are several anti-trust metrics."

Mr. Barry said he may come back to more questions later.

Mr. Seidman added,

> "I want to separate the very technical anti-trust question about geographic market from how we have thought about this merger, generally, and we certainly have looked at the entire systems which spans both states. If your question is about looking at this region in total, we have."

Mr. Barry stated, let me give this one more try, "Do you agree that patients, employees, vendors, contractors and everybody involved with these systems freely cross state lines?"

Mr. Seidman responded, "We have seen nothing that suggests otherwise."

Dr. Thompson also noted that patients do cross the border in the data.
Mr. Barry replied, "Ok, great! Thank you."

Ms. Stephanie Wilkinson, who is the Attorney Advisor in the FTC Office of Policy and Planning, stated

> "I am going to spend my time today addressing the Applicants proposed commitments; particularly their price commitments. MSHA and Wellmont recognize that their merger is likely to raise significant anti-trust concerns, so they attempt to mitigate the likely adverse effects on pricing and quality by proposing several commitments that they claim would restrict their post-merger pricing and contracting behaviors and would lead to quality improvements. At the onset, I think it is important to note that the Applicants have stated that their monetary commitments are possible solely based on savings to be realized by merger efficiencies. However, experience and evidence demonstrate that many hospital mergers do not achieve their projected efficiencies. What that means is that if the Applicants do not achieve the full $450 million dollars in projected cost savings, there is serious doubt of their being able to fulfill all of their commitments and deliver the level of community support they promised."

She said that although MSHA and Wellmont have revised some of their proposed commitments, perhaps partly in response to the FTC staff comments. The commitments would still prove difficult to implement; to monitor and enforce would not eliminate the benefits of competition. Generally, these types of commitments regarding post-merger conduct are inadequate to prevent consumer harm. In her staff's comments, they attempted to point out some of the obvious ambiguities and attempt to avoid pitfalls of the pplicant's commitments. She said that the staff's comments are not intended to be an exhaustive list of the challenges associated with those proposed commitments.

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Ms. Wilkinson explained that there could be many additional problems with the commitments including some that may not be foreseeable. In fact, the Applicants explicitly acknowledge that there may be changes in circumstances that could affect the feasibility or meaningfulness of the commitments which are not possible to for see today.

Ms. Wilkinson continued,

> "The FTC is not in a position to determine what commitments will be necessary for the benefits of the cooperative agreement to outweigh the disadvantages. Our intention is to raise issues, questions and potential concerns that the Authority and the Commissioner may wish to consider as they review the Applicant's cooperative agreement application. Ultimately, the burden is on the Applicants to demonstrate that their proposed commitments will work and that the benefits will outweigh the disadvantages. The Authority and the Commissioner will have to decide if they are comfortable with the commitments and that the commitments are sufficient, and whether they will have the ability and the resources to monitor and enforce these commitments perpetuity.
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> So, there is a lot of attention paid to the price commitments that have been proposed by the Applicants. So, I am going to spend most of my time focusing on these. However, I would like to note that we continue to have serious concerns about whether the proposed quality commitments can be achieved or enforced. Economic studies show that a reduction in competition is likely to cause a reduction in clinical quality. Adverse quality effects of mergers are particularly likely in markets where prices are regulated. Perhaps because pricing restrictions can reduce incentives to improve or maintain quality.

Ms. Walker said,

> "We continue to believe that the proposed price commitments are unlikely to adequately protect the consumers from price increases that are likely to result from the loss of competition between MSHA and Wellmont. Despite the additional explanation provided by the Applicants in their response to the FTC comments, many of the specific terms of the price commitments remain ambiguous and still appear to contain gaps. As such, we can for see all of the possible ways that these commitments could fall short of their intended purpose, could be circumvented or could result in unintended consequences. As delivery and payment models for health care services are likely to continue to evolve, we also question whether the proposed price commitments would be applicable to new value based contracting models which may not rely on negotiated fee for services reimbursement rates. Competitive environments naturally allow for these changing dynamics, but regulatory environments such as what is being proposed by this cooperative agreement may not allow for such adjustments.
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> As explained in our comments, the proposed price commitments do not set specific reimbursement rates. Instead, the Applicants propose a price growth cap intended to

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limit the degree to which they would be allowed to increase prices each year. They claim that the reduction in price increases would benefit insurers in the form of a lower cost trend, and that insurers will pass along the associated cost savings to consumers. It is important to understand that the price growth cap proposed by the Applicants would not actually guarantee lower prices than what might be achieved by competition. Again, to be clear, the FTC is not in a position to determine what particular price commitments would be adequate in order to protect consumers. However, we are familiar with regulatory economics literature and we understand some of the challenges associated with rate negotiations. So, we provided the following example of possible concerns and questions that the Authority may want to ask the Applicants and payers in the region.

First, the Applicant states that as a result of the price commitments, pricing will increase by less with the merger than if the merger were not to occur. However, it is possible that in a competitive market, payers would be able to negotiate a reduction in pricing levels; which would presumably be better for consumers than just limiting the degree of annual price increases. To determine whether this would be possible, the Authority and the Commissioner may want to ask the Applicants and payers if such price reductions have ever been negotiated in prior years.

Second, it is also possible that after the merger, payers would be able to negotiate lower price increases than would be guaranteed using the proposed price growth cap. Thus, the Authority and the Commissioner might want to look at whether payers have been able to resist or mitigate price increases in prior years. Although the Applicants have tried to clarify when the price commitments will take effect, the price growth cap is still likely to be a floor for rate increases; despite the Applicants claim to the contrary. As explained in our public comment, if the cooperative agreement is approved, MSHA and Wellmont would no longer serve as competitive restraints to each other. They would face no meaningful hospital competition and only limited competition in other services such as out-patient and specialty physician services. Thus, there would be nothing to prevent the new health system from exercising its market power in negotiating the maximum increases allowable per the proposed price commitments. So, although the commitments may guarantee the payers a rate no higher than the cap, and that is assuming there is no way for them to circumvent the cap, it also effectively ensures a rate no lower than the cap.

Third, it is also unclear to us how the price growth cap would apply to services that do not have fixed rates. The consumer price index proposed by the Applicants only apply to fixed rates; so, for example, if the contract includes percentage discounts of the hospital charge master rates, it is unclear how the price growth cap would apply. One question the Authority may want to consider is would it be possible for the new health system to inflate its charge master rates if it no longer faces any significant competition. So that it could capture higher prices and revenues for services under these types of contracts without running afoul of the price growth cap.

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Fourth, another issue to consider is the Applicants estimated $10 million dollars in annual savings to the consumer that they claim would result from the price commitments. It is unclear to us how the Applicants calculated this figure; particularly if they are relying on payers to pass along any cost savings to consumers. Importantly, they state that this estimate is nonbinding.

Fifth, there does not appear to be any way for the Commissioner to pose rate increases that exceed the price growth cap. Although the cooperative agreement calls for mediation between the new health system and principal payers, if they are unable to reach agreement on a negotiated rate. It is unclear what happens if this mediation is unsuccessful in resolving the dispute.

Sixth, the Applicants have revised the definition of principal payers so that it now includes both commercial and governmental payers at negotiated rates. However, it is still limited to those payers that provide more than two percent of the new health systems total net revenue. It remains unclear to us which payers may be excluded from the price commitments; or why it is necessary to exclude them at all. Also, the Applicants have stated that the original exclusion of governmental payers was an unintended omission. This raises potential concerns about other inadvertent or unintended omissions throughout the cooperative agreement application and revised commitment amendments. Now, beyond the issues that we have just raised, we are aware that Meri-group and the Virginia Association of Health Plans have raised additional points regarding the price commitments that the Authority and Commissioner might wish to consider.

Finally, practical enforcement mechanisms for the proposed price and quality commitments still seem to be lacking. While enforcement of the price commitments seems difficult enough, we question whether there is any feasible way to enforce the quality commitments. Although the Applicants have agreed to file reports with the Commissioner, there does not seem to be an effective way for the Commissioner to address deficiencies short of terminating the Cooperative Agreement."

Ms. Wilkinson continued,

"Mr. Seidman wanted to talk about the enforcement mechanism available to the Health Commissioner should the Cooperative Agreement fail. The only apparent mechanism for enforcing the terms of the cooperative agreement is the plan for separation submitted by the Applicants, and it is discussed in detail in our public comment. The plan of separation is not an actual plan, but rather a process by which a plan could be developed. A more detailed plan of separation, the Applicants filed in Tennessee; and was attached to their response, adds some length and some detail to the process, but does actually little to resolve the fundamental challenges of prying apart a massive 19 hospital system. The revised plan of separation proposes what appears to be an 18 month freeze on the current structure of the current hospital system; in order to facilitate an orderly dissolution of the merger. There are a couple of issues with this.

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First, it is unlikely that Virginia and Tennessee DOH would agree within the first 18 months of the cooperative agreement that it isn't working and must be dissolved; absent some obvious failure from the Applicants. This is likely too short a time frame in which to analyze the success of the cooperative agreement. Many of the Applicant's commitments are not even required to be completed within those 18 months including several programs and investment initiatives that will take between 24 and 36 months, and some as long as ten years. Indeed, the Applicants acknowledge that the EMR and electronic health records would not be merged at that point in any event; it will take well beyond 1.5 years to complete that complex and costly project.

Second, the FTC's experience has shown that even in the so called "whole separate situation" that the Applicants appear to propose in their revised plan, separating assets is still not easy. For example, in the aftermath of Commissions pro Medicaid hospital litigation, it took the Commission over a year to effectuate the best ensure to the merged hospitals; even though the defendants were under a court order not to integrate the assets of the loan acquired hospital for the entire pendency of that litigation. Even in that instance, it took the Commission a year to sell off the hospital. After the initial 18 months, the revised plan largely raises the same concerns identified in our public comments. A key concern is that if a hospital or other health care facilities are closed or services are reduced, physicians may go to other hospitals or leave the area entirely. If equipment is transferred to another facility or exposed of completely, if managers or other staff are laid off, or if the patient travel pattern changes, then it will be exceeding difficult; if it is possible at all, to restore the competition to what it is today. An example of this is in Commission litigation St. Louis Saulser matter in Boise, IL where a physician group merger that the FTC successfully challenged after it had been consummated for about a year, we are still trying to effectuate a divestiture of that physician group nearly two years after an appeals court affirmed the district courts order to invest the physician group.

Ms. Wilkinson said,

"Additionally, the plan of separation here provides little clarity on how or which assets would be restored to MSHA and Wellmont, which again leads to questions about the viability of a plan to return a competitive health care market to Southwest Virginia. Importantly, it appears that the plan for separation is the only tool available to the DOH in the event that the hospitals don't live up to their commitments. Having only this nuclear option one must presume would be exercised in conjunction with Tennessee limits the Health Commissioner's ability to regulate the merged entity. According to the Cooperative Agreement statute, the Commissioner of Health can impose consequences if the Applicant does not meet a commitment. We have seen no proposed consequences as of yet. Without some proposed mechanism to regulate the myriad commitments made by the Applicants, DOH will be only left with this nuclear threat of dissolving this Cooperative Agreement and merger. It is far from clear whether this threat would be sufficient to ensure the Applicants compliance with the commitments

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in the application.

In summary, we have serious concerns regarding the significance in loss competition between MSHA and Wellmont, and the commitments and claimed benefits lack the level of specificity and perhaps more importantly, the enforceability of those commitments. With that, we are happy to take any questions the Authority might have or to address any other details you would like for us to address. We recently received some questions from the Authority and we have done our best to go through those. We are happy to do so. I do want to follow up with one question you had during the presentation. In terms of the question on Virginia Tennessee, we focused on Virginia and the effects on Virginia. We don't limit that to imply that the effects are only Virginia, but the comments were for the Authority in Virginia."

Mr. Mitchell asked if Ms. Wilkinson could go back to the "Pac-Man" map. Mr. Mitchell noted,

"Down in the fine point, I want to make sure the Board sees that the source for the information is from the hospital discharge data 2014 which is probably the most recently available data. I certainly have not been able to find anything more current than that, but I wanted to make sure you all saw the date on that; that was after the closure of Lee County Hospital as they closed October 2013, so it probably is included in the data. The 2014 data seems to be the most recent out there."

Chairman Kilgore asked if it would be possible to get a copy of the Power Point to put on our website as people on the phone could not see the presentation.

Mr. Seidman agreed to get a copy for the webpage and noted that it is not a formal presentation but a presentation to offer suggestions and input into the proposed merger.

Chairman Kilgore thanked the FTC for coming down and for presenting to the Authority and noted that through this process, he has learned something new from every meeting. He said,

"We may have questions back and forth, and, by all means, these questions are not to be argumentative. We are just trying to figure out where we are and where the region is as we move forward with a meeting tomorrow and possibly next week. We do have some questions that were prepared by members and the Staff and our Staff include Dennis Barry, Tom Massaro and Dick Brownlee that are here today."

VI. <u>Questions from the Authority</u>

Mr. Barry thanked the FTC for having made the drive from DC down here more than once and for all of the effort they put into it. He continued,

"Also, the FTC is a very well-respected agency; known for the thoroughness and talent. I recollect that you have been working on this for a year or longer. Can you give us some indication of what background you did; what research you have done; who you have talked to and if you can't give us names, give us categories of people you have talked to

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and times you have been in this area and that sort of thing."

Mr. Seidman stated that they are constrained regarding the details of what they can talk about because it is not a public investigation, but the Commissioner authorized us to disclose the fact that we have an investigation. He said the details of the investigation remain nonpublic and that this is important because the staff wants people to be as candid as possible when we talk to them, and we tell them that we will not reveal what we discuss publicly. He said,

> "We can't talk specifically about who we talked to, but I can say generally in a hospital investigation, we seek to talk to as many market participants as we can possibly talk to such as other hospitals, payers, employers, physician groups and others. I want to make something clear about that though; when we talk to market participants, our goal is to understand the dynamics of the market. Unquestionably, people will tell us whether they are for or against the merger and that is something that inevitably comes up. Although it is typically not the focus of any interview we conduct. During our investigation, we are not counting heads in terms of who is for and who is against. Our analysis focuses on what does competition look like today in a given market and what effect will the merger have on that competition market and what benefits might result from a merger. Those were the questions we were trying to answer during the investigation, and certainly the kinds of questions we were trying to answer here.
>
> Because this investigation is a little bit different than others we have done in terms of the roles of the states in both Virginia and Tennessee, we have tried to participate in this process and the Tennessee process as much as we can participating in hearings in both Virginia and Tennessee. We hope to continue doing that as the process moves forward."

Mr. Barry stated that there are probably many in the room that are not familiar with the FTC process. He said that the presentation started out saying that they are not speaking for the Commission and that the Commission has not voted but the Commission have given them permission. Mr. Barry asked, **"**How/Why hasn't the Commission acted on this and how common is that this sort of staff work is done without the Commissioner participating?"

He said,

> "Stephanie can speak to the technical details there, but Mr. Seidman stated that he wanted to make clear that our investigation is ongoing. The Commission acts in an official capacity in very specific circumstances. So, we are Commission staff, and we can act in ways that are a bit outside of that with authority from the Commission. To take an official action requires a much more official process. Since the investigation is still pending, we had to seek authorization to provide information to the Authority and for it to be timely for your consideration."

Ms. Wilkinson stated,

> "That with respect to how common that the approach th**e** staff has taken here is, it is

very common for FTC staff to submit comments in the manner that we did. We often file comments on a range of competition and consumer protection issues. For example, in the context of pending bills, rule makings and regulatory proceedings that may occur at a state or federal level, FTC staff could often weigh in on those issues. Typically, the Commission votes to authorize FTC staff to submit these comments; that is the way it is done. In this instance, the Commission acted exactly in this manner by voting to authorize staff to submit comments to the Authority. The language in the first footnote that you cited reflects the standard practice and indeed that language is identical to what is included in all of the FTC staff comments. So, pretty standard stuff per Ms. Wilkinson.

Mr. Barry asked, "So, you might submit comments to proposed rules of other agencies through the staff process"?

Ms. Wilkinson stated that they have done that, "Yes". She noted that she heard Mr. Seidman or Ms. Walker comparing the Virginia statute to the merger guidelines and drawing some equivalence between them, but that she is paraphrasing and not trying to put words in their mouths, so they can feel free to disagree. Ms. Wilkinson asked if they think that the weighting of the various factors, the advantages and disadvantages in the Virginia Statute is contemplated to be the same as the weighting that the FTC staff has given it.

Mr. Seidman stated,

"I am not sure. First of all, given that the statute is new, I don't know that there are any court cases that have interpreted the Virginia Cooperative Agreement. Mr. Barry interrupted, you make a good point. The Statute was enacted with Southwest Virginia in mind, right? Are there any circumstances that you can contemplate where the FTC staff would not oppose a merger between these two systems?"

I want to be very careful with my words here. We haven't taken a position on the merger as an anti-trust issue yet; that is a separate question for the Commission. Today, we have opposed the cooperative agreement and recommend that it not be approved as it stands now. Your question is in terms of whether we would recommend the Authority approve it, I don't know if that exists; that is a hypothetical. I will say that our agency's mission and mandate is to promote competition, and we put a premium on competition. Even given that our bottom line from our experience and our analysis lends some expertise to the specifics that are being considered here regardless of our bottom line recommendation in terms of the cost savings, benefits and commitments that are being proposed. Stephanie stated that she might add to what Mark said, very importantly, we are not aware of evidence establishing the regulatory scheme that has been proposed here that would yield a better outcome than competition and that is part of what we favor with the competition. On the other hand, we are aware of many economic studies that do establish the benefits of competition."

Mr. Barry referred to it as a chicken and egg problem. He said there are other cooperative agreements out there which you all talked about a little bit, but it is a very small sample. Mr. Barry asked how there

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could be evidence of the benefits in the same way as your market studies on what has happened when there are mergers.

Ms. Wilkinson replied,

> "With my understanding, the few COPAs that have applied and have been in existence; have been in existence for many years. You had one in Montana that lasted for about ten years and you recently had one in North Carolina that just ended that had lasted about 20 years. That is a lot of period of time that could be covered. So, I do feel like had there been benefits of competition that there would be shown.

Mr. Barry stated, "So, in North Carolina in reference to prices, what happened?"

Ms. Wilkinson stated that she could not speak to that because she was not aware of any robust economic studies that have been fully evaluated the impact on price, cost and quality. She said,

> "The MN one when it ended the prices went up 16%. I think that is the Montana one you are referring to and the FTC has not studied the price effects of any of these COPAs and I am not aware of any robust economic studies that have been conducted. I think what you are referring to was an article where somebody had estimated a price increase.

Mr. Barry said, "Right, I believe the citation was in a footnote to an article."

Ms. Wilkinson agreed.

Mr. Barry said, "I believe the same article that said the prices went up; that they were still considerably below the prices of others in that market."

Ms. Wilkinson stated that without having access to that data, she is unable to speak to the specifics. She said,

> "The FTC has not conducted an empirical assessment of these COPAs, but we are aware of some publicly available information regarding the COPAs and some of which has raised some concerns for us. So, we provided this information with you as you evaluate the MSHA and Wellmont COPA application, and that was really the point for providing that additional information.
>
> Mr. Seidman, you said earlier that you were not counting votes. So, can the Authority members infer from that what appeared to me, others were at that meeting, was a substantial support for employers, also written comments of employers, civic leaders, and business community? Did that not figure into the FTC's analysis? Mr. Seidman did say that he would go so far as to say that it did not figure in. We talked to people, and, certainly, we have seen expressions for support of the merger and we have seen expressions of support for other mergers, but I would reiterate that in our minds it

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tends to be secondary to understanding the competitive dynamics that exist prior to the merger and the competitive dynamics that result after the merger.

Mr. Barry asked, "To the extent that those employers are self-insured, do you think they were acting against their own self-interest and that they were unwise to speak out in favor of the merger?"

Mr. Seidman replied,

> "I am not going to paint with a broad brush and say that anybody acted unwise and they acted as a group in an unwise fashion. I think in our experience and this goes to insurers as well, when we speak to people even confidentially, and given assurance of confidentiality, there are varied reasons why someone may support the merger and it is fundamentally a business decision whether or not to complain to the government entity or support a merger. It is always a pure objective economic analysis which is why we tend to focus on the competitive end. I also wanted to go back and mention one thing, when you were asking about our investigation, one thing I left out was that we often get a substantial amount of documentation from the merging parties; and from third parties as well and that also factors into our assessment."

Mr. Barry asked, "Have you sought any information from the Applicants in this case; independent of what they included in their application?"

Mr. Seidman said,

> "Yes, and given the nonpublic nature of our investigation, the nonpublic nature of any subpoenas and civil investigations done that is where I can go. I would say that it is fairly standard practice as we investigate a huge number of hospital investigations and some of those hospital investigations can go very quickly and some of the them, we can look at a day or a couple of weeks and realize there are no problems, but any substantial hospital investigation typically involves gathering documents and data from the parties."

Mr. Barry noted that in the Southwest Virginia market, the understanding has been that Anthem has approximately 80 percent of the market share of the nongovernmental market. He asked Mr. Seidman, "Without tying it down to 78 percent, is that generally consistent with your understanding?"

Mr. Seidman replied, "Yes, without endorsing any particular number, I think we are probably in the same ballpark."

Mr. Barry noted that in Virginia Anthem is on record as opposing this proposed merger and he believed it is on record in Tennessee as opposing it. He said Tennessee has additional larger payers than the Virginia market and that they have Signa and United as major players in Tennessee. He asked Mr. Seidman, "Are you aware of Signa or United opposing this in Tennessee?"

Mr. Seidman replied,

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> "I am not aware of anything public. I think one thing to keep in mind is while Goldie walked through the bargaining dynamics of the insurers and hospitals and the market share of the insurer can be a factor in the bargaining dynamic and whatever bargaining dynamics of the insurer; including Anthem has before the deal that largely remains unchanged after the deal. Our merger investigation focuses on what changes as a result of the merger, and if you think of bargaining leverage you have bargaining leverage on both sides. If you are thinking there is a change on one side that will have a material effect, and so regardless of what Anthem's leverage is today, the big change you would see in the leverage as a result of this merger would be on the provider side."

Chairman Kilgore asked, "In terms of size, is the merger a big merger, a medium merger or a small merger in your world?"

Mr. Seidman stated, "That they normally do not classify mergers in that manner but would think that it is on the larger end merging 19 hospitals into one bigger system."

Dr. Thompson stated,

> "In terms of the degree of competition, it is a very large merger. In terms of the economic analysis, the degree of substitutability and the degree of competition between hospitals currently, it is a very big merger."

Mr. Seidman stated that is our focus more than the overall size of the system. He said they focused much more on the degree of competition between the hospitals prior to the merger and whether it is one hospital buying another hospital or creating two hospital systems that can raise significant concerns for us as well. He said that they have litigated cases involving just two hospitals.

Dr. Tooke-Rawlins stated that the Authority has to look at a lot of material in order to make the decisions. She said,

> "You say that you are concerned about the effectiveness of the market cap, we are talking about oversight of the process and if that oversight is spelled out, I don't understand how we can't look at the effectiveness of the market cap and think it is something that you have to look at. I am confused how you can say that it wasn't here, or it wasn't there effective with these agreements and oversight. In the context of having the type of oversight that we are talking about, would you still believe that there is not a way to make that market cap effective?"

Mr. Seidman stated that he thought there were a few ways to look at this. He said,

> "I think it is clear in the presentation, but the Applicants tried to combine the two issues, we think about what Eileen was talking about the pricing increases. We think about that without any of the commitments of the price caps to just try to understand what the market power would look like following the deal and the second thing we looked at was whether the commitments would mitigate any of that. I think there are

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two important things to think about with the commitments and I think this will help answer the question; one is about the clarity of the commitments. I think one way to look at it is the contract with the hospitals. If it is not clear exactly what they are promising to do with the rates, and in our public comments, we tried to identify just some places as examples, as Stephanie said, it was not intended to be exhaustive but looked at places where it wasn't clear what the rate commitments intended to or applied to.

One example that stands out was the application relevant to payers that comprise two percent and it doesn't comprise payers that are two percent of the revenue. I don't think there are any questions about which payers this would include or exclude. We want to make sure that the price commitments are crystal clear, and we know what they mean and that everybody understands going forward. The second step is the enforceability of them if the hospitals were to run afoul of the price commitments; what are the powers of the health commissioners to say, 'No, you have violated the commitments, now you have to do X'? I don't think we have a perfect solution there, but we are concerned that there doesn't appear to be a specifically targeted mechanism for the Commissioner to discipline violations of the commitments. Does that help?"

Dr. Tooke-Rawlins stated that it does help to understand.

Dr. Tooke-Rawlins asked,

"We are looking at the benefits of competition and there is a big difference in urban and rural which we have to look at as well. Sitting in Virginia, we have a lot of rural and I think we are all aware that the competition that exists now hasn't done a lot to help these little hospitals a lot. So, when we are wearing our hats sitting here, we are looking at what will keep the rural hospitals opened, and that is a hat we have worn a lot here as we have discussed what about our rural communities. There does seem to be a lot of guarantees in the application of what they will do in all of the responses that have come back from the Applicants many times. We have asked a lot of really tough questions as an Authority; which I don't know how many of those you have had access to all of them. We have asked, and they have made specific commitments; so in your presentation to us, are you saying that you don't feel the commitments are effective or that they don't matter? I am asking that because to us, the commitments are effective, because right now, we don't have any commitments.

Is that a benefit if they say, 'hey as a result of this we are going to keep all of the hospitals open, and we are going to do this because we know they are at risk'? They are saying that we will keep these hospitals open for five years and not only that, but we are going to guarantee what services would be there and some of the types of services are difficult to offer, but there is a guarantee these services in a rural area. This is a real commitment that has gone through a lot of initial stages, and we did not take it lightly. So, I guess I am asking you, how did you consider those commitments to keep these rural hospitals open and to offer all of these services? How did you consider that when

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you evaluated the benefit? Did you think that it really is going to benefit the rural areas? Did you look at these in your investigation because I am a little confused about that piece because we do see benefit and I see a big broad brush of benefits."

Mr. Seidman replied,

"I think there are a few ways to think about this and we have certainly thought a lot about it in our investigation and comment about what the merger would be on the rural hospitals and I think that is a key factor for the Authority, and we have thought about that a lot and we have tried to address that. I think there are a few things to think about. One thing, it is not clear, the parties have made some claims about the struggling nature of their rural hospitals, and I want to make sure the Authority is thinking about those rural hospitals in this context. The rural hospitals don't exist in isolation; they are part of a larger system. So, it is not always appropriate to look at a single hospital that might be part of a system standing alone, because a lot of those high acuity cases from that hospital may go to a tertiary hospital or the flagship hospital and that revenue might be counted somewhere else, so, it is not as if those rural hospitals don't serve a purpose.

I think this is also a place where we talked about the Applicants putting forth other details of the arrangement and what other potential acquirers would be willing to do or would plan to do with any of the rural hospitals. I think another thing to look at now is that their commitment now is fairly vague regarding the rural hospitals. Item # 20 talks about keeping a facility open for five years; which is relatively a short period of timeframe especially when you think of the life of this merger we could be talking about a regional monopoly for decades; so, a five year commitment is keep the facilities operating as healthcare or clinical institutions which is fairly undefined term which doesn't mean that they will continue to operate as an inpatient hospital. So, in terms of weighing the commitment here versus some other option, I think there is very little detail in what the other options are, and the commitment is relatively short-term and relatively vague."

Dr. Tooke-Rawlins stated,

"We received commitments for specific services to be offered in the most recent revision, per Jeff, and with the trend of healthcare now, I don't think anybody can predict what inpatient vs outpatient will look like in five years from now. I am looking at the specifics and we asked them to be specific about what services would be offered. It is in item #20, but also in Item 25 and 26. Mr. Seidman stated and again, I think this is a place where words are important and I do see the bold points that list the services and it does say that it will continue to provide these essential services to the community, but I don't read the commitment as continuing to provide those services through the facility that exists today in the community. I think that leaves them the ability to provide this service through another hospital or another facility that is farther away from the community. I am not saying that is what they mean or that is what the commitment is

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intended to do, but the words are less clear than they could be."

Mr. Mitchell asked in clarification for the Board,

> "When you talk about a rural hospital that may be losing money but the services are being referred up to the larger hospital, I think the economic point that you are making is that it may not be a loss for this system because money they are losing at the outlying hospital, they are making up for at the larger hospital."

Mr. Seidman said that was the point he was trying to make. He said that in looking at the hospital that is losing money, but is part of a larger hospital, that hospital's balance sheet may not be the total picture.

Mr. Mitchell stated to the Board that he wanted to be sure the Board understood the point,

> "Because I know that Mr. Mosley and the folks at Lee County have struggled to try to understand that, and although that hospital has closed, they are trying to alter their patterns of where they go to get those services. So even though they are offered in an outlying area, to have to travel and hour or more to get there is an impact, but I think that the point that Dr. Rawlins was making was that having the facility there, even if it is for just five years is a significant commitment for whatever form it is going to be available and one of the things they are struggling to weigh is how relevant is that more social/medical factor versus the economic factor when they consider the disadvantages, and I think that struggle of having the facility in Russell County, Smyth County and Dickenson County still there as part of the community weighed against the economic factors that are also just as important in this consideration. How can they do that? How would you react to that?"

Dr. Tooke-Rawlins interjected,

> "If we are going to talk about Lee County or even some of those services, what are the minimum services would you guarantee at these rural sites?

Mr. Mitchell said,

> "We asked very specific questions when we had our discussions, and part of that was that we asked that Lee County be included in that, so they could increase their services compared to what they have right now. We asked them to reinstitute some things that aren't there right now. So, I feel that there has been commitment per Dr. Rawlins."

Ms. Wilkinson said that she would like to follow up on. She said,

> "I appreciate you making that clarification because I think that is an important point that Mark was raising, and I think that the synergy of the market that Mark was describing that

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some of the rural hospitals are contributing to the overall financial health of the system. I think what that means then is it likely that the health systems really would have closed some of these rural hospitals if they are contributing to the overall financial stability. We are not aware of any plans where the hospitals have stated that they intend to close some of these other facilities. I understand what happened to Lee County, and I do understand your concerns about that facility, but beyond that facility, I am not aware of other specific rural hospitals that the Applicants have discussed closing."

Mr. Barry asked,

> "Following up on that, could the parties have asked as part of this process 'hey we are planning to close this hospital or that hospital'? Would that have been an improper exchange of information between them?"

Mr. Seidman responded that he did not want to get into that much of a legality of the actions that they might want to take.

Ms. Wilkson said that generally speaking, there are ways that merging parties can share information with one another that does not run counter to any anti-trust restrictions so that they can make certain plans.

Mr. Seidman interrupted to say the staff does not want to be in any position of giving out anti-trust advice.

Ms. Wilkinson stated, "I know that it is touchy, but I don't want it to appear that there is no way the parties cannot share information due to anti-trust restrictions."

Mr. Seidman stated that Ms. Wilkinson was talking about whether the hospitals had specific plans to close hospitals more so than what they actually did discuss, absent the merger, and that is the point we are driving at.

Senator Carrico stated,

> "Listening to some of the things the staff has said and understanding that this group has worked diligently to try to make sure that the delivery is there in the health care system and making sure that it is doable and knowing what the work process is for legislators to look at and what we are being given. He said, being a legislature and this law being on the books for two years, and not hearing from the FTC when this law was being discussed, I am interested why."

Ms. Wilkinson stated that her understanding was that the underlying COPA statute in Virginia and Tennessee was passed last April 2015. She said,

> "The FTC literally found out about this one day before they were filed and from what she understood, it was approximately a two-week period from the time they were introduced to the time they were finalized."

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Mr. Carrico stated they work very efficiently, and Ms. Wilkinson and others laughed. She agreed they worked very efficiently and were faster than Washington, D.C.

Ms. Wilkinson said that the FTC would have welcomed Virginia or Tennessee legislature reaching out to the FTC and asking for their perspectives on that. She said the FTC did not receive that request and therefore they were not able to weigh in on it.

Senator Carrico stated that he picked up on their concern that near monopoly, impact on competition and limited price increases and market caps, but asked what the staff is doing as far as the ACA? He said,

> "These other states now you are seeing the competition with insurance bailing out. How do you compare these two to the ACA and are you involved, investigating and seeing how that monopoly is occurring? Because, it seems to me that the ACA is allowing a monopoly of insurance companies to be able to weed out the smaller ones through the current systems. You look at MN, there is no cap in the increase in delivery under the ACA. You are seeing the 154% increases; you are seeing the doubling in Virginia of increases in health insurance. So, compare with me and help me understand how the federal government looked at their legislation not creating a monopoly and why the concern now with Virginia and Tennessee legislation."

Ms. Wilkinson stated,

> "This is a question that we typically get, how do the anti-trust laws pear up with the goals of the ACA. Right? Some people have tried to suggest that they are inconsistent. At the FTC, we look very careful at these issues, and it is our position that the goals of the ACA to reduce the prices, to improve quality and to improve access to health care services. Those are the same kinds of goals that the anti-trust laws are intended to promote. So, we are actually pretty vocal about this. We think that the goals of the ACA are entirely consistent with the goals of the anti-trust laws and are not mutually exclusive".

Senator Carrico responded,

> "So, with the increase that we are seeing and the insurance companies that are leaving the marketplace that you are seeing in MN, you are seeing in AZ and are seeing all these insurance companies that can't afford to compete leaving, is that a concern of the FTC? Or is it that we just want to look at the States?"

Ms. Wilkinson responded,

> "So, here is where my answer may not be entirely satisfying to you. The Department of Justice – Anti-trust Division has the authority to investigate insurance markets. The FTC focused more on health care and provider markets. So, while we are generally informed about what goes on in insurance markets, I would say that it is DOJ that really looks at those issues. I would also note that the DOJ has recently challenged the two large insurance system mergers between Aetna and Signa. They have filed complaints and

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> they are currently challenging both of those."

Mr. Seidman said that this is something that has come up in a number of hospital investigations and litigations. The courts have opined on the relationship between the ACA and anti-trust laws both in the St. Luke's case in the 9th Circuit. He said that the courts have said that there are no anti-trust exceptions for the ACA and the 3rd Circuit ruling on the PA-Hershey merger recently just reiterated that same idea, and the goals of the anti-trust laws are not in conflict with the ACA.

Senator Carrico stated, "Still, I am confused as to why this merger would be in violation if you are allowing insurance companies to merge."

Mr. Seidman responded that this is a DOJ challenge.

Ms. Wilkinson stated that she would say their concern with the merger was in looking at the goals of the ACA, which are to reduce prices, improve quality and improve access to care. She said that the concern with this merger is that staff thinks it is contrary to those goals. She said, "We think this merger is more likely to increase prices and will reduce quality."

Mr. Mitchell stated that there was an insurance question following the public hearing that may be appropriate to. He said,

> "At the public hearing, there were several companies that were self-insured stepped up and spoke in favor of the merger, and clearly the way they handle their insurance is if there is a cost savings, it is going to lead to the sustainability of that business to lower health care cost and those sorts of things. Just react to this comment if you can. I replied to the director when they asked, you cannot assume that if they are able to hold down cost they are talking about, that those savings will be passed on to the consumer when they are dealing with the insurance agency because there is no way for them to assume and require the insurance company that is the payer to hold down the cost that they pass on to the consumer even though the system itself may be able to hold down its cost, and I think that is why you have some of the director weighing more heavily in that balance of what the self-insurers are saying because they know that the savings that are achieved even if those savings are a reduction in costs; there is more likely to be a direct benefit to the business whether it is sustainability or those sorts of things. Do you want to react to that?"

Mr. Seidman stated,

> "I think there are a couple of points there, and I think you are right to suggest competitive dynamics in the broader market that can dictate how negotiations with insurers play out and there is a separate set of competitive dynamics in the insurers market as Stephanie was eluding to, and DOJ is focused on right now. I think it is fair to say that when price increases from providers to insurers increases are almost frequently passed along whether it is self-insured or fully insured, those are passed along to employers and then to patients, employees and families. The reverse can be true as well, and those dynamics of price decrease can be passed along as well. But I do want

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to make sure also that we are speaking clearly about cost savings. The parties have talked about their use of cost savings and those cost savings would be a driver for the $450 million-dollar investment, and that is where they are attributing the cost savings to also say that the cost savings would also allow them to lower prices seems to double count those cost savings. Whether they actually achieve cost savings as Stephanie mentioned is a separate question. If they are going to take that cost savings and invest it, then that may be a totally allowable goal and that may be worth the Authority considering it. You can't, however, take the same cost savings and invest it and also pass it along too. I want to make sure you all understand that. Part of the question was whether the insurance companies have the incentive to pass on any savings that they would get it could go both ways. So, when insurance companies compete against each other to attract employers, if the cost falls, they would have an incentive to pass the savings on, and if the cost rises, they would have to eat the cost.

Mr. Mitchell stated that in a perfect business dynamic that is true, but as was pointed out earlier whether it is 78 or 82, when an insurer has that market leverage, is it possible those benefits would not be passed on because there is no real competition to make that happen. He said, "So, I think the director that asked me that question was trying to understand that. It is theoretical."

Mr. Seidman said that it was a complex economic question and he thought that there were black and white terms where the savings would be passed on fully or not passed on at all. He said that there is a spectrum there and a lot of factors that could affect it. He said,

"Holding all things equal, I think if you give an insurer with a lower market price, then they may pass it on."

Mr. Barry noted that the Authority has spent much time on insurers. He asked,

"Isn't it true that many employment plans are self-insurance? They may have some stop loss or catastrophic insurance ailments, but most employer health insurance is self-insurance?"

Mr. Seidman stated that he did not have the information to make a broad statement on that but that is something that they can look into. Mr. Seidman stated that when his staff litigates a case they do not make a strong distinction between employers that are fully insured or self-insured. They do talk about the difference in how they would be affected but they usually talk about the competitive effect.

Mr. Barry stopped him and said that they have an answer. He continued on to introduce Dr. Cantrell. He said that Dr. Cantrell put together some data in terms of the follow-up to Dr. Rawlins question about the impact to rural communities and she has some information on health outcomes.

Chairman Kilgore asked that she state her position.

Dr. Sue Cantrell works for the Virginia Department of Health and is the Health Director for the

Lenowisco Health District. She said,

> "In talking about how competition in the past has served Southwest Virginia, one of our concerns has been our poor health outcomes. The handout looks at the top five causes of death both in Virginia and in Southwest Virginia, as well as some cancer incidence data on the next page where we have statewide higher incidence than we see out here and the mortality data is worse than the state averages. Similarly, the diabetes mortality death rates from diabetes are significantly higher than the rest of the State. Stroke interestingly is not higher, we have been spared from that and that is something that we have all studied. Heart disease is significantly worse than the rest of the state, as we are in chronic obstructive pulmonary disease mortality and injury mortality, and finally on the last page are hospitalizations for ambulatory sensitive conditions where they normally wouldn't result in hospitalizations are much higher and these are all the data collected during the time that we had competition. I am really interested in your thoughts on how competition contributed to these outcomes and how a lessening of competition or a change in competition what your concerns are about the future about these outcomes if the competition changes. These are outcomes when we had very robust competition based on our discussion up to now, and they are not good. So, in general, these are generally indicators of quality care and some access; so, this has been the subject of a lot of discussion out here in terms of are they going to be additional resources to address some of these significant health challenges and outcomes if the merger were to go forward, and how continuing competition change this picture.

Dr. Thompson stated that staff has not looked at these numbers relative to the state of Virginia. She said,

> "We will have to take the time to look more carefully at them. For our investigation we have looked at both Wellmont and MSHA numbers relative to the national averages, and they generally do quite well. They are at or above the national averages. They are only a few categories where MSHA and Wellmont do not perform as well as the national average; so, the quality is pretty good. We just looked at the two hospitals relative to the national average. Ms. Smith from the audience stated, 'The other thing that you have to take into account when you are looking at these numbers is, but was interrupted by the Chair that only Board members are allowed to participate at this time.' Dr. Cantrell noted that these were outcomes that would be general population health metrics which based on the Pac-Man slides that we saw that a significant amount of healthcare was provided by the two Applicants, but it would also include other sources of healthcare, but I guess the general question we have tossed around is that this was in that competitive environment, so continuing competition; how would we expect that to change the outcome? Or what could we do to improve these outcomes?"

Dr. Thompson stated that economic studies were general and not specific to Virginia. She suggested that generally economic studies have found that competition is more likely to lead to a higher quality of care in terms of these types of metrics. She said,

> "We have cited the two studies in the UK where they did find that parties that were

regulated that quality of care as represented by these types of indices was much higher in areas where there was competition than areas where there were fewer competitors. In areas where there was competition, quality of care was higher and there were fewer mortalities in areas where providers were highly concentrated, the outcomes were lower and that was in a price regulated environment."

Ms. Wilkinson commented that she understood the question but was wondering if staff should ask the reverse question, "how is this merger likely to improve any of these outcomes?" She asked,

> "To the extent that the Applicants are saying that they are ways that they can come together and offer these benefits, are there other ways beyond that merger that you can try to achieve those benefits? Are there kinds of collaboration that the parties can engage in? Are there independent actions that the parties can take to try to achieve some of those benefits? Also, are there alternative mergers if they think it is absolutely necessary? Are there other mergers whereby you could achieve these benefits and this kind of investment and improve population health without incurring the risk associated with the merger and a monopoly?"

Mr. Barry stated that he had some follow up to these comments. He said, "First, the UK study, was payment in the UK; what was studied there, was it in any way tied to quality?"

Dr. Thompson replied that that was a question they are looking into. She said there have been reports in the UK that have instituted some forms of quality. She stated, "So, we don't know specifically, and it appears there may have been some overlapping, but we don't know the answer yet and we will look at that too."

Mr. Barry asked about alternatives and stated,

> "I think the answer here is obvious, but I want to be sure we get it on the table. If some out of area system came in and acquired all of the Wellmont and all of the MSHA hospitals at the same time, I am assuming you would find that as subjectable as this proposed merger. That is not an acceptable alternative per Mr. Barry.

Mr. Seidman stated, "Yes, that would present the same competitive concerns."

Mr. Barry asked if it would be possible in an individual market. He said,

> "I believe it is Wise County that has three hospitals with MSHA and Wellmont and both having hospitals in Wise County, could they set up a joint venture and operate those three hospitals and whatever number of hospitals they end up with jointly?"

Mr. Seidman stated that staff was not permitted to answer hypothetical questions like that. He said that there is a process by which companies that are considering a joint venture can propose to the anti-trust agency. He said,

> "We have an advisory opinion process if they have something specific and not

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> hypothetical that they were considering. There is a way to request opinion from the FTC. In addition to that, the FTC has issued significant guidance to the providers about ways they can collaborate without running afoul of the anti-trust laws. It is the 1996 statements of anti-trust enforcement policy in health care and that type of collaboration would be included in this per Ms. Wilkinson."

Mr. Barry asked, "Is there any way under that guidance that competitors can allocate markets for services among themselves?"

Mr. Seidman commented on the term market allegations for services and stated that he could not comment on hypotheticals like the one proposed. He said it is a very fact specific analysis, but there may be ways to do a joint venture. He explained that there are ways for the Applicants to get that information and get an answer to that question per Ms. Wilkinson.

Mr. Barry asked how long the process would take.

Mr. Seidman replied that it would be shorter than a hospital merger. He noted that there is a statutory time and he did not remember it off the top of his head. It is months not years.

Ms. Wilkinson said she would get that information back to the Authority.

Mr. Barry noted that there is a sense among some of the Authority that competition has not worked especially well in this area and have listed factors such as high rates of insured, transportation issues, poverty, and low education attainment. He said, "My question to you is: what if any you think those factors affect how well you think the market works?"

Mr. Seidman stated that he did not think there was any reason not to think that competition doesn't work for certain populations but works for others, given the certain economic conditions in the area.

Mr. Barry interrupted, "that wasn't my question, Mr. Seidman, the question was: do these have any impact on how well the market works?"

Mr. Seidman stated that they are not aware of any study that would suggest that the market would work less well in these circumstances.

Mr. Barry noted that there were some comments in Mr. Seidman's letter that nothing is stopping the Applicants from putting more money into population health or this or that. Mr. Barry explained,

> "The Applicant's response is that they are dealing with finite resources and unless we achieve the savings that we are going to get out of this proposed merger, we are not going to have the money. So, I am in the interest of time going to make this sort of a compound question, and I think you would come back and say, "well the alternatives can give you these savings, be they an out of market merger or some of this joint venture stuff. At least with respect to out of market mergers, the Applicants are going to say I believe that is not going to eliminate duplication of services, and I believe they would say that the savings achieved through elimination or reduction of duplication of services is a merger specific savings in this instance."

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Mr. Barry asked, "Would you disagree that savings of duplication of potential merger specific savings in this instance?"

From the Authority's standpoint, Mr. Seidman replied;

> "I think it is hard to make that kind of determination without something concrete on the other side of the scale. Without really understanding what those alternatives are and what the plans would be with an alternative merger, I think it is hard to opine on generally what would and wouldn't with those alternative mergers and to the extent that there are duplicative services. I think they are hesitant to make the jump from duplicative services to unnecessary or wasteful services. There are often good reasons and good effects from two competing hospitals or two competing entities offering the same services. They increase competition; they do so in a way that encourages the other to continue to improve and innovate and train the people that are providing that service, and on top of that I would note that both Virginia and Tennessee are certificate of need states and there has been a been a public policy determination by the states that for most of those services or most of the capital equipment we are talking about; there was a need when they were purchased."

Mr. Brownlee asked, "Have you gone through the COPN applications and tied them back to these facilities to determine what they have and when these applications were submitted?"

Mr. Seidman stated, "We have not seen those kinds of analysis from the Applicants."

Mr. Brownlee asked, "And you haven't conducted that type of analysis?"

Mr. Seidman responded, "No. But this is the place where the burden should be on the Applicants."

Mr. Brownlee asked, "So, there could have been a CON in 1985 to build a hospital and whatever determination of needs then might be completely irrelevant in 2016?"

Mr. Seidman responded, "And that certainly is a possibility. We haven't done that analysis, but we haven't seen that analysis from the Applicants."

Mr. Brownlee responded, "I will give that up. I am trying to inform."

Mr. Brownlee commented,

> "In your comments and also in the Anthem declaration; there is reference to market and trade, or maybe it was just in the Anthem declaration that they have observed that there have been virtually no new entries into Southwest Virginia and NE Tennessee by outside providers. Do you have any opinion if any why that might be the case that there has not been entry into this market?"

Mr. Seidman responded,

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"Hospitals are difficult; they are time consuming to build a new hospital, especially a new hospital system, and that is one of the reasons we are so focused on this merger is that combining these two hospital systems is that the market conditions could create could last for a very long time because the likelihood of a new system coming in five years or ten years down the road and deciding to build a seven or eight hospital system in this region is a relatively remote possibility. So, whatever market conditions are created here, this region could be living with those conditions for a very long time."

Ms. Wilkinson stated,

"We asked very specific questions when we had our discussions and part of that was that we asked that Lee County be included in that, so they could increase their services compared to what they have right now. We asked them to reinstitute some things that aren't there right now. So, I feel that there has been commitment per Dr. Rawlins. That since we were just talking about Certificate of Need, it is important to realize that CON laws can complicate to an extent, the timing for entry and sometimes it prevents new entry. We certainly see situations where hospitals object to new providers."

Dr. Tooke-Rawlins stated,

"I think it is funny because CONs are the most anti-competitive thing I can think of right now in nature seems funny to me; as with Anthem occupying 75%, but there are not people looking much at that either. So, I think all those impacts and how your hospital functions looking at CON firstly. We have that here with people wanting one thing or another at their hospital, and they can't do that. I know we are not trying to duplicate services, but if you were thinking competition, you would. If you want these competitive markets that drive down the cost, only one person having an MRI in the area is not going to help that. So, that is what you are saying. Well, we already have that situation and it has not been resolved. I wanted to ask you. I want to get back to this because it hasn't been resolved. There are two things that were not mentioned. One was that we have no real in-patient substance abuse treatment within the region; we have some out-patient and we certainly suffer here from the huge epidemic, as does every place else. So that certainly was a benefit that did get mentioned somewhere that we took seriously besides these other commitments, and there is commitment to spend money on research and development and things to improve Health Population, and I just want to say that. These are the commitments that we have gotten back from the Applicants and we are looking at the Health Population in our work groups when we were asking those questions. So, I have to come back to the effectiveness of the market cap; is there a situation that you have looked at anyone who has done this or that you have ever felt comfortable? When you say you don't know about the effectiveness, have you looked at situations that have worded it better that made you feel there was an effective way or guarantee? Is there any situation you have seen in a merger of hospital systems that have done that?"

Chairman Kilgore asked, "In controlling costs?"

Dr. Tooke-Rawlins responded, "Yes, in controlling costs and she said, how do you enforce the effectiveness of the market cap is there a good example or a situation of one that made you feel comfortable?"

Chairman Kilgore, added, "or a little more comfortable."

Mr. Seidman responded,

> "I think it would be a little too far for us to use the word comfortable. As we have stated, our policy typically focuses on the benefits of competition, and generally we see competition as yielding more efficient and better results than price regulations; that said, there are other systems that issue price regulations, and we talked a little bit about the enforcement mechanisms. The commitment alone doesn't do any good unless you have enforcement mechanisms. I would note certainly without endorsing the SW Virginia Cooperative Agreement, I would note that in that agreement, there was a clause where the Attorney General was required to improve any new health plan contract; so that gives a way to enforce. The AG has a bit more of a scalpel so to speak than just the nuclear option we just talked about."

Chairman Kilgore stated,

> "I know that we provided or staff provided questions. Are there any that we haven't asked that you feel that you should address, or will you let us know as the Authority how you feel about some of the questions? I know we haven't had time to get through each and every one of them, but are there some you have thought to be more important than others that you would like to address?

Mr. Seidman responded, "Probably (and laughed). It is hard to say because we have talked about a lot of things."

Ms. Wilkinson responded to Dr. Rawlins question. She said,

> "I just want to reiterate that the point you were talking about the benefits that the parties have promised here, and I can understand why that seems attractive, but again I do want to point out that experience and evidence does show that with these mergers, often times, the projected cost savings are not often realized. So, when they said that their commitments were fully contingent on achieving those cost savings, there is a real question as to whether or not they will be able to achieve them and whether or not they will be able to provide those investments they have promised."

Mr. Seidman commented,

> "Further responding to the question, you mentioned the commitment to substance abuse and one of the things that we discussed in our comments was the application with SPH not sure what the SPH stands for but was another company that applied for a CON in

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this area to open a behavioral health institution and the CON was opposed by MSHA. I wanted to make you aware and it is in our comments as well in response to that concern."

Mr. Brownlee commented,

"In consideration to where we are today, I am going to try to wrap this up in five to ten minutes. Have you seen instances where I will say Blue Cross because of their individual state plans, but BC is often a dominant payer in the nongovernmental market, have you seen instances where major market payers have not entered into agreements with BC? For example, I think Washington Hospital Center/Med Star didn't have a contract with BC for a number of years, and it comes up periodically. Do you have examples of instances where providers have not entered into a contract with a major payer and how has it played out? How long it takes to come to a resolution and what players become involved the press, state agencies, governors, and that sort of thing."

Mr. Seidman replied,

"That in terms of specific examples, I am not sure I have one off the top of my head, and certainly we have access to confidential information that we receive through our investigations, and it is hard for me to separate that. What I would say is that generally we do see situations where providers and insurers are unable to come to an agreement and the provider goes out of the network. I think what is important to understand, and this goes back to the bargaining that Goldie was talking about both for the insurer and the provider, they are both in a better situation if they come to some kind of an agreement. They both benefit from some kind of an agreement because if they don't come to an agreement, the insurer's network becomes less marketable, and the hospital loses access to that insurer's patients. So, it doesn't surprise us that you usually see them even after a long drawn out and sometimes volatile negotiation; they ultimately come to some kind of an agreement and even dropping a provider from the network; I think we (FTC) sees that as much a negotiation tactic as anything else. That is a step in the process. It does turn public sometimes when you see press advertisement where certain providers won't cover BC, Anthem, Signa or whatever.

I think what is important to remember there is that this is competition playing out, and it is not necessarily competitive failure; that is the bargaining dynamic and sometimes negotiations are so strident that it gets to that point, but it rarely lasts very long. I think sometimes we see a provider go out of network for maybe a year or two, but that really is the extent of it, and I don't see that very often because both sides realize they are better off with one another and there is a compromise there, but what compromise is reached is determined by the bargaining leverage and is determined by who is worse off by the failure to reach an agreement, and that is determined by competition."

Mr. Brownlee asked, "In my next question, I am not asking you anything about substance, I am just asking if you have seen something. Have you seen Anthem's contracts with MSHA and/or Wellmont?"

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Mr. Seidman responded that they could not talk about what they have received from a third party.

Mr. Brownlee stated that,

> "Some information about those contracts has been shared on a confidential manner and not either party knows what the other has said, just that some information has been shared with the Authority and may be relevant to some members of the Authority. Hospital system HCA, Community, and many nonprofit systems that spin off hospital all the time at a very large integrated system that the hospitals are spun off; so, why is it such a challenge if the Commissioner were to withdraw approval of the Cooperative Agreement? Why would it be such a challenge for these hospitals and other facilities to be divested?"

Mr. Seidman asked, "Are you talking about through the plan of separation?"

Mr. Brownlee said,

> "Let me clarify something first. If the Commissioner of Health were to withdraw approval of the Cooperative Agreement, and the COPA no longer exists; and no longer state supervision and monitoring of these systems, and I am assuming the combined system would be subject to attack on the anti-trust grounds, wouldn't it? It would no longer have the benefit of state actions and protection."

Mr. Seidman responded,

> "So, a couple of points in that. First, I want to stay on the state action, and we are not going to talk about the merits of the state action. I think as a technical/legal matter it is impossible to prosecute an anti-trust case after hospitals have merged. It is possible, but very rare and if you look at the __________case, that was the rare case where the FTC did it and found liability and found that the underlying merger was illegal, but in that case declined to force stopping it because that would have been too disruptive. So, I think if your question is asking with just the removal of the Cooperative Agreement, would the result of that be that the FTC comes in and prosecutes the anti-trust case. I certainly don't want to get ahead of the Commissioner and speculate, but I think it would be unwise to approve the Cooperative Agreement with that expectation."

Mr. Brownlee stated,

> "I am not trying to argue with you. I am trying to understand your answer on why it is so hard to divest hospitals once there has been a merger because as I say, large systems divest hospitals all the time; so, this would be a large hospital system divesting some combination of whatever number of hospitals there might be at that time."

Dr. Thompson responded,

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"There is concern that consolidating the facilities for example, then it is hard to unwind the merged system afterwards to what it was before because the parties may have merged services, closed down services in one hospital and opened them up, or expanded them somewhere else. So, you would not be divesting the exact same facilities as they are now. That is one situation where it is very hard to unwind."

Mr. Seidman stated,

"I wouldn't make an analogy where a hospital makes a business choice to spin off a hospital. That is a situation where they are presumably only doing it if it is feasible, and here we are talking about a situation where a governmental entity or court is coming in and trying to order a domestic measure presumably against the will of the hospital and that is extremely difficult and raises all the concerns that we have discussed."

Mr. Brownlee asked,

"You have seen the Applicant's comments and what we have solicited from you; is there anything in there where you disagree with the facts, assumptions, inaccurate, misleading, irrelevant…? What I am trying to do here is avoid you all having to go through everything they say and have a tit for tat. It is really more on the facts and assumptions or citations is there anything you think is misleading or wrong?"

Mr. Seidman responded,

"I think there are a number of things, but I don't want to get into going line by line. and I don't think that is productive. I will point out a couple of things, and then I will turn it over to my colleagues. There were a couple of things that jumped out at me as I am always sensitive when the Commissioners are quoted especially against us; footnote 11 quoted former Commissioner Julie Briel, in a comment that she made in a certificate of need laws and talked about the limits of the FTC's expertise in that context; first of all, note that was in dissent to a COPA action. Secondly, the Certificate of Need laws are not entirely analogist to a cooperative agreement legislation that Commissioner Briel might have felt that our expertise was more limited with CON laws. When you are talking about a COPA, you are talking about a hospital merger and that is literally what we do every day, and I think that is much closer to our core expertise, and Commissioner Briel has joined every staff comment that we have filed whether in response to propose a COPA or in response to an actual COPA. She did support the staff and, in those instances, she also voted in favor of every challenge that the Commission has brought against health care providers. I also wanted to point out that in that footnote, there was a block quote from a 2004 report that Commissioner Brocoid introduced and the block note is included in the footnote that talks about competition not being a panacea for health care and that was accurately quoted from the report, but I think it was taken out of context here because that report is entitled, "Improving Health Care: A dose of Competition" and the report is focused on the important of

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competition in health care."

Mr. Brownlee interrupted, "Mark, I think we understand your sensitivity to Commissioner Briel's comments."

Mr. Seidman said that

> "He did want to make a point that there they are talking about government regulations which we are talking about here in addition to competition, not replacing competition. I think that is an incredibly important distinction, and I was sensitive to the muddy waters on that point, and similarly footnote 19, the Commissioner was quoted about talking about the effects of out of market mergers and again taken from the speech where that given, she said in the same paragraph, 'we focused our enforcement efforts on horizontal mergers between competing health care providers and with good reason giving the mounting evidence of competitive harm for these deals.' So, she is highlighting that mergers like this horizontal deals with two competitive hospitals that are the most concerning type of mergers and then she layers on top of that there are some research that shows that there is something going on with out of market mergers too, but it is secondary given the direct horizontal mergers that we are focused on."

Chairman Kilgore said,

> "To close this out unless somebody else has something, I have one question that I think all of us have been struggling with and maybe you can speak to 70% of you all anyways. How much did you look at the uniqueness of our region in weighing your comments? That is something that I think all of us wonder given the fact that in Virginia, most of our hospitals and counties are very rural. In fact, all of them are rural and that is something I personally would like to know, and I feel others may have the same question."

Mr. Seidman answered,

> "As we said in our early comments, we are very aware of the challenges facing this region. We certainly are aware of them and we did take them into account and I think it is fair to say that given those challenges that doesn't make competition any less important."

Dr. Thompson responded,

> "I think the number of the objectives and commitments are tied to the fact that it is a rural area, and I think one of our key questions that we had when reading the application is whether or not there are better ways to meet these goals. Are there other alternative arrangements or are there other ways to get these commitments, enforce commitments or to provide incentives to provide these services short of a merger? And our big concern too is that the merger is long lasting, and it is very hard to unwind. So, I think our main concern is there may be more efficient ways to meet these

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goals."

Ms. Wilkinson responded,

> "Just to follow up on that, following up on a question you had, were there questions we did not get to that were not very important. You all asked the question about how common is it in the FTC's experience in healthcare mergers and acquisitions that funding is created for such community benefit activities such as those which the Applicants are committing to? We feel that it is not uncommon at all for acquirers of hospitals to make promises to keep acquired hospitals open for minimum periods of time and to commit to making financial investments in the acquired area or community. We actually went through and found publicly available information on several instances in which these commitments were made and I think we can provide those following up on this meeting if that would be useful to you."

Chairman Kilgore agreed that would be very useful.

Ms. Wilkinson continued, "There probably are other alternatives out there, and there are good samples of the kinds of commitments that could occur."

Chairman Kilgore thanked the FTC for taking time to travel to far Southwest Virginia and thanked everyone for making themselves available.
Someone from the audience asked if they were allowed to ask questions.

Chairman Kilgore said no and that this segment was for the Authority. He said that the Authority already hosted a segment for public comment.

Person from audience said he had a question for the FTC.

Chairman Kilgore again told him he was sorry it is for the Commission.

The man asked if Chairman Kilgore was trying to stifle freedom of speech.

Chairman Kilgore stated no, but the authority already had public comment and that he was sorry.

The man said, "I see how you are."

Chairman Kilgore thanked the FTC for answering the questions, for the presentation, and said "that it has been very informative sitting here today and he has learned a lot." He thanked Dennis Brownlee for his help.

Chairman Kilgore said,

> "Tomorrow, we have our meeting where we actually start going through the process of looking at the application and that will begin promptly at 3:00 p.m. Look forward to seeing you back here tomorrow and let me say how much I appreciate the

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Commissioner's time and all of your time and energy that you have devoted to this important process for our region. "

"With that said," Dr. Rawlins asked, "Do you want additional information or questions tomorrow?

Chairman said, "Yes, if you have additional questions or need additional information get it to him before tomorrow."

VII. Announcements

There were no announcements.

VIII. Next Meeting of the Authority

Tomorrow, October 28, 2016 at 3:00 p.m. at the Southwest Virginia Higher Education Center.

IX. Adjournment

Meeting adjourned by motion of Senator Chafin and seconded by Mr. Mosley. The meeting was adjourned at 6:50 pm.

____, Chairman
Terry Kilgore

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