RESPONSE BY APPLICANTS

TO SUBMISSIONS OF

ANTHEM HEALTH PLANS OF VIRGINIA, INC.,

VIRGINIA ASSOCIATION OF HEALTH PLANS, AND

AMERICA'S HEALTH INSURANCE PLANS

AND SUPPORTING MEMORANDUM

TO THE SOUTHWEST VIRGINIA HEALTH AUTHORITY

REGARDING

COOPERATIVE AGREEMENT APPLICATION

Pursuant to Virginia Code § 15.2-5384.1
and the regulations promulgated thereunder at 12VAC5-221-10 *et seq*.

Submitted by:	Mountain States Health Alliance Wellmont Health System
Date:	October 21, 2016

Mountain States Health Alliance and Wellmont Health System ("the Parties") submit this response to address the submissions by Anthem Health Plans of Virginia, Inc. ("Anthem") regarding the Parties' Cooperative Agreement Application ("Application") ("Anthem Submission"). In addition to the discussion below, due to the substantial overlap between Anthem's comments and those of Federal Trade Commission staff submitted on the same day, the Parties incorporate herein by reference their submission dated October 14, 2016, responding to FTC staff's comments.[1]

The Parties also address the submissions by the Virginia Association of Health Plans and America's Health Insurance Plans to the Authority regarding their Application.

I. Response To Anthem Introduction

Anthem's overlapping arguments with those of FTC staff begin on page one of the Anthem Submission. Like FTC staff, Anthem takes issue with the legislative policy that underlies the Cooperative Agreement Law.[2] Anthem asserts "that there are numerous reasons why Cooperative Agreements are a poor substitute for competition." Then Anthem describes "five reasons" in support of this view once espoused by FTC Chairwoman Ramirez. (Anthem Submission at 1) The policy prerogatives of Anthem, the FTC Chairwoman and FTC staff, however, are not relevant in this proceeding. The Virginia Legislature chose a different policy through its unanimous approval of the Cooperative Agreement Law. The Commonwealth's sovereign policy is to encourage health care mergers – even mergers that may be anticompetitive within the meaning of federal and state antitrust laws – where the benefits outweigh the disadvantages resulting from the loss of competition between the merging parties.

This is a policy formed only *sixteen months ago* specifically, and exclusively, for Southwest Virginia in direct response to the very difficult health and economic conditions facing the citizens of this mostly rural region. It is revealing that in its submission Anthem does not – just as FTC staff in its submission does not – acknowledge the hard facts about these conditions.

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[1] Response by Applicants to Federal Trade Commission Staff Submission on September 30, 2016 and Supporting Memorandum to the Southwest Virginia Health Authority and Virginia Department of Health Regarding Cooperative Agreement Application, Mountain States Health Alliance and Wellmont Health System (October 14, 2016) (hereinafter, "Response to FTC Staff Submission"). The FTC staff submission is referred to herein as the "FTC Staff Submission."

[2] When it unanimously passed the Cooperative Agreement Law, the Commonwealth of Virginia clearly articulated and affirmatively expressed a policy to improve the welfare of Southwest Virginians by encouraging integration among healthcare providers, even in anticompetitive transactions, if the overall net effect is to facilitate better care for rural patients:

> The policy of the Commonwealth related to each participating locality is to encourage cooperative, collaborative, and integrative arrangements, including mergers and acquisitions among hospitals, health centers, or health providers who might otherwise be competitors. To the extent such cooperative agreements, or the planning and negotiations that precede such cooperative agreements, might be anticompetitive within the meaning and intent of state and federal antitrust laws, the intent of the Commonwealth with respect to each participating locality is to supplant competition with a regulatory program to permit cooperative agreements that are beneficial to citizens served by the Authority, and to invest in the Commissioner the authority to approve cooperative agreements recommended by the Authority and the duty of active supervision to ensure compliance with the provisions of the cooperative agreements that have been approved. Such intent is within the public policy of the Commonwealth to facilitate the provision of quality, cost-efficient medical care *to rural patients*. (emphasis added).

Virginia Code Section 15.2-5384.1.A *et seq*. (hereinafter the "Cooperative Agreement Law").

It is therefore not surprising that Anthem, like FTC staff, cannot show how the status quo that each endorses better serves Southwest Virginians or offers a better solution to the problems in the region than the Cooperative Agreement outlined in the Parties' Application.

The remainder of Anthem's Introduction is a summary of points made later in the Anthem Submission. The Parties respond to those points in the sections that follow.

II. Response To Anthem Discussion Of "The Loss Of Competition From The Merger"

In this section, Anthem presents the same antitrust law arguments found in the FTC Staff Submission, relying on statistics calculated from draw area shares and concentration, and evaluating the merger using the analytical steps set forth in the FTC-DOJ Horizontal Merger Guidelines. (Anthem Submission at 6-9)[3] As the Parties' noted about FTC staff's virtually identical structural antitrust analysis, the discussion of market shares and concentration merely informs the Authority that staff, or in this case Anthem, believes the merger is anticompetitive under Section 7 of the Clayton Act. The structural analysis does not address whether the merger meets the different balancing test and evidentiary standards of the Cooperative Agreement Law.[4]

Anthem's emphasis on market shares and concentration and characterization of the transaction as a "merger to monopoly" (Anthem Submission at 6) underscores another point: that it was highly foreseeable to the Virginia General Assembly in enacting the Cooperative Agreement Law that a Mountain States-Wellmont merger is one of the few hospital mergers, if not the only one, that would potentially trigger an application for a Cooperative Agreement, given that the Law applies only in Southwest Virginia. This suggests that the Legislature passed the Cooperative Agreement Law with this merger specifically in mind as potentially part of the solution to the distressed health and economic conditions in the region.[5]

III. Response To Anthem Claim That Benefits Are "Illusory And Unsubstantiated"

Anthem's premise for this section is based on an alleged quotation from the Cooperative Agreement Law that does not exist. Anthem states: "In order to [balance] procompetitive considerations like these against the likely substantial competitive harm from the proposed merger detailed above, the *Commissioner should only take into account those benefits that are merger-specific*." (Anthem Submission at 9; emphasis added) The source that it claims for this quotation is the Cooperative Agreement Law, specifically, "Va. Admin. Code § 15.2-5384.1E and F (2015)." (Anthem Submission at 9 n.30) The statement does not exist in the statute or the accompanying regulations.

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[3] In addition to the Guidelines, the other authorities on which Anthem relies in this section are a letter from the FTC's Director of Policy Planning, FTC staff's (rejected) comments to the West Virginia Healthcare Authority ("WVHCA") regarding a cooperative agreement application before that body, and an economic paper by Michael Doane and Luke Froeb. (*Id.* at 7-8 & notes 15-27) In their Response to FTC Staff Submission, the Parties described WVHCA's instructive reasoning in rejecting staff's comments and approving the cooperative agreement filed by two competing hospitals. Response to FTC Staff Submission at 10-13. The Parties also pointed out the unrealistic conclusions and significant economic flaws contained in the Doane and Froeb paper. *Id*. at 17 n.17.

[4] Response to FTC Staff Submission at 14.

[5] *See* Response to FTC Staff Submission at 14.

What the Cooperative Agreement Law does provide concerning benefits attributed to a merger (which Anthem correctly quotes) is that the Commissioner "must evaluate the availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition."[6] The Authority and the Commissioner must evaluate that factor along with many others in making the determination whether the transaction's benefits outweigh the disadvantages caused by the loss of competition between the merging parties.[7]

As the Parties previously described, in this respect, the Cooperative Agreement Law is very different from how the FTC assesses a merger's efficiencies (or benefits) under the Merger Guidelines.[8] The reason for the difference is that the FTC assesses mergers only for their effect on *competition*. The Cooperative Agreement Law, in contrast, creates a pathway for qualified mergers *even if they may be anticompetitive*. The FTC gives no credit whatsoever in a merger antitrust analysis to efficiencies that are not merger-specific. (Merger Guidelines § 10) The Cooperative Agreement Law requires only that the availability of other transactions that would generate the same benefits be considered as a factor among others in an overall balancing of benefits versus disadvantages. The FTC evaluates efficiencies only insofar as they enhance the merged firm's "ability and incentive to compete" and to the extent they "reverse the merger's potential harm." (*Id*.) It will refrain from challenging an otherwise anticompetitive merger only if the efficiencies "are of a character and magnitude such that the merger is *not likely to be anticompetitive* in any relevant market." (*Id.*) None of these concepts are embedded in the Cooperative Agreement Law.

Anthem, like FTC staff, rejecting the unanimous will of the Virginia Legislature, tries to shoehorn antitrust law enforcement concepts into the evaluation of Cooperative Agreements, but cannot do so because they are completely different frameworks.[9]

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[6] Va. Code § 15.2-5384.1F (2015).

[7] *Id.*

[8] Response to FTC Staff Submission at 8-9.

[9] A recent Federal Trade Commissioner herself recognized that the agency does not possess sufficient information to opine on non-competition-related public policy goals of state laws that restrict competition. In a January 8, 2016, dissent to an FTC and Dept. of Justice joint statement on repeal of the South Carolina Certificate of Need statute, then-Commissioner Julie Brill states:

> "My concern is I do not believe the Agencies possess sufficient relevant information to opine on noncompetition-related public policy goals of the CON laws. Our experience is broad but it does not extend to every issue. The FTC should advise South Carolina policy makers based on our area of expertise—competition—and not overstep our collective knowledge. Health care policy makers at the state level are faced with difficult issues separate and apart from the strong benefits competition brings to health care markets. These include the critically important issue of preserving access to care for the needy, and doing so in a complex market, involving informational asymmetries among patients, providers, and payors. In this context, it is important to understand that competition will not move resources from those that can afford health care to those that cannot. As the Agencies stated in 2004:
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> > 'competition is not a panacea for all of the problems with American health care. Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover, competition cannot eliminate the inherent uncertainties in health care, or the informational asymmetries among consumers, providers, and payors. Competition also will not shift resources to those who do not have them.'"

FTC staff's comments are an example of the agency's representatives "overstepping their collective knowledge" and clearly lack merit in this proceeding. Former Commissioner Brill's full statement can be found at

A. Response To Anthem Claim That The Proposed Benefits Do Not Reflect Significant Investments Beyond What They Are Doing Currently

In questioning the Parties' specific commitments totaling $450 million, Anthem quotes language from the Application that the merger is motivated in large part by "the important and increased need for investment in population health, management of information and measurable improvement in cost and quality, combined with the continued downward pressure on reimbursement from government and commercial payers . . . ." (Anthem Submission at 10, quoting Application at 4) Anthem does not challenge the "important and increased need for investment in population health, management of information and measurable improvement in cost and quality" and the other stated motivations for the merger. Instead, Anthem attempts to belittle the Parties' specific commitments totaling $450 million for various important programs needed in the region, arguing that despite this "soaring language," the Parties are already making investments which could total over $450 million over ten years.[10]

In response to Anthem's criticisms, the Parties have expressly stated that the $450 million commitment is **incremental**, specifically that the "investments are intended to be incremental and constitute additions to current spending costs." (July 13, 2016 Responses to Southwest Virginia Health Authority Questions dated May 27, 2016 (hereinafter "July 13 Authority Responses") at 67) As the Application states, funding the population health, access to care, enhanced health services and commitments would be impossible without the efficiencies and savings created by the merger. (Application at 96, *see* Anthem Submission at 10[11]) Both the Authority and the Commissioner can and will monitor and enforce the Parties' commitment of this $450 million incremental investment to provide additional important health care services in the region.

The Parties' specific commitments are based on review of the Southwest Virginia Health Authority *Blueprint for Health Improvement and Health Enabled Prosperity*, the Virginia Department of Health's draft of *Virginia's Plan for Well-Being*, and extensive feedback received over many months from the people the Parties serve across the region—direct feedback from hundreds of people ranging from regional leaders to health care consumers, including feedback from the four Community Health Work Groups. That feedback revealed strong support for local governance and control because local governance and control works hand in hand with local input. These commitments, shaped by local input, address the unique needs and goals of this region because they are developed by local people who live, work, and raise families in this region. The commitments provide solutions to address an epidemic of behavioral health and

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https://www.ftc.gov/system/files/documents/public_statements/905323/160111ftc-doj-sclawstatement.pdf?utm_source=govdelivery (citation omitted).

[10] Anthem does not dispute the importance of these programs and identifies the programs to include expanding mental health, addiction recovery and substance abuse prevention programs; developing and growing academic and research opportunities supporting post-graduate health care training; developing programs for children's health and preserving and expanding rural services and access points. (Anthem Submission at 11-13) Importantly, Anthem also concedes that some of the Parties' commitments, if met "could offer substantial value to southwest Virginia and northeast Tennessee." (Anthem Submission at 18)

[11] Importantly, the Anthem Submission shows the extent to which these two local hospital systems are already making substantial expenditures to improve health care in the region, based on the Parties' first-hand knowledge of the needs of this region. It is unlikely that any out-of-market acquirer would be willing to continue this level of funding. Further, the Anthem Submission assumes that the hospital systems will be able to continue their current level of funding if they remain independent, but given the documented financial pressures, there is no assurance this level of funding will continue.

addiction problems with new resources, to help turn the tide of poor community health and chronic disease, to invest in services not currently available, and to create economic opportunity through academics and research.

In addition, since the Application was deemed complete by the Authority, the Parties have proposed revised and broadened commitments based on valuable input from the Authority. The Authority and the Commissioner continue to demonstrate their first-hand knowledge of the region through their active involvement in and supervision of the development of the Cooperative Agreement. The revised commitments also include more specific ways in which achievement of those commitments can best be demonstrated and measured by the Authority and the Commissioner on an ongoing basis.[12]

Coming from an organization based outside the area, Anthem's criticism that local control and governance is only "a nice sound bite" (Anthem Submission at 3) is both dismissive of and disrespectful to the people of the region, the local government entities that have expressed their support, and to the Authority who have made it clear that local solutions are needed to solve the serious challenges facing the region and who have invested significant effort in identifying those challenges and formulating proposed solutions.

B. Response To Anthem Claim That The Benefits Could Be Achieved Without The Merger

Building upon its mistaken argument that the investments "reflect nothing more than the Parties' current activities," Anthem then argues that out-of-market acquisitions may provide similar benefits to the region.[13] Anthem provides no basis for this speculation other than to cite self-serving press releases posted by the out-of-market acquirers. Importantly, even a cursory review of these releases demonstrates that they do not involve areas with similar characteristics to this region. Specifically, the out-of-market mergers cited do not involve rural regions with high poverty rates, higher rates of serious health problems, very high percentages of Medicare, Medicaid, Medicare managed care and uninsured patients, a declining population, a small and shrinking base of commercial patients and rural hospitals with very low patient volumes requiring substantial financial investment to ensure that important services remain available in smaller rural communities.

For example, Anthem references Novant building a 60-bed hospital in Prince William County in Northern Virginia, a much more affluent and growing area than the Southwest Virginia area.[14] In fact, the press release cited states the hospital will serve the "growing" northern Virginia community. As pointed out in the Application, many of the Parties' hospitals in Southwest Virginia have an average daily census of less than 30 patients with significant

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[12] Proposed revised commitments available at https://swvahealthauthority.net/commitments/.

[13] As the Parties pointed out in the Response to FTC Staff Submission, the West Virginia Health Care Authority ("WVHCA") recently rejected a similar argument when it approved a cooperative agreement between two West Virginia hospitals under a law very similar to the Virginia Cooperative Agreement Law. The WVHCA held that it was unwilling to jeopardize important programs for the region based on speculation that another purchaser may offer similar programs. In Re: Cabell Huntington Hospital, Inc., Cooperative Agreement No. 16-2/3-001, June 22, 2016 ("W.Va. Decision") at 17, 40, 43-45.

[14] A news release from this entity states that the population of western Prince William County is projected to grow more than 20 percent over a two-year period. http://www.prnewswire.com/news-releases/prince-william-health-system-completes-merger-with-novant-health-to-expand-quality-health-care-in-northern-virginia-62090857.html, July 1, 2009.

excess capacity and a declining area population.[15] Similarly, the other examples involve situations where new hospitals and facilities were being built to serve growing demand, not situations where out-of-market acquirers were committing to maintain low occupancy, struggling rural hospitals in areas with high poverty and serious health challenges.

Further, since Anthem references the Novant acquisition of Prince William Health System, which occurred in 2009, it may prove educational to review the publicly available data in order to determine the outcome of this out of market acquisition. From the date of acquisition in 2009, through 2012, the hospital consumer price index increased by a compounded annual growth rate ("CAGR") of 3.4 percent.[16] According to the publicly filed hospital cost report data, over that same time period, the hospital's case mix index remained flat, but Gross Revenue per Adjusted Admission grew by a CAGR of 8 percent, or 30 percent over three years. Net Revenue per Adjusted Admission grew by a compounded annual growth rate of 7 percent. This revenue growth per adjusted admission was in excess of expense growth of 3.5 percent CAGR. This revenue growth per adjusted admission is roughly twice the growth of the hospital Consumer Price Index. While the specific pricing at Prince William Medical Center is not available, it is clear that, on a case-mix adjusted, volume adjusted basis, gross revenue per adjusted admission increased dramatically after the acquisition. Generally, gross revenue per adjusted admission relates to gross charges, while net revenue per adjusted admission relates to collections on a per-unit basis. Adjusted for case mix, there appears to be no other explanation for such dramatic increases in volume adjusted revenue other than pricing increases. The Parties are not aware of publicly available data to suggest substantial improvements in quality, cost, or patient satisfaction. The Parties believe that this type of "out-of-market" acquisition is not what is best for the region and this data underscores why we believe there is greater value in the proposed merger than turning the Parties' hospital assets over to an outside system, as Anthem would have the Parties do.

Anthem also argues that the Parties could achieve some of the proposed efficiencies and benefits without merging (Anthem Submission at 16), but offers no examples of collaborations that would not be challenged under the antitrust laws and/or involve a very complicated and costly antitrust compliance infrastructure. Such alternative collaborations would very likely require, among other things, sharing of confidential and competitively sensitive cost and price information between competitors along with agreements regarding the services each system will offer and not offer, the direction of referrals, which facilities to keep open, close, downsize or repurpose and the number, type and the compensation of specialists and subspecialists. The cost-savings potential is much smaller without full integration, moreover, leaving the Parties with fewer and probably insufficient resources with which to fund the capital investments that would likely be required in such a collaboration.

As noted in the July 13 Authority Responses, most of the Parties' Virginia hospitals were previously owned by not-for-profit or for-profit systems that, due to the increasing downward

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[15] Anthem also cites to Novant "steering" members to a UVA hospital, but it is unclear whether members were being steered to an out-of-market hospital. (Anthem Submission at 14) Here, the Parties intend to provide needed services locally, including specialty services.

[16] *See* Novant Health UVA Health System Prince William Medical Center Profile, American Hospital Directory, *available at*: https://www.ahd.com/free_profile.php?hcfa_id=98bd57eed13c350c01e783b9186db671&ek=6f27bcb739d76b93b4326cdfc35ad934.

pricing pressure and reduced utilization of services, chose to end their ownership or affiliation of the hospital and sold the facility to Mountain States or Wellmont, or simply stopped compensating for the operational losses of the hospitals. Without the commitments contained in the Application by the New Health System to keep these hospitals open, the reality exists that few of the Southwest Virginia hospitals could survive, or if they did, would only do so with significantly reduced services.

IV. Response To Anthem Claim That Commitments Offered By The Parties Are Not A Replacement For Competition And Will Not Adequately Protect Patients Against Competitive Harm

Anthem claims that the Parties' commitments must be designed and structured in such a way as to mirror the results of competition. (Anthem Submission at 17) This is legally inaccurate. Anthem further claims that the commitments will not assure that the Cooperative Agreement will result in the claimed benefits.(Anthem Submission at 4) This assertion is false.

As noted in the Response to FTC Staff Submission, the legislative intent of the Cooperative Agreement Law is to create a pathway for approval of hospital mergers in this unique region, which might be seen as anticompetitive, if they qualify under the statute's balancing test for benefits versus disadvantages. (Response to FTC Staff Submission at 9) To ensure that the balance of net benefits is maintained in keeping with state policy, the Law, including the Regulations accompanying the Law, provides for the Commonwealth to obtain commitments that the state may enforce.[17] There is no requirement that the commitments mirror the results of competition.

Instead of evaluating the commitments on whether they mirror the results of competition, the Authority must evaluate whether the benefits of the Cooperative Agreement outweigh the potential disadvantages "in consideration of the Commonwealth's policy to facilitate improvements in patient health care outcomes and access to quality health care, and population health improvement, in rural communities and in accordance with the standards set forth [in this statute]…."[18]

The Parties have made commitments in the Application to address the specific areas listed in the Cooperative Agreement Regulations.[19] In addition, the Parties have made comprehensive, substantial other commitments addressing fundamental health issues and priorities in Southwest Virginia that compel the need for highly integrated and organized solutions led by the New Health System in close collaboration with community leaders and under the direct, active supervision of the Commonwealth.[20] The commitments made by the Parties create mechanisms such as rate restrictions to ensure reasonable prices, conduct restrictions to ensure non-exclusionary practices, commitments from the Parties to pursue high

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[17] Virginia's Rules and Regulations Governing Cooperative Agreements ("Cooperative Agreement Regulations"), 12VAC5-221-90.C. The Parties note that they have made commitments in each of the specific areas listed in 12VAC5-221-90.C of the Cooperative Agreement Regulations that the Commissioner may seek. In addition, the Parties have numerous substantial other commitments made

[18] Virginia Code § 15.2-5384.1.D.

[19] 12VAC5-221-90.C.1-6.

[20] *See* Application Section 17 (pages 130-133) for a summary of the Parties' 30 commitments.

quality performance, and significant other commitments to invest money from merger-generated cost savings into programs that will improve population health, expand access to care, and create community benefits tailored specifically to the needs of Southwest Virginia's rural patients. Active and ongoing supervision of these commitments will be performed by the Commonwealth, as set forth in the Cooperative Agreement Law, to ensure the New Health System's compliance with the policy goals articulated by the Virginia General Assembly.[21]

The Parties do not argue that they should be held to commitments that are both meaningful and enforceable. The Authority has been engaged in the hard work of identifying the commitments and achievement scoring mechanisms that it thinks are necessary and important to hold the New Health System adequately accountable, and the Parties expect the same diligence by the Commissioner and her staff in their review of the Application and ultimately in the oversight of the Cooperative Agreement. In fact, the Parties proposed specific accountability mechanisms in their Application to enforce *each* commitment, and these accountability mechanisms have been further refined with timelines and metrics in the ongoing discussions with the Authority.[22]

To ensure that the commitments are enforceable, the Parties have also proposed that the New Health System be held to an overall standard each year under the Scoring of the Quantitative Measures. If the New Health System fails to achieve an agreed upon passing score in any year, the Commonwealth may invoke its authority to seek modifications to the Cooperative Agreement or to begin action to revoke the Cooperative Agreement and dismantle the New Health System according to the agreed upon Plan of Separation that will be filed and updated annually.[23]

A. Overall Achievement Scoring

The "Overall Achievement Scoring" system proposed in the Application was intended to be a proposal for the two states to consider. Ultimately, the states will determine the active supervision mechanism that is required to ensure the continuing public advantage of the Cooperative Agreement as required by the Cooperative Agreement Law and regulations.

As noted in the Response to FTC Staff Submission, the Parties have been engaged in productive dialogue with the Authority about the commitments. (Response to FTC Staff Submission at 33-34) Based on its extensive knowledge of the health care needs of the region, the Authority has provided valuable input on some specific areas of focus for a set of broader commitments and ways in which achievement of these commitments can best be demonstrated and measured by the Authority and the Commissioner on an ongoing basis after the Cooperative Agreement is approved. Since Anthem submitted its comments on September 30th, the Authority and the Parties have announced potential revised commitments with specific outcomes.[24] A number of the proposed revisions under discussion would make the original commitments stronger or clearer, or would make certain commitments Virginia-specific. In addition, a revised

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21 Virginia Code § 15.2-5384.1.G.
22 *Available at:* https://swvahealthauthority.net/commitments/.
23 Virginia Code § 15.2-5384.1.H.
24 *Available at*: https://swvahealthauthority.net/commitments/.

achievement scoring mechanism based on these discussions has been developed which addresses Anthem's criticism regarding the relative weights of the commitments and the necessary performance threshold. The discussions with the Authority are ongoing as of this date. The Authority's review of the Parties' proposed Cooperative Agreement has been, and continues to be, thorough and focused on the health care needs of the region it serves. Likewise, the Parties anticipate that the Commissioner, during her review of the Cooperative Agreement, may have additional input on specific focus of the commitments and how achievement of these commitments should be substantiated.

B. Rate Commitments

Anthem criticizes the Parties' rate commitments on the grounds that "[s]ubstituting price regulation for market-based competition is rarely done because it is almost impossible to do." (Anthem Submission at 22) This is wrong on two grounds. First, this criticism is aimed at the Commonwealth's policy to supplant competition with a regulatory program for qualified health care transactions in Southwest Virginia. Anthem's policy objection is not relevant to the Authority and Commissioner in their consideration of the Parties' Application.

Second, Anthem's criticism is wrong because the Parties' rate commitments are not "regulation" in the sense that Virginia would be tasked with affirmatively setting rates. The Parties propose as part of its commitments a reduction to existing commercial contracted fixed rate increases that have already been negotiated and a rate cap for new contracts. This represents a commitment by the Parties to be subject to a rate cap as previously stated:

> As set forth in the Application, the Parties have agreed to two distinct rate commitments. The first is to reduce any inflator increase for Principal Payers by 50% in the first contract year following the first fiscal year after the formation of the New Health System ("One Year 50% Rate Reduction Commitment"). This would automatically reduce the rate of increase in any existing Principal Payer contract with a fixed inflator or indexed inflator measured by a particular index by 50% of the fixed rate. The second commitment is to not increase negotiated rates by more than a fixed index rate for both existing and prospective Principal Payer contracts. For negotiated hospital rates, this cap is the hospital Consumer Price Index (CPI) minus 0.25%. For physician and outpatient service rates negotiated by the New Health System, the cap is medical care CPI minus 0.25% (collectively, the Rate Cap Commitment).[25]

Anthem makes much of the fact that "there are only a few examples of hospital mergers being granted an exemption from antitrust scrutiny under the state action doctrine." (Anthem Submission at 22) This argument is meaningless. One of those examples occurred this year in West Virginia. It is an example of the dynamic responses recently taken by many states to worsening health and economic conditions, including those in Virginia, Tennessee (COPA amendments passed in 2015) and New York (COPA law passed in 2011). Anthem does not identify a single application for a cooperative agreement or COPA for a hospital merger rejected

[25] Response to FTC Staff Submission at 15.

by any state. Not surprisingly, Anthem also does not come forward with any argument or evidence that the twenty-year Mission Health COPA in North Carolina led to supra-competitive prices or sub-competitive quality. Indeed, the facts show otherwise.[26]

Anthem lists various alleged "serious problems" with the Parties' rate commitment that leave open opportunities to "game the regulation" to charge higher prices and reduce attention to quality performance goals. (Anthem Submission at 23-24) These claims are unfounded. Anthem apparently does not understand its own contracts, because they contain many terms and conditions as a normal course that greatly minimize if not eliminate "gaming" – particularly by a health system subject to binding commitments and active state supervision. Any attempt to evade the rate commitments or re-write them without justification related to incumbent contract provisions that protect the payer would be easily identified by both the payer and the state supervising officials. Where, for example, contracts involve terms for inpatient care at fixed rates per DRG regardless of length of stay or services utilized (i.e., a fixed price for a particular diagnosis) and a similar system for outpatient care, the provider is at risk for managing length of stay. Anthem suggests in its comments that that the New Health System may over-utilize services or extend hospital stays without clinical justification (Anthem Submission at 24); however, existing provisions limit economic incentives for such actions. Moreover, with regard to the other means that Anthem suggests, there are for example, "circuit breaker" provisions that effectively prevent rate increases above a certain level.

Anthem states that the Parties do not specify what CPI index will be used. (Anthem Submission at 23) The answer is that the Parties propose using the national CPI, which in fact tends to be lower than regional CPI index, and also is somewhat less volatile. It is well-known and uniformly calculated. Anthem also contends, as did FTC staff, that the rate cap will operate as a price floor rather than a cap. (Anthem Submission at 23) This is not correct. It ignores the commercial realities of contract negotiations when both payer and New Health System will be informed with data and information about their current contract as well as the CPI and rate cap.[27] Moreover:

> The rate cap is also considerably below the model-predicted (and highly unrealistic) estimate of 130% price increases that FTC staff references and well below any levels that would appear likely to raise concerns about price increases. Moreover, the cap will be a cap – even if it is a floor, the floor is also the ceiling, and rate increases will be constrained to reflect measures of overall cost changes

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[26] *See* Response to FTC Staff Submission at 34-39. See RANDALL R. BOVBJERG & ROBERT A. BERENSON, URBAN INSTITUTE, CERTIFICATES OF PUBLIC ADVANTAGE: CAN THEY ADDRESS PROVIDER MARKET POWER? (2015), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf (accessed October 14, 2016) which states in part:

> "Both Medicare and private payer per-person costs have been found to be low in Asheville, while quality is good, according to independent findings using different data. Indeed, well-recognized policy experts have held up Asheville as one of the best communities for providing high value hospital care."

[27] *Id.* at 17. So the Authority and Commissioner have no misunderstanding, Anthem publicly disclosed Wellmont's and Mountain States' rate increase information from each Party's last negotiated Anthem contract without either Party's permission and in violation of each contract.

based on neutral benchmarks that in recent history have been small percentage changes.[28]

The Wellmont and Mountain States rate increases disclosed by Anthem (Anthem Submission at 23)[29] reflect the latter's negotiating power in Southwest Virginia due its approximate 80% share in that region[30] – a fact that will not change if the Cooperative Agreement is approved and potentially will increase if Anthem is allowed to acquire Cigna. It is also not true to state, as Anthem does, that the rate commitments interfere with payments conditioned on performance goals. Current rate inflator provisions already are conditioned on Q-HIP targets and the rate cap applies only to fixed increases, so incentives will not change to improve quality scores. The same holds true for physician rates. Anthem's comment that the rate cap would be above market rates for physician fee schedules ignores the fact that Anthem offers only non-negotiable, take-or-leave fee schedules. Importantly, both Anthem and the New Health System's incentives are aligned to achieve improved quality and value, and thereby reduce costs – and to seek contractual terms that will achieve improved outcomes as well as cost reduction. Where the Parties are constrained to keep rate increases across the scope of its healthcare activities consistent with CPI rates that are anticipated to change at only a low rate, the Parties have every incentive to align quality and cost of care with payer's incentives to manage these for their enrollees.

Anthem argues that the rate cap should apply to all commercial payers, not just Principal Payers. (Anthem Submission at 24) As it stands, this commitment applies to over 90% of the Parties' commercial business. Moreover, neither Party has any incentive to impede competition from any commercial payer, particularly competition against Anthem and its dominant market share in the region. From a business perspective, however, the rate cap could risk net losses to the New Health System if applied to contracts with payers who have so few covered lives.[31] In two other comments in this section of its submission, Anthem is also wrong. (Anthem Submission at 24) The Parties have amended the rate cap commitment to extend to negotiated government plan contracts including managed Medicaid and Medicare Advantage plans. And it is incorrect that the "Parties do not commit to applying the cap across all services and across the entire chargemaster." The rate cap will also apply to any services and any charges where a fixed inflator would impact reimbursement. In addition, the contracts have chargemaster protection language for the benefit of payers.

Anthem criticizes the Parties for not addressing how the rate cap will apply to risk-based payment models. The Parties greatly desire such contracts but they require collaboration among all parties including the payer. Both the Parties and the payer have aligned incentives to seek contracts that provide downside and upside risk, and where the Party (e.g., the health system) that takes on significant additional risk for achieving improved outcomes, improved quality, or savings for the payer's population is appropriately reimbursed for the important value that it

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

[29] So the Authority and Commissioner have no misunderstanding, Anthem publicly disclosed Wellmont's and Mountain States' rate increase information from each Party's last negotiated Anthem contract without either Party's permission and in violation of each contract.

[30] HealthLeaders InterStudy, Decision Resources Group Health Plan Data Enrollment, Virginia (July 1, 2015).

[31] Even very small changes in the risk profile of payer's with very small numbers of enrollees could cause relative costs to change very substantially.

provides. The Parties will have every incentive to engage in these type of arrangements – and have committed to do so – so as to be able to provide and align incentives for coordinated care to achieve them across the critical needs of the population in this area. Trying to apply a rate cap to a risk-based payment model encompassing all the possible permutations of such an arrangement in isolation and without the payer's participation, is premature. The Parties would not want to preclude their ability to work with payers for mutually beneficial and desired risk-based payment arrangements by negating the very contract mechanisms that incentivize such arrangement. The Parties are confident that these arrangements can be reviewed by the Authority.

C. Service Commitments

Anthem claims that the service commitments are incomplete and lack any details regarding specific plans, timelines or the costs to achieve them. (Anthem Submission at 5) The Parties address each of Anthem's claims individually below.

Anthem Claim about Commitment #1: Anthem claims the commitment that "[a]ll hospitals in operation at the effective date of the merger will remain in operation as clinical and healthcare institutions for at least five [(5)] years" is too vague to be meaningful. (Anthem Submission at 26)

Response: As noted above, the Parties have been engaged in dialogue with the Authority to further refine the proposed commitments. In the revised commitments presented at the Authority meeting on October 12, 2016, the Parties proposed to define "essential services" for purposes of this commitment as:

- Emergency room stabilization for patients;
- Emergent obstetrical care;
- Outpatient diagnostics needed to support emergency stabilization of patients;
- Rotating clinic or telemedicine access to specialty care consultants as needed in the community and based on physician availability;
- Helicopter or high acuity transport to tertiary care centers;
- Mobile health services for preventive screenings, such as mammography, cardiovascular and other screenings;
- Primary care services;
- Access to a behavioral health network of services through a coordinated system of care; and
- Community-based education, prevention and disease management services for prioritized programs of emphasis based on goals established in collaboration with the Commonwealth and the Authority.[32]

The Parties believe this proposed definition of "essential services" provides clarity for the minimum levels of service availabilities that the Parties are committing to post-combination for this five-year-period.

[32] *Available at*: https://swvahealthauthority.net/commitments/.

Anthem Claim about Commitment #2: Anthem claims the Parties commitment to maintaining three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol is too vague to be meaningfully enforced without additional information - namely definitive access standards. Anthem also criticizes the Parties for not having made any commitment to maintain a full-service tertiary referral hospital in Virginia. (Anthem Submission at 27)

Response: Based on its comments, Anthem appears to be unfamiliar with the health care services available in Southwest Virginia. There is no full-service tertiary referral hospital in Southwest Virginia for the Parties to commit to maintain. The closest full-service tertiary referral hospitals to the Southwest Virginia community are the Parties' tertiary referral hospitals in Bristol, Kingsport, and Johnson City, Tennessee. The Parties have committed to maintaining ALL of these tertiary referral hospitals so that the Southwest Virginia community has access to these services.

Anthem raises concerns that without definitive access standards, an entire service line (e.g. all heart services) could be moved from one tertiary hospital to another. (Anthem Submission at 27) The Parties do not envision transferring all of any particular service line to one facility and, in fact, such a move with a tertiary service such as heart care would no longer allow that facility to be considered tertiary. Anthem does not seem to understand that it is commonplace for residents from the region to utilize tertiary services at multiple locations based on physician referral and consumer preference. This will continue under the New Health System. The Parties' commitment to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol will ensure higher-level services are available in close proximity to where the population lives in Southwest Virginia.

Anthem Claim about Commitment #3: Anthem claims the Parties' commitment to adopt a Common Clinical IT Platform as soon as reasonably practical is too vague. Anthem further claims that Wellmont's participation in the OnePartner HIE makes the Parties' commitment to participate meaningfully in an HIE open to community providers a benefit that is not merger-specific. (Anthem Submission at 27)

Response: The Parties direct Anthem to the detailed timetable for implementation of the new Common Clinical IT Platform in their July 13 Authority Responses.[33] Anthem also fails to note that neither Wellmont nor Mountain States is a full participant in OnePartner and even if they were, that would not replicate the functionality of a single, integrated electronic health record system.

Anthem fails to recognize the difference between a Common Clinical IT Platform and an HIE. As noted in the July 13 Authority Responses, the Common Clinical IT Platform is designed to facilitate the sharing of electronic health information across the New Health System, while the HIE will allow the New Health System to share electronic health information with participating providers across the region and nation - regardless of their affiliation with the New Health System.[34]

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[33] Exhibit 22A to July 13 Authority Responses.

[34] *See* July 13 Authority Responses, Question 22, pages 22-26.

Providers across the Geographic Service Area use a variety of EHR systems that may not be able to share data with the New Health System. The HIE is a way of sharing electronic health information among doctors' offices, hospitals, labs, radiology centers, outpatient centers, and other health organizations. While the OnePartner HIE system is useful in reaching out to independent physicians, the current system is limited in the data that it can transmit.[35] A provider on the Common Clinical IT Platform will be able to pull up the patient's *entire* medical history contained in the patient record including current charts and images, while the information available within an HIE is typically limited to certain fields that are most commonly used or accessed by providers.[36]

The investment in a Common Clinical IT Platform is essential to creating a "One Patient, One Record" approach that allows all clinicians practicing within the New Health System to effectively evaluate a patient's clinical profile and to make decisions that support high quality care without duplication of clinical resources. Better communication of patient data and best practices via a thriving regional HIE will also improve patient care and lower cost of care.

D. Quality Reporting Commitments

Anthem attacks the quality reporting commitments as too vague, apparently conceding that such commitments would have value if more clearly defined.[37] (Anthem Submission at 27-28) However, as noted, the Parties have been engaged in productive dialogue with the Authority about these commitments, including valuable input from the Authority on broader commitments and ways in which achievement of these commitments can best be demonstrated and measured by the Authority and the Commissioner on an ongoing basis.

E. Physician Commitments

With respect to physician commitments, Anthem lists a number of commitments made by the Parties which it does not challenge. (Anthem Submission at 29)[38] Anthem then argues that there are inappropriate concentration levels in certain physician specialty areas, but lists only five of the twenty-three specialty areas identified by the Parties. (Anthem Submission at 29)[39] Notably, Anthem does not mention that it is referencing only a very few categories out of the twenty-three physician specialties serving the area that happen to have shares where 60% or a lower percentage of physicians are independent. Nor does it mention that these categories account for only a small proportion of the total physicians in the area. In fact, a very large number of physicians in the area are independent, and there are several specialties in which there is no overlap between the Parties (in terms of employed physicians) and the majority are in categories where independents' shares are high (and the Parties' share is commensurately low).

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[35] See July 13 Authority Responses, Exhibit 22B for a detailed description of the Parties' plans for the EHR system, a description of the plan to convert to a single records system, and the expected features, the benefits of the Common Clinical IT Platform, and the expected benefits of the Common Clinical IT Platform to the Regional Health Information Exchange.

[36] *Id.*

[37] In this regard, Anthem recognizes that the exchange of health information across a common IT platform "is a benefit." (Anthem Submission at 27)

[38] These commitments described by Anthem include maintaining open medical staffs, not engaging in exclusive contracting for physician services (other than hospital-based physicians), not requiring exclusivity by physicians practicing at the new systems' hospitals, and not inhibiting independent physicians from participating in health plans and health networks of choice.

[39] *See* July 25, 2016 Supplement to Responses to Questions Submitted May 27, 2016, Replacement Ex. 14.1 (Section E).

Of the five specialty areas selected by Anthem, two are hospitalists and urgent care physicians who, because of the nature of their practice, would not be competing for ongoing patient relationships as their interaction with patients is based on facility use. Even in these categories, there are a large number of independent physicians in the area – 146 hospitalists, and 38 urgent care physicians. By referencing only the share numbers, Anthem suggests that there are limited alternatives, which these numbers show otherwise. Similarly, for the other three categories, which include more highly specialized physicians, these also have a number of independent physicians (50 cardiovascular, 39 pulmonology, and 19 hemotology/oncology physicians in addition to those employed or affiliated with the Parties). In sum, of the remaining eighteen categories of specialists, they are made up mostly of independent specialists and half of the categories show no overlap between Mountain States and Wellmont. (*Id.)*

Anthem also speculates, without foundation, that despite the Parties' commitment not to materially increase the percentage of physicians employed or affiliated with the New Health System, this may still happen, especially with respect to high-level specialties. (Anthem Submission at 30) Anthem ignores the specific statement by the Parties that the physician employment model will only be used to facilitate bringing **needed** specialties to rural or underserved areas or when private physician groups do not want to expand or do not exist. (July 13 Authority Responses at 46) Anthem's objection is misguided in a region currently deprived of needed specialties. The Parties also expressly state in their submissions that their objective is to support the independent practice of medicine. (*Id.*) Anthem also acknowledges that the use of caps on physician numbers is not always effective.[40] This is an important notation because of the national trend of physicians to seek employment with health systems or large physician groups. While it is not the desire of the New Health System to grow numbers of employed physicians, the New Health System must be able to attract and retain high quality physicians in specialties that require employment.

F. Plan of Separation

Anthem claims that the Plan of Separation has not been made publicly available. (Anthem Submission at 30) Anthem's statement is factually incorrect. The Plan of Separation was submitted as Exhibit 18.1 in the Virginia Application on February 16, 2016 and has been made publicly available on the Authority's website for over eight months. As noted in the Response to FTC Staff Submission, at the request of the Tennessee Department of Health, the Parties revised the initial Plan of Separation to provide additional details to specifically address how the separation would be handled in the first 18 months after closing. The revised Plan of Separation was provided as Exhibit 5 to the Response to FTC Staff Submission.

V. Response To Virginia Association Of Health Plans (VAHP) Comments – September 29, 2016

The Sept. 29, 2026 submission of VAHP complains that the Parties' commitments are vague, unsubstantiated and lacking specificity on measuring performance. However, as pointed out above, now that the Application has been deemed complete, the Parties have been engaged in

[40] *See* Anthem Submission at 30.

productive dialogue with the Authority about the commitments, including valuable input from the Authority on some specific areas of focus for a set of broader commitments and ways in which achievement of those commitments can best be demonstrated and measured by the Authority and the Commissioner on an ongoing basis.

VI. Response To America's Health Insurance Plans (AHIP) Comments – September 30, 2016

AHIP claims that the detailed economic analysis conducted by Michael Doane and Luke Froeb demonstrate that the merger is likely to significantly reduce competition and raise prices for consumers. The Parties note that these comments principally rely on the January 2015 report of these authors (Competition Economics), which was written well before the Application was even submitted on February 16, 2016.[41] As a result, this report and the Doane/Froeb analysis totally ignore the significant health care challenges in Southwest Virginia and the significant commitments of the Parties, including pricing commitments. In fact the report was written even before the Cooperative Agreement Law was introduced, and, as evident in the report, fails to consider the important public policy justifications for the statute and the needs of residents of the Southwest Virginia region, as set forth in the statute.

VII. Conclusion

For the reasons stated above, the Authority should reject the arguments contained in the comments submitted by Anthem, the Virginia Association of Health Plans, and America's Health Insurance Plans.

[41] The Parties also pointed out the unrealistic conclusions and significant economic flaws contained in the Doane and Froeb paper in the Response to the FTC Staff Submission at 17 n.17.