

**STATE OF RHODE ISLAND  
OFFICE OF ATTORNEY GENERAL**

February 17, 2022

**DECISION**

**Re: Hospital Conversions Act Initial Application of Rhode Island Academic Health Care System, Inc., Care New England Health System, Kent County Memorial Hospital, Women & Infants Hospital of Rhode Island, Butler Hospital, Lifespan Corporation, Rhode Island Hospital, The Miriam Hospital, Newport Hospital, and Emma Pendleton Bradley Hospital**

The Office of Attorney General has considered the above-referenced application pursuant to the Hospital Conversions Act, R.I. Gen. Laws Section 23-17.14-1 *et seq.* In accordance with the reasons outlined herein, the application is **DENIED**.

**EXECUTIVE SUMMARY**

Before this Office for decision is an application under the Hospital Conversions Act (“HCA”) for a proposed merger of Lifespan and Care New England (together, the “Parties”), who propose to merge and create a new academic health system affiliated with Brown University (the “Proposed Transaction”). Lifespan and CNE are the two largest healthcare systems in Rhode Island, and are two of the largest employers in the state. Countless Rhode Islanders rely on these two systems for some or all of their healthcare needs and tens of thousands of Rhode Islanders are employed by them.

If allowed to come together, they would control an extraordinary amount of health care in Rhode Island, and would take Rhode Island’s healthcare market from one in which there is healthy competition to a virtual monopoly. They would control 75% of all inpatient acute care hospital beds in Rhode Island and roughly 80% of the statewide market for inpatient hospital care. The new healthcare system would also have 79% of the statewide market for inpatient psychiatric care, and more than 60% of the statewide market for many outpatient surgery specialties. Around half of all commercial spend for Rhode Island members is through the Parties’ Accountable Care Organizations, and the system would employ 67% of Rhode Island’s registered nurses working full-time at a hospital.

This level and degree of healthcare consolidation in a small, but densely populated, state like Rhode Island is unprecedented, and would concentrate Rhode Island’s healthcare market far beyond the levels in neighboring New England states. For example, in Massachusetts, the largest system—Mass General Brigham, formerly known as Partners—has around 20% of Massachusetts’ acute care hospital beds, 27% of the statewide market for inpatient hospital care,

and 27% of the statewide market for outpatient care. The same is true of Connecticut, where a coalition of healthcare organizations, consumer groups, and unions objected to and intervened, unsuccessfully, in the 2016 acquisition of New London's main hospital by the Yale New Haven Health System, because it would result in Connecticut's largest system controlling 31% of the statewide inpatient hospital market share. Here, the projected increase in market power from a Lifespan and Care New England merger would be the largest increase on record when compared with all other health system and hospital mergers the federal government has moved to block since 2004.

The Attorney General knows how critical healthcare is for the State and for every Rhode Islander. And the COVID-19 pandemic has only further underscored the vital importance of affordable access to high-quality care for all. Healthcare is also the most significant sector of the Rhode Island economy. We spend billions of dollars a year on health care, and around 70,000 Rhode Islanders work in healthcare jobs, more than any other sector, representing one out of every seven workers in the state.

This Office takes very seriously its obligations under the HCA, particularly in light of the profound and far-reaching impact that this transaction would have on nearly every single Rhode Islander. Under the HCA, among the criteria that guide the Attorney General's review and particularly important to the review of this proposed merger—are whether the proposed merger is proper under Rhode Island's antitrust laws, whether the transaction is financially feasible, and whether the merger would in fact accomplish the benefits claimed by the Parties—all in the context of the underlying purposes of the HCA, to “[a]ssure the viability of a safe, accessible and affordable healthcare system that is available to all.”

In order to fulfill this statutory duty to Rhode Islanders, this Office performed a necessarily exhaustive inquiry: collecting more than 3.6 million documents (totaling over 11 million pages), taking more than 20 statements under oath, retaining six outside experts or firms, reviewing scores of academic studies, and receiving more than 250 public comments.

Having concluded this extensive review, and with the bases and justification set forth more fully throughout this Decision, the Parties application is **DENIED**. **Put simply, and among other reasons articulated in the Decision, if this extraordinary and unprecedented level of control and consolidation were allowed to go forward, nearly all Rhode Islanders would see their healthcare costs go up, for health care that is lower in quality and harder to access, and Rhode Island's healthcare workers would be harmed.**

This Executive Summary will provide a high-level overview of the major components of the Decision. First, explaining how, by eliminating the competition between Lifespan and Care New England, the Proposed Merger would increase Rhode Islanders' healthcare costs, threaten the quality of care they receive, limit their access to care, and disadvantage skilled healthcare workers. Second, the Decision will describe how, rather than putting Lifespan and CNE on stronger financial footing, the proposed merger would put Rhode Island's healthcare system in even greater financial peril. Third, illuminating how the Parties' have nothing more than a “plan to make a plan” with respect to achieving the claimed benefits of combining, without accounting

for the costs and challenges associated with achieving these benefits. Finally, the Decision will describe why the problems created by the proposed merger cannot be solved through more regulation or conditions.

The Attorney General recognizes the public's significant interest in this proposed merger, and there is no question that this review has greatly benefited from careful consideration of more than 200 public comment letters, along with testimony from more than 50 Rhode Islanders heard over the course of three public hearings. Plainly, there are some who strongly advocate in favor of the proposed merger, and some who strongly advocate against it. The Attorney General thanks all those who took the time out of their busy lives to express their thoughts and concerns regarding this proposed merger.

The Attorney General also recognizes the impressive work of the labor unions and their leadership in securing additional commitments from the Parties. Even though the Attorney General concludes, based on this review, that they are not enough to cure the risks and harms of this Proposed Transaction, it is clear that the unions were able to negotiate meaningful concessions and protections, and that their members were well-represented.

Finally, the Attorney General takes this opportunity to acknowledge and thank those who actually make possible the delivery of health care in this state – the state's healthcare workers. These nurses, doctors, technicians, and operational and administrative staff have cared for all of us, and they have done so throughout this pandemic, and all of its associated challenges. The Attorney General's recognition of and gratitude for their contributions to health care in Rhode Island are an inherent part of what drives this Decision.

***Competition benefits consumers and workers and Rhode Island's antitrust laws play an important role in keeping prices down, ensuring better quality goods and services, and spurring innovation.***

Antitrust laws protect competition and, by extension, the consumers and workers who benefit from it. Accordingly, the Office's antitrust analysis under the HCA is critical—it is not merely a theoretical, academic exercise, but rather the analysis necessary to uncover and understand the potential real-life consequences of the proposed merger that would be felt by healthcare consumers and workers throughout the state.

Other state and federal regulators regularly take action to prevent markets from consolidating to this degree. Keeping competition alive in healthcare markets is particularly critical. Because when a hospital or health system has to do the hard work to be recognized by patients and insurers as its community's source for healthcare – work that in turn sustains its own bottom line – that system will be better. When a system is so big, so dominant, that it is the only system that the vast majority of patients will go to for, say, inpatient care, that system no longer has to do the hard work to strive to be better than the alternative, because; there is no alternative.

The evidence, both here in Rhode Island and across the country, bears this out. Study after study demonstrates that, when markets become highly concentrated, they often stop rewarding consumers with the benefits of competition—lower prices, better quality goods and

services, and innovation—and instead funnel the gains back to the organizations that control the supply of those goods and services. And just because an organization is not-for-profit does not mean that it behaves differently; in fact, research has shown that mergers of nonprofits are just as likely to result in reduced competition and higher prices. In healthcare markets, health systems and hospitals are the main providers competing to attract more patients, negotiate better rates with insurance companies, and generate more revenue. They are competing because patients, along with their doctors, are making choices about where to seek or refer care—choosing one in-network hospital over another because it is easier to schedule an important surgery or because one hospital has a talented and well-known specialist that the other hospital does not. Their insurance companies are making choices, too. Insurers are deciding what rates they are willing to pay and which hospitals to include in their networks to successfully market affordable plans to businesses and individuals—decisions that ultimately impact the prices consumers pay and the healthcare they can access.

But, when health systems that are fierce competitors with the largest market shares, like Lifespan and Care New England, combine into one system, their hospital systems lose the necessity and motivation to compete against each other because, often enough, patients who would have chosen one system's hospital over the other system's hospital are now choosing between hospitals controlled by the same system. The hospital systems themselves acknowledge their highly competitive relationship to each other. Because patients have such a strong preference to receive care in their own communities, a system that controls the local market can count on these patients showing up at its hospitals whether or not it improves the quality of the healthcare services it is providing. Similarly, it can count on being included in most insurance plans whether or not it makes efforts to keep its rates affordable—because without that system, an insurer could not assemble a health plan attractive to local employers and may be unable to meet regulatory requirements. It can also count on local skilled healthcare workers, like nurses, seeking jobs at its hospitals whether or not it increases its wages and benefits because of geographic considerations.

This is market power and abundant evidence proves its impacts are far reaching.

***By eliminating the competition between Lifespan and Care New England, the Proposed Merger would increase Rhode Islanders' healthcare costs, threaten the quality of care they receive, limit their access to care, and disadvantage skilled healthcare workers.***

As Section II.A explains, the Proposed Transaction would concentrate an immense and unprecedented amount of market power in the new system, and the data, experts, studies, and experience in other states show that Rhode Islanders will be harmed as a result. **On cost**, Rhode Islanders' insurance premiums and co-pays will go up because health insurers negotiating with the new system will no longer be able to rely on competitive pressures to keep hospital rates down. **On quality**, as the new system's hospitals stop competing against each other for patients, they will lose a proven incentive to make investments that improve hospital performance and patient experience, and healthcare quality will suffer or, at best, stay the same. **On access**, the new system, making decisions about when, where, and how to make care offerings available to most Rhode Islanders, will be able to decide to stop offering certain treatments at community

hospitals or decide that its doctors need to refer patients to one hospital or specialist group over others. **For workers**, as the new system becomes the state's dominant healthcare employer, it has significantly increased power to set wages, which means the power to hold down the wages it pays or benefits it offers to Rhode Island's skilled healthcare workers.

If the Proposed Transaction were to be approved, Rhode Islanders and their employers would pay more for health care. We know from expert analysis of Rhode Island data that insurers directly pass on increased healthcare costs to consumers in the form of higher insurance premiums and higher out-of-pocket costs, and expert economic analysis of the state's healthcare market projects that a merged system would be able to demand and extract significantly higher rates in its negotiations with insurers. Studies and analysis by the Attorney General's healthcare economics expert also show that this increased leverage means the new system could increase its prices by at least nine percent, if not more, and this would be over and above the increases we already experience on a periodic basis. From blood transfusions, to C-sections, to knee replacements—and the insurance plans that cover them—Rhode Islanders will have to spend more on health care. Recent mergers in other states confirm that these kinds of price increases can be expected, and that prices tend to rise even more when merging hospitals and systems already serve the same people and geographic area, like Lifespan and Care New England do in Rhode Island.

Right now, Lifespan and Care New England invest in greater quality and access in their own systems to compete with each other for Rhode Islanders' healthcare business. Most Rhode Islanders have seen Lifespan and Care New England's efforts to attract patients—billboards on I-95 and frequent commercials on TV and radio stations—but their hospitals are also taking less visible steps to improve quality in ways that lead to more patients and revenues. For example, when Care New England's Kent Hospital noticed an opportunity to perform more complex, high-revenue heart surgeries, it developed an affiliation with cardiologists at Brigham & Women's Hospital and built a new lab for those procedures. Care New England saw its market share for those surgeries rise relative to Lifespan's and, subsequently, Lifespan established a call center to improve its appointment scheduling operation and win back more patients. Rhode Islanders benefit from this competition—they can more easily make appointments for important procedures, they are cared for by dedicated specialists, and they are operated on in state-of-the-art, new facilities, improvements that would not have occurred but for competition.

Within a consolidated system, Lifespan and Care New England's hospitals would no longer have the same incentives to make these investments and Rhode Islanders' healthcare quality would suffer. Instead of purchasing robots that sterilize hospital rooms between patient stays, as Kent Hospital did when one of its quality ratings dropped relative to other hospitals, the new system may make fewer of these investments when its hospitals do not feel the same competitive pressures. Or, instead of hiring an internationally recognized thoracic surgeon, as Rhode Island Hospital did following Kent Hospital's clinical affiliation with Brigham & Women's Hospital, the new system may spend its resources in areas where Rhode Islanders' healthcare needs are less pressing.

Following the merger, the combined system would also be empowered to make important decisions, without the pressures of a significant competitor, that could reduce access to care for most Rhode Islanders. The new system would have the discretion to decide that its doctors can only provide certain types of surgeries at one of the system's hospitals, or that primary care physicians under its control should be incentivized to shorten their patient visits. These measures might be designed to keep the system's costs down, particularly as cost reduction would be a major driver given the financial realities facing a merged system. Such measures could also limit Rhode Islanders' access to services and care options like procedures with smaller profit margins. To that end, the new system could direct its hospitals to focus on higher revenue-generating care system-wide rather than maintaining the infrastructure to support a full range of services.

The merger is also likely to have a negative impact on wages, benefits, and working conditions for the tens of thousands of Rhode Islanders working in skilled healthcare jobs. While pandemic-related staffing shortages are disrupting healthcare markets across the U.S., leaving hospital administrators struggling to fill open positions, it is important to look beyond the labor conditions created by the pandemic when analyzing a transaction that will change the face of Rhode Island's healthcare landscape for decades. Data, studies, and expert analysis establish that, as the new system becomes the State's largest employer, its extraordinary market power can insulate it from pressures to raise wages and benefits. For a registered nurse living in Warwick, this means that employment options narrow significantly with nearly three quarters of the hospital-based job opportunities in Rhode Island within the proposed merged system.

***Rather than putting the healthcare systems on stronger financial footing, the proposed merger would leave Rhode Island's healthcare system in even greater financial peril.***

The Proposed Transaction is based on a financial paradox: that somehow by combining two organizations that each have significant and distinct financial challenges, Rhode Island would be left with one dominant and financially healthy system that can make substantial investments in prestigious initiatives, all while living up to the Parties' promises not to close facilities or cut services, or pass on those costs to consumers and workers. As explained in Section II.B, the financial realities facing the Transacting Parties make the creation of such a system all but impossible. On the contrary, if the transaction were approved, Rhode Island would be left with almost its entire healthcare infrastructure in one system that is both financially vulnerable and too big to fail at the same time.

Lifespan and Care New England are each currently in tenuous financial condition. In the best of times, these systems have relatively slim margins and modest cash reserves. This allows them to maintain their operations and invest in services to meet the needs of Rhode Islanders. Faced with an ongoing pandemic, and despite cash infusions from federal relief funds, the Parties' own financial projections raise a substantial concern of a combined Lifespan/CNE becoming financially unstable within a few years. While the parties provide blanket assertions that, by combining, the system will be able to achieve healthy operating margins and financial stability, they do not have, and have not gathered, adequate financial information to know whether those prospects are realistic. As a result, neither the Attorney General nor even the Parties' own experts have a basis to conclude a merger is financially feasible.

Additionally, mergers are not a cost-neutral proposition; they require a significant financial investment that these parties are not in a position to make. A combined Lifespan/CNE will need to fund the basic costs of integration such as implementing a uniform information technology system. On top of that, the Parties propose a number of ambitious capital projects as identified in the Chartis Report submitted as part of their Application to merge. But the parties have not calculated how much those initiatives would cost and how a combined entity would pay for them. Given what the Attorney General knows about the financial outlook of a combined entity, answers to these questions are essential.

Despite numerous requests for additional financial information and robust questioning of key executives from both parties during this investigation, the Transacting Parties have failed to provide a realistic plan to create a financially healthy system with enough capital to make their proposals a reality. Instead, they have essentially asked the Attorney General to take them at their word that this transaction is financially feasible and will not endanger Rhode Island's healthcare system.

Notwithstanding all of the above, the Attorney General has no doubt that a combined Lifespan/CNE system would have to develop a plan to improve its financial outlook or face significant financial challenges. But if the Attorney General were to approve this merger as is, without a financial plan, the Parties' path through these financial difficulties would be unreviewable by any public entity, and would not require approval by the Attorney General or Department of Health. If push comes to shove, Lifespan and CNE could be left to use their size, and stranglehold over Rhode Island hospitals, to repair their financial outlook through price increases, layoffs, or asking the State for a bailout. And the record shows they have considered seeking financial support from the State. The Attorney General cannot sanction this type of risk without a realistic plan to maintain financial viability.

***The Parties' claims of attractive outcomes from the integration of their systems is left to future planning and fails to account for the costs and challenges of achieving these outcomes.***

Benefits in the form of a 'cradle to grave' continuum of care for all Rhode Islanders, increased access, reductions in disparities, a new cancer center, a biotech hub, investments in community health, an internationally recognized academic health center, and "destination programs" in behavioral health, cardiac care, women's care and more—all of these are benefits promoted by the Parties to both the public and the Attorney General as outcomes available to Rhode Islanders if this merger is approved. Indeed, they are offered as evidence that this transaction will be transformational and in the best interests of the people of Rhode Island, and are offered as the reason it should be approved.

Yet, the Application for the proposed transaction the Parties submitted to the Attorney General and the Department of Health does not include a system integration plan. It postpones even the planning process for system integration until after the systems are combined at the corporate level and no longer under HCA review.

The Parties' "plan to make a plan" Application contains no commitment to achieving the programs and outcomes they describe. Although outcomes such as these require financing, the Parties have not costed out these claimed benefits to determine their financial feasibility. And,

notwithstanding abundant literature showing that other attempts to achieve such benefits through hospital mergers and consolidations have fallen far short, the Parties have not acknowledged or addressed the large and specific challenges in achieving outcomes like a bio-tech hub or population health improvements.

The Attorney General has been asked to approve a transaction when the Transacting Parties, and the consultants on whom they rely, have not done even basic due diligence to show whether or not what they project is financially or practically realistic, while the evidence suggests it is not. In the absence of a plan, financial projections, and a clear-eyed assessment of potential risks, this Office cannot possibly conclude that these projected benefits, which do not appear to have a likelihood of materializing, outweigh the extraordinary anticompetitive harms.

***The Parties' approach to the merger raises questions about whether they will be able to effectively integrate and improve healthcare delivery and outcomes throughout the state.***

It is important for Rhode Islanders to recognize that this merger is not something for which the State gets a trial run, as Section II.D makes clear. Once the systems combine, it is nearly impossible to “unscramble the eggs” and restore the prior competition in Rhode Island’s healthcare market. This means that Lifespan and Care New England are asking Rhode Islanders to place blind trust in them—that in the absence of financial and system integration plans, we can count on them being able to become financially stable, effectively integrate, and improve healthcare delivery and outcomes throughout the state. The commitment of the systems’ leaders, doctors, nurses, and staff to pursuing these critical goals is more than evident. But, Lifespan and Care New England’s approach to this merger deserves scrutiny when their words in one setting have often diverged from the facts in another.

An important example is the difference between the Parties’ internal and public statements about their status as competitors. Publicly, they have said they are not competitors but offer “complementary” services. However, their own documents consistently show they see each other as their closest competitors. They have also publicly said the new system will improve healthcare quality, while the Attorney General sees evidence that the Parties actually believe that there is not much on quality they do “Better Together.”

The role of Brown is a key example of this dichotomy. While publicly heralding Brown’s involvement in the venture, Lifespan and Care New England structured their transaction and application to exclude the university and keep it largely out of the regulatory review process. One example illustrates this concern. When questioned by regulators about potentially anticompetitive efforts underway to merge Brown’s physician group with Lifespan and Care New England’s physician organizations, the health systems’ leaders paused the three-way consolidation. It is evident to the Attorney General that the Transacting Parties plan to resume those efforts after first securing approval to merge their systems through this HCA application. Sequencing transactions and limiting a key partner’s on-paper involvement are both legal strategies that Lifespan and Care New England are entitled to employ, but their use here does little to allay concerns about allowing the new system to take control of a large part of the State’s healthcare market.



***Conditions and regulation cannot solve the anticompetitive problems created by this merger and the shortfalls in the transaction's financial and integration planning.***

Section II.E demonstrates that the problems created by this type of healthcare consolidation, and the shortfalls in the transaction's integration and financial planning, cannot be solved through more regulation or conditions. Other states have approved mergers of competing hospitals with large market shares and tried to use regulatory constraints, like hospital price controls, to protect patients from the dangers of a highly concentrated healthcare market. These regulatory approvals consistently result in higher costs over the long term without improving quality. These new hospital systems have often used their market power and influence to remove the regulatory constraints, leading to single year price increases as high as 20 to 40 percent. State-level attempts to ensure better healthcare quality following a consolidation have also struggled, with one recent merger of competing hospitals resulting in an immediate decline across most quality metrics, including patient satisfaction.

While Rhode Island has taken important steps to control hospital price growth through its Office of the Health Insurance Commissioner ("OHIC"), this agency and the tools at its disposal are also insufficient to regulate a new system that will dominate the State's healthcare market, a fact that OHIC's commissioner has acknowledged. Existing and new regulatory approaches are unlikely to succeed because, contrary to Lifespan and Care New England's claims, the competition between the systems' hospitals is significant. Care New England's Kent Hospital competes head-to-head with Lifespan's Rhode Island Hospital and The Miriam Hospital on approximately 90 percent of the hospital services it offers on a volume adjusted basis. But, even if Kent Hospital were not part of the Proposed Transaction, the merger would still eliminate significant competition in the markets for behavioral health, outpatient surgical services, primary care, and the labor market, as Section II.A.6 shows. Where competition is eliminated in so many different areas, it is particularly challenging to identify structural or regulatory remedies—the market power of such a system is difficult for regulators to constrain because the system controls so many healthcare services.

While this Office is of the view that they would nevertheless be insufficient, Lifespan and Care New England's leaders have shown little appetite for any of the above-described measures. They have balked at strengthening OHIC's authority, and objected to the agency's existing cap on hospital rates, with CNE's hospitals filing suit against OHIC in January 2022. The leaders of the two systems have also been reluctant to make firm commitments that would control costs, promote quality improvements, and ensure sufficient oversight.

Finally, the Attorney General acknowledges and applauds the impressive efforts of the Rhode Island Foundation and other stakeholders across the State's healthcare landscape to develop a thoughtful set of recommendations for conditions and initiatives the Parties could pursue. While the Attorney General has concluded, after careful consideration, that they are unable to cure the harms posed by the new system's market power, many are worthy opportunities that Lifespan and Care New England could pursue without merging.

***The fate of healthcare in Rhode Island does not depend on the Proposed Transaction and the Attorney General must promote competition and preserve the financial viability of the State's hospitals until structural reforms are embraced and pursued.***

The Attorney General appreciates the question that inevitably flows from this Office's decision to deny the merger application: if Lifespan and Care New England do not merge, what is next for healthcare in Rhode Island?

Some supporters of the merger contend that, notwithstanding the competition problems created by the deal, anything short of a combination of Lifespan and Care New England will lead to a loss of Rhode Island patients, talent, and control to Boston- or New Haven-based healthcare systems. As Section II.A explains, these assertions overlook important realities, like the preference Rhode Islanders have for healthcare facilities within a 30-minute drive of their homes. Data shows that nearly 90 percent of Rhode Islanders receive inpatient care at Rhode Island hospitals. When patients leave the state, they usually do it because they are going to nearby hospitals, as St. Anne's or Charlton Memorial in Fall River are for Bristol, Tiverton, and Warren residents, or because they are receiving specialized care, like cardiac care or cancer treatments in Boston at two of the world's top ranked hospitals—Brigham & Women's/Dana Farber and Mass General. It is unlikely that a potential future merger with an out-of-state party would significantly change either of these patterns of Rhode Islanders crossing the border for care. On the contrary, we could expect that competition would continue to apply pressure on any new entities to meet the needs and preferences of Rhode Islanders by serving them locally.

There is a further concern that, absent the opportunities presented by the merger, Rhode Island doctors, health system leaders, and their control over Rhode Island's hospitals will shift to neighboring states. Evidence shows these worries are not realistic. Around 50 percent of physicians who completed medical school and residency at Brown, the State's only medical school, practice in Rhode Island, suggesting that the state already is an attractive home for talented medical professionals. Fears about the health systems' experienced leaders suddenly turning to Massachusetts, at Rhode Island's expense, also seem exaggerated when Lifespan's current board chair lives in Rehoboth and Care New England's president regularly sees patients at UMass Memorial Medical Center in Worcester. Finally, those unsettled by the recent growth of Massachusetts and Connecticut health systems should take comfort in knowing that any future proposal to acquire a Rhode Island hospital will be subject to a similar regulatory review by the Attorney General's Office and the Department of Health under state law. And while, as explained more fully in this Decision, the Office does not have adequate regulatory tools or conditions sufficient to cure the anticompetitive harms of this Proposed Transaction, the HCA does have tools to address concerns regarding local governance and control.

Furthermore, the review of this transaction has shown that there could be more competition in the marketplace and that Rhode Islanders would benefit from such an increase. Lifespan, for instance, could revisit its choice to not compete with Care New England for obstetrics patients. Lifespan could also withdraw from its anticompetitive ground lease with Care New England, whereby Women & Infants Hospital occupies the land on which it sits for \$100 a year but is prohibited from competing with neighboring Rhode Island Hospital by expanding its services beyond maternity and gynecology.

While many have expressed appropriate concern regarding the role of for-profit actors in health care, the Attorney General has demonstrated an understanding of and willingness to act on the specific perils and concerns posed by transactions involving for-profit health systems seeking to acquire Rhode Island hospitals. In the Prospect Medical HCA decision issued in June 2021, the Attorney General imposed unprecedented conditions to safeguard two Rhode Island hospitals. Any similar proposed merger or acquisition will require robust review under the HCA, and the Attorney General will continue to scrutinize these transactions to safeguard care, access, and affordability for healthcare in Rhode Island. Again, while the Office does not have regulatory tools or conditions to prevent the competitive harms of this Proposed Transaction, there are tools to guard against bad actors in the for-profit space.

Promoting competition and preserving the solvency of Rhode Island’s hospitals are key objectives for regulators until state leaders decide to pursue more ambitious healthcare reform, and until those efforts are accompanied by meaningful support and reform at the federal level. One example of a more ambitious reform would be Maryland’s state-set hospital rates and caps on healthcare spending and hospital revenues. But to follow in Maryland’s path, Rhode Island leaders would be unable to go it alone because these kinds of structural reforms require the federal government’s assistance and support. In Maryland, the federal government has historically agreed to pay more for Medicaid and Medicare patients if hospitals agreed to accept lower rates for commercially insured patients, creating a single “all-payer” rate set by the state.

The Hospital Conversions Act and Rhode Island’s antitrust laws are critical tools, and this Office’s regulatory and oversight role in the context of mergers and acquisitions cannot be discounted. But these laws and regulatory review processes are not appropriate vehicles to redesign Rhode Island’s healthcare market, and we need to stop relying on them as the only avenues for reform.

Under the HCA, the Attorney General must review the transaction that is before it—the merger proposed by Lifespan and Care New England. And, based on the extensive review conducted by this Office, and as more fully set forth in this Decision, the transaction that is before this Office must be DENIED.

#### ***A Note about Redactions in this Decision***

As part of this Office’s role as regulator under the Hospital Conversions Act, the Attorney General takes seriously the Office’s obligation to the public to ensure the greatest degree of public access and transparency possible—both with respect to the application and materials that were before the Attorney General, as well as the bases for this decision. When the Office considers a proposed merger that would impact healthcare in Rhode Island for decades, it is imperative that the public understands what the parties were proposing to do, and why the application must be denied.


The Attorney General has an equally important obligation under state and federal law to responsibly manage and safeguard certain highly sensitive and confidential information that the

Parties provide to the Office in good faith in order to facilitate the review. In the normal course, under the HCA, the release of the Decision is followed by a thorough review of all records and information that the parties deem confidential so that the Office can independently make or revise its own confidentiality determinations.

The Parties have strongly maintained that the redacted information in documents and testimony is confidential, sensitive and competitive business information that, in the hands of their competitors, could do harm to their respective organizations. The Attorney General would only be in a position to lift redactions with the consent of the Parties, and they may not be willing to give such consent because, notwithstanding their public representations to the contrary, they are in fact each other's primary competitors.

Accordingly, the redactions in today's Decision reflect the Attorney General's legal obligation to respect the determinations of the parties at this time and out of an abundance of caution. They do not reflect this Office's determinations as to whether or not the underlying information is or will remain confidential. Particularly given that the transaction is being denied, the Attorney General feels an obligation to protect the Parties' confidentiality requests, as either or both may now choose to seek out a different partner with which to join.

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## I. Introduction

### A. Background

The Hospital Conversions Act (“HCA”) requires the Attorney General to review a proposed hospital conversion to “[a]ssure the viability of a safe, accessible and affordable healthcare system that is available to all.”<sup>1</sup> A HCA review begins when the “Transacting parties” (“Parties”) file a hospital conversion application.<sup>2</sup> As set forth in the application for the Proposed Transaction (the “Application”), the Parties are defined collectively as: the Rhode Island Academic Health Care System, Inc.; Care New England Health System (“CNE”); Kent County Memorial Hospital; Women & Infants Hospital of Rhode Island; Butler Hospital; Lifespan Corporation (“Lifespan”); Rhode Island Hospital; The Miriam Hospital; Newport Hospital; and Emma Pendleton Bradley Hospital.<sup>3</sup> Lifespan, CNE, and all of their hospitals are Rhode Island non-profits and both systems are headquartered in Providence, Rhode Island.<sup>4</sup> The Attorney General and the Rhode Island Department of Health (“RIDOH”) (together, the “Agencies”) conduct concurrent reviews of a HCA application submitted by two nonprofit corporations.<sup>5</sup>

The Parties filed the Application on April 26, 2021. They resubmitted the Application on October 1, 2021. In the Application, the Parties describe the transaction for which they are seeking approval: Lifespan and CNE both designate Rhode Island Academic Health Care System, Inc. (“RIAHCS”) as their sole corporate member, with RIAHCS thereby becoming their parent corporation. The Parties anticipate that governance for RIAHCS will include a board of 15 to 33 members, including the CEOs of Lifespan and CNE, who will serve as co-CEOs of RIAHCS until the selection of a new CEO of RIAHCS.<sup>6</sup> Once that new CEO is chosen, the co-CEOs will be replaced by the new board.<sup>7</sup> The co-CEOs, however, will chair a “Pre-Integration Steering Committee” for two years post-closing.<sup>8</sup> This is the committee the Parties expect to

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<sup>1</sup> R.I. Gen. Laws § 23-17.14-3(1).

<sup>2</sup> “Transacting parties” is defined at R.I. Gen. Laws §23-17.14-4(17).

<sup>3</sup> Hospital Conversion Application, resubmitted Oct. 1, 2021 (“Application”), R-CNE-LS-0000001 at -015. Hasbro Children’s Hospital is the pediatric division of Rhode Island Hospital and shares the same license.

<sup>4</sup> Application at R-CNE-LS-0000027-28.

<sup>5</sup> R.I. Gen. Laws § 23-17.14-9 (“The review by the two (2) departments shall occur concurrently and neither department shall delay its review or determination because the other department has not completed its review or issued its determination.”). R.I. Gen. Laws § 23-17.14-10 governs the review process for the Attorney General and RIDOH when the transacting parties are nonprofits.

<sup>6</sup> Definitive Agreement By and Between Care New England Health System and Lifespan Corporation dated February 23, 2021, Article 4, R-CNE-LS16-0000807-811.

<sup>7</sup> *Id.*, R-CNE-LS16-0000808.

<sup>8</sup> *Id.*, R-CNE-LS16-0000811.

lead post-closing integration planning, which will not commence until the Parties are consolidated at the corporate level.<sup>9</sup>

The Parties “envision [ ] a new System Academic Affiliation Agreement between the [AHS] and Brown [University].”<sup>10</sup> Brown University (“Brown”) is not a transacting party to the Proposed Transaction but currently has separate affiliations with Lifespan and CNE.<sup>11</sup> In the Application, the Parties propose, but do not commit, to filling up to three (3) RIAHCS board seats with Brown representatives. They also suggest that RIAHCS may finalize a new affiliation agreement with Brown prior to the closing of the Proposed Transaction. But neither granting Brown board seats nor finalizing a new affiliation agreement is a condition to closing the Proposed Transaction. In other words, references to a role for Brown in the Application is precatory, and any benefits or obligations arising from Brown’s involvement with RIAHCS at this point is limited to a minimum contribution by Brown of \$125 million over five years. This funding commitment is evaluated in more detail below in Section II.B, along with the financial feasibility of the Proposed Transaction.

The HCA allows the Attorney General to consider “[w]hether the board considered the proposed conversion as the only alternative or as the best alternative in carrying out its mission and purposes.”<sup>12</sup> Here, the Parties state in the Application that a CNE and Lifespan merger is of a “unique nature” and “CNE and Lifespan were in exclusive talks together and not comparing one or more health care providers.”<sup>13</sup>

## **1. Procedural history**

### **a. The Parties’ HCA Application**

The Parties filed the first Application on April 26, 2021. After review, the Attorney General and RIDOH issued a joint deficiency letter dated May 26, 2021 stating that the Application, as received, was deficient. “To attempt to redress the inadequacy of the Parties’ Initial Application,”<sup>14</sup> the Attorney General and RIDOH requested that the Parties provide “complete, accurate, and forthright responses” to 196 deficiency questions (the “First Deficiency Questions”).<sup>15</sup> The First Deficiency Questions requested *inter alia* additional financial data, governance information – and the Parties’ plan for system integration.

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<sup>9</sup> *Id.*

<sup>10</sup> Application at R-CNE-LS-0000020.

<sup>11</sup> *Id.*

<sup>12</sup> R.I. Gen. Laws § 23-17.14-10(b)(4).

<sup>13</sup> HCA Application at 29, R-CNE-LS-0000043.

<sup>14</sup> Letter from Jessica Rider and Fernanda Lopes to P. Rocha (May 26, 2021).

<sup>15</sup> *Id.* at Exhibit A.

Pursuant to the HCA, responses to deficiency questions are due to regulators within thirty (30) working days after being requested.<sup>16</sup> Following submission of the initial Deficiency Questions, the Parties requested extensions of time to respond and the Agencies granted the extensions. On September 10, 2021, the Agencies issued a second joint deficiency letter identifying a non-exhaustive list of specific topics reflecting “significant areas of deficiencies” including integration plans (the “Second Deficiency Questions”).<sup>17</sup> On October 1, 2021, the Parties resubmitted the Application in response to the Second Deficiency Questions. By letter dated November 16, 2021, the Attorney General and RIDOH deemed the Application complete as submitted on October 1, 2021.

**b. The Attorney General and the Federal Trade Commission**

As discussed in Section II.A below, the Attorney General completed a 12-month-long investigation into whether the proposed merger between Lifespan and CNE is proper under the Rhode Island Antitrust Act.<sup>18</sup> During the same period, the Federal Trade Commission (“FTC”) conducted a pre-merger review of the proposed merger under federal antitrust law. Because the Attorney General’s investigation and the FTC’s review address the same question – namely, the implications of the merger under their respective antitrust laws – the two agencies have coordinated with each other in gathering and analyzing information from the Parties as well as from nonparties. For example, the FTC was generally present for statements under oath taken by the Attorney General and the agencies jointly took testimony. This coordination has not only allowed the agencies to conserve resources, but has also benefitted the Parties who, for example, avoided the burden of making witnesses available for separate interviews with each agency.

Notwithstanding the agencies’ coordination, this Decision reflects the independent determination of the Attorney General and of the Attorney General only.<sup>19</sup>

**c. Post-completeness review of HCA application**

Included with the notification of completeness to the Parties was a first set of supplemental questions containing 75 questions. On December 7, 2021, the Attorney General and RIDOH sent the Parties a second set of supplemental questions containing 95 questions.<sup>20</sup> To date, the Attorney General collected more than 3.6 million documents (totaling over 11 million pages). This includes the Application and its exhibits; responses to the first and second sets of supplemental questions; and information specific to the antitrust review under the HCA

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<sup>16</sup> R.I. Gen. Laws § 23-17.14-10(a)(2).

<sup>17</sup> Letter from Jessica Rider and Fernanda Lopes to P. Rocha (Sep. 10, 2021) at 2.

<sup>18</sup> R.I. Gen. Laws § 23-17.14-10(b)(22), discussed *infra*.

<sup>19</sup> As discussed *infra*, the Attorney General engaged the law firm of Farella Braun + Martel LLP to serve as its outside counsel in its investigation of antitrust issues.

<sup>20</sup> An Amended Second Set of Supplemental Questions was sent on December 10, 2022 addressing clarifications to S2-40 and S2-55. A third set of supplemental questions was sent to the Transacting Parties by RIDOH only.

criteria at R.I. Gen. Laws §23-17.14.-10(b)(22), including from nonparty insurers and nonparty hospital providers.

The Attorney General is permitted under the HCA to take sworn testimony of witnesses as part of the review of a transaction.<sup>21</sup> Since November 2021, the Attorney General obtained statements under oath related to the Proposed Transaction from many individuals, including:

***Lifespan***

1. Dr. Timothy Babineau, President and CEO, Lifespan
2. Lawrence Aubin, Sr., Chair of Board of Directors, Lifespan
3. Jane Bruno, Senior Vice President of Marketing and Communications, Lifespan
4. Jessica Gelinis, Manager, Planning and Analysis, Lifespan
5. Dr. Margaret Miller, Chief of Women's Medicine, Lifespan Physician Group
6. Daniel Moynihan, Vice President of Contracting and Payer Relations, Lifespan
7. Cedric Priebe, Director of Information Services, Lifespan
8. Dr. Saul Weingart, President, Rhode Island Hospital and Hasbro Children's Hospital, Lifespan
9. Mamie Wakefield, retired Executive Vice President and Chief Financial Officer, Lifespan

***Care New England***

9. Dr. James Fanale, President and CEO, CNE
10. Robert Haffey, President and Chief Operating Officer, Kent County Hospital, CNE
11. Joseph Iannoni, Chief Financial Officer, CNE
12. Phil Kahn, Chief Information Officer, CNE
13. Mary Marran, President and Chief Operating Officer, Butler Hospital, CNE
14. Heather-Rose Mattias, Director of Contract Administration and Payer Relations, CNE
15. Charles Reppucci, Chair of Board of Directors, CNE

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<sup>21</sup> R.I. Gen. Laws §23-17.14-14(a).

16. Gail Robbins, Senior Vice President, Planning and Finance, CNE
17. Shannon Sullivan, President and Chief Operating Officer, Women & Infants Hospital, CNE

The Attorney General also took statements under oath of key consultants that the Parties engaged specifically for the Proposed Transaction. Similarly, the Attorney General took statements under oath from former Kent President and Chief Operating Officer Dr. Michael Dacey and from representatives of Brown, including President Christina Paxson, Dr. Jack Elias, Dean of Medicine and Biology and Senior Vice President for Health Affairs, and Kimberly Galligan, Dean of Administration at Brown's medical school. Finally, as part of its antitrust review under the HCA, the Attorney General obtained sworn declarations from representatives of Blue Cross Blue Shield of Rhode Island and South County Health.

As Section III details, the Attorney General also considered public comments received during the course of its review. The Attorney General and RIDOH jointly held three public meetings about the Proposed Transaction via Zoom on January 20, 2022, January 26, 2022, and February 10, 2022. Public notices were published regarding these meetings. Written comments regarding the Proposed Transaction were also solicited through those public notices and accepted through February 11, 2022. At the beginning of each public meeting, the Parties were provided an opportunity to give comments regarding the Proposed Transaction; afterwards, comment from the public were taken. Over the course of the three meetings, 55 speakers (excluding Dr. Babineau, Dr. Fanale, and Brown President Christina Paxson) provided public comment. Over 600 individuals attended the three meetings in total, with the first two meetings having over 250 participants each. In addition to the public comments provided at each public meeting, about 200 written comments were received by the Attorney General and RIDOH and are publicly available on the Agencies' respective websites.<sup>22</sup> The transcripts and audio recordings of each public meeting are available on both the Attorney General's website and RIDOH's website.<sup>23</sup>

The Attorney General is grateful for the public's interest in and comments on the Proposed Transaction. In issuing this Decision, the Attorney General has had the advantage of accessing millions of documents, healthcare data, and expert analysis that was unavailable – and may continue to be unavailable for confidentiality reasons – to members of the public and key stakeholders. The Attorney General is uniquely positioned to reach the conclusions that it did because of its thorough review of all of the information accessible to its Office, both public and confidential, under its HCA and antitrust authority.

Acknowledging the complexity and far-reaching impacts of hospital conversion matters, the HCA permits the Attorney General, at the expense of the Parties, to “engage experts or consultants including, but not limited to, actuaries, investment bankers, accountants, attorneys, or

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<sup>22</sup> Attorney General: [RIAG.ri.gov/about-our-office/divisions-and-units/civil-division/public-protection/healthcare](https://riag.ri.gov/about-our-office/divisions-and-units/civil-division/public-protection/healthcare) (under “Recent HCA Reviews”) RIDOH: [Health.ri.gov/programs/hospitalconversionsmerger/](https://health.ri.gov/programs/hospitalconversionsmerger/) (under “Pending HCA Applications”).

<sup>23</sup> *See id.*

industry analysts.”<sup>24</sup> In addition to the Attorney General’s internal team of five attorneys, the Attorney General engaged the following experts to assist in this review:

**Farella Braun + Martel LLP**, outside legal counsel (San Francisco, CA)

Farella Braun + Martel’s Healthcare Litigation & Investigations practice is nationally recognized. Farella represented the plaintiff class in the landmark healthcare antitrust action against Sutter Health. The case settled minutes before opening statements for \$575,000,000 and comprehensive injunctive relief that will be overseen by a court-appointed monitor over the next 10-13 years. As Harvard Business School Professor Leemore Dafny stated in the *Los Angeles Times*, the Sutter “settlement has provided a marker for the rest of the nation.” Farella has been retained by, and worked with, state attorneys general across the country in connection with healthcare antitrust matters. The expertise of Farella’s Healthcare Litigation & Investigations extends beyond physical health. Last year, the Chief Magistrate Judge of the United States District Court for the Northern District of California appointed a senior member of Farella’s Healthcare Litigation & Investigations practice to oversee the injunctive relief ordered in the *Wit v. United Behavioral Health* action. The Farella team of attorneys, led by Christopher Wheeler, and including Janice Reicher, Jin Kim, Claire Johnson, Kelsey Mollura, and Richard Young, provided antitrust counsel to the Attorney General.

**Shipman & Goodwin, LLP**, outside legal counsel (Hartford, Connecticut)

Shipman & Goodwin, LLP has over 75 years of experience representing hospitals, academic medical centers, hospital systems, integrated health networks, community-based providers, behavioral health and substance-use disorder providers, federally qualified health centers, home health agencies, skilled nursing facilities, life-science companies, and insurers. More specifically, Shipman regularly advises its healthcare clients on regulatory matters and corporate transactions, including corporate affiliations, mergers, joint ventures, and other business combinations. The Shipman team of attorneys, led by Joan Feldman, and including Vincenzo Carannante, Mark Ostrowski, Patrick Fahey, and Christopher Cahill, provided consultative advice and legal services to the Attorney General.

**Dr. Kevin Pflum**, healthcare economics expert; Principal at Bates White Economic Consulting (Washington, DC)

Dr. Kevin Pflum is a principal in the healthcare practice of Bates White, a leading economic consulting firm. He has extensive experience analyzing the competitive effects of mergers and acquisitions in the healthcare industry and has worked on the last two hospital mergers challenged by the FTC. He supported the FTC in its successful action to enjoin Hackensack Meridian Health’s proposed acquisition of Eaglewood Health. He supported Jefferson Health and Albert Einstein Healthcare Network in their successful opposition to the FTC’s challenge to their proposed merger. Dr. Pflum also supported Beaumont Health and Spectrum Health during the FTC’s investigation of their proposed merger, which closed in January of this year. Dr. Pflum has published several articles on the issues of hospital and provider competition and their effects on prices and quality that have appeared in economic

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<sup>24</sup> R.I. Gen. Laws § 23-17.14-13.



journals, including the *RAND Journal of Economics*, the *American Economic Journal*, and the *Journal of Economics and Management Strategy*. Dr. Pflum conducted healthcare economic analysis for the Attorney General.

**Veralon Partners**, healthcare finance experts (Bala Cynwyd, Pennsylvania)

Veralon Partners is a healthcare consulting firm with over 25 years of experience and has served over 1,300 healthcare clients including: health systems, community hospitals, teaching hospitals, academic medical centers, physician groups, ACOs/PHOs/CINs and health plans. For example, Veralon assisted the Massachusetts Health Policy Commission in their review of Partners HealthCare System's proposed acquisition of Hallmark Health Corporation. Similarly, Veralon assisted Massachusetts-based Beth Israel Deaconess Medical Center, Lahey Health, and other affiliates in responding to regulatory review of their proposed merger by the Massachusetts Department of Health, Health Policy Commission, and Office of Attorney General. The Veralon team of consultants, led by Danielle Bangs and Dave Robeson, conducted financial feasibility analyses for the Attorney General.

**Professor Lawton R. Burns**, Ph.D, MBA, Healthcare management expert; Wharton School of Business at University of Pennsylvania (Philadelphia, PA)

Professor Lawton Burns is the James Joo-Jin Kim Professor of Health Care Management at the Wharton School and Director of the Wharton Center for Health Management and Economics. He is one of the nation's leading scholars in the field of healthcare management and has spent the past two decades studying clinical integration in hospital systems and in physical-hospital vertical arrangements, conducting work on behalf of the FTC, Department of Justice, and the Attorney General of Washington State. Professor Burns has a Ph.D in organizational sociology and an MBA in hospital administration. Professor Burns's research focuses on organized delivery systems, including physician group practices, physician practice management companies (PPMCs), ambulatory surgery centers (ASCs), and a variety of integrated delivery networks (IDNs) such as physician-hospital organizations (PHOs), management services organizations (MSOs), clinically integrated networks (CINs), accountable care organizations (ACOs), and economic and clinical integration. He is the published author of countless papers and books on hospital consolidation, most recently *Big Med: Megaproviders and the High Cost of Healthcare in America* (2021) and *The US Healthcare Ecosystem: Payers, Providers, Producers* (2021). He is also the co-editor of the textbook *Health Care Management: Organization Design and Behavior* (2012), and the author of *India's Healthcare Industry* (Cambridge, 2014), *The Business of Healthcare Innovation*(Cambridge, 2012), and *The Health Care Value Chain* (2002). Professor Burns conducted healthcare management analysis for the Attorney General.

**ECG Management Consultants**, Boston, Massachusetts

ECG Management Consultants is a nationwide consulting firm that typically works exclusively with healthcare organizations. Led by ECG's newly named president, Christopher T. Collins, ECG provided consultative advice on integration and information technology issues to the Attorney General.

**d. Confidentiality review**

The Attorney General “has the power to decide whether any information required by this chapter of an applicant is confidential and/or proprietary.”<sup>25</sup> Due diligence documents must remain confidential under the HCA.<sup>26</sup> Due diligence documents aside, information is considered for redaction or, in some instances, wholesale withholding only if the Parties request that material be considered confidential and withheld from public view. While the HCA gives the Attorney General sole authority and discretion to make confidentiality determinations, the Attorney General must consider legal precedent and statutes in its confidentiality determinations. Such precedents include Exemption 4 of the Freedom of Information Act and Rhode Island’s Access to Public Records Act at R.I. Gen. Laws § 38-2-2(4)(B), which require that commercial, financial, and/or trade secret information remain confidential. Confidentiality determinations were made with respect to the October 1, 2021 HCA Application and generally fell into three categories: due diligence, confidential business/proprietary information (*i.e.* information of a highly sensitive competitive nature, the disclosure of which could harm the Parties), and personally identifiable information. Confidentiality determinations as to testimony transcripts and responses to the supplemental questions are ongoing, and the results of those determinations will be made public once complete.

As part of its role as regulator under the HCA, the Attorney General’s Office takes seriously its obligation to the public to ensure the greatest degree of public access and transparency possible – both with respect to the Application and materials that come before it, as well as with respect to the bases for its decision. When the Office considers a proposed merger that would impact health care in Rhode Island for decades, it is imperative that the public understands what the parties are proposing to do, and the reasons for the Decision the Office makes.

The Attorney General’s Office has an equally important legal obligation to manage responsibly and safeguard certain highly sensitive and confidential information that the Parties provide to it in good faith in order to facilitate its review. Because at present there are outstanding confidentiality determinations that have not been resolved, the release of a redacted Decision is followed by a thorough review of the records and information that the parties have asserted is confidential so that the Office can independently make or revise its own confidentiality determinations.

The Parties here have vociferously maintained that the redacted information in documents and testimony is confidential, sensitive, and competitive business information that, in the hands of their competitors, could do harm to their respective organizations. The Attorney General would be in a position to lift redactions only with the consent of the Parties, and they may not be willing to give such consent because, notwithstanding their public representations to the contrary, they are in fact each other’s primary competitor.

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<sup>25</sup> R.I. Gen. Laws § 23-17.14-32

<sup>26</sup> R.I. Gen. Laws § 23-17.14-6(a)(31)

Accordingly, the redactions in today’s Decision reflect the Attorney General’s legal obligation to respect the determinations of the Parties at this time and out of an abundance of caution. They do not reflect the Attorney General’s final determinations as to whether or not the underlying information is or will remain confidential. Particularly given that the transaction is being DENIED, the Attorney General maintains an obligation to protect the Parties’ confidentiality requests, as either or both may now choose to seek out a different partner with which to combine.

## 2. Prior attempts to merge

This is the third time Lifespan and CNE have attempted to merge within the past 24 years, most recently in 2007.<sup>27</sup> Lifespan and CNE signaled their intention to merge on July 26, 2007 and underwent review by this Office and the RIDOH for the next 31 months before ultimately withdrawing their application on February 25, 2010. On December 31, 2010, former Attorney General Patrick Lynch issued a decision accepting the Parties’ withdrawal.<sup>28</sup>

Both Lifespan and CNE also have abandoned merger attempts with other entities. Most recently, on December 17, 2018, Massachusetts-based Partners HealthCare System, Inc. and CNE filed a HCA Application with the Attorney General and RIDOH. Partners withdrew its Application on June 4, 2019, at the same time then-Governor Raimondo announced she had “asked Lifespan, CNE, and Brown University to resume negotiations and determine whether they can come to an agreement that would create a locally-run, academic medical center in Rhode Island.”<sup>29</sup> This request has resulted in the Application that is the subject of this Decision.

In 1997, Lifespan entered an agreement with New England Medical Center (NEMC – also known as Tufts Medical Center) under which Lifespan would become NEMC’s corporate parent and NEMC would operate as one of the hospital subsidiaries in Lifespan’s system. According to court documents, “Lifespan saw the proposed affiliation as an opportunity to expand its healthcare system beyond Rhode Island into Massachusetts, in preparation for what it anticipated (wrongly, as it turned out) would be a movement toward ‘regionalization’ of the healthcare industry across state lines.”<sup>30</sup> The affiliation ran for five years (1997-2002) and ended in a disaffiliation agreement for various reasons, including that “the parties were unable to grow

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<sup>27</sup> See Alexa Gagosz, *Lifespan and Care New England’s merger application was just deemed ‘complete.’ Here’s how the R.I. hospital systems got to this point*, The Boston Globe (Nov. 16, 2021), [BostonGlobe.com/2021/11/11/metro/lifespan-care-new-englands-merger-application-could-soon-be-deemed-complete-heres-how-ri-hospital-systems-got-this-point/#:~:text=Nov.,the%20proposed%20merger%20with%20conditions](https://www.bostonglobe.com/2021/11/11/metro/lifespan-care-new-englands-merger-application-could-soon-be-deemed-complete-heres-how-ri-hospital-systems-got-this-point/#:~:text=Nov.,the%20proposed%20merger%20with%20conditions). The systems proposed to merge in 1998, 2007, and today in 2021. The Attorney General considered the application filed in 2007 and again in 2009 as one transaction, as the 2009 application was resubmitted after the Parties were told that the 2007 application was incomplete.

<sup>28</sup> Decision by Attorney General Lynch dated December 31, 2010.

<sup>29</sup> Press Release, RI.gov, Governor Raimondo Asks Lifespan, Care New England to Reconsider Plans for Integrated Academic Hospital System Jun. 4, 2019, <https://www.ri.gov/press/view/36014>.

<sup>30</sup> *Lifespan v. NEMC et al.*, Civil No. 06-cv-421-JNL, Opinion No. 2011 DNH 083, 5/24/11 at ¶ 6. (*Lifespan v. NEMC, et al. CV-06-241-JL 5/24/11 (uscourts.gov)*).

a network in Massachusetts” and NEMC lost money the last two years of the affiliation.<sup>31</sup> There also seems to have been what could be characterized as a cultural or administrative difference that resulted in NEMC becoming “increasingly upset with Lifespan over the performance of its health insurer contracts . . . the unfavorable outcome of a complex financial transaction . . . and the amount of Lifespan’s corporate overhead charges.”<sup>32</sup> It should be noted that the court found that Lifespan dealt with NEMC in good faith.

## **B. Review criteria**

With respect to every review under the HCA, the Attorney General must “[a]ssure the viability of a safe, accessible and affordable healthcare system that is available to all.”<sup>33</sup> The HCA further specifies that the Attorney General’s review will culminate in a decision approving, approving with conditions, or disapproving the conversion within 120 days of completeness.<sup>34</sup> In reaching this Decision, the Attorney General “may consider” twenty-two (22) enumerated criteria in reviewing an application for a conversion where the transacting parties are not-for-profit corporations.<sup>35</sup> Consideration of these criteria specific to the Attorney General is discretionary, with good reason. Each proposed transaction under the HCA is different in scope and content, with different parties and different goals. Not all 22 criteria are applicable to every transaction. For the proposed merger of Lifespan and CNE, the Attorney General focused its review on whether the transaction as proposed is proper under the Rhode Island Antitrust Act; whether the transaction as proposed is financially feasible; and whether the integration as proposed is realistically achievable. Each of these areas of review is described in more detail below, but at the outset, the relevant criteria as applied to these analyses are:

- whether the board of each system, when deciding to pursue the transaction, established appropriate criteria and considered whether the transaction is the only or best alternative, all in relation to the mission and purpose of each system;<sup>36</sup>
- whether the boards “exercised due care in accepting assumptions and conclusions provided by consultants engaged to assist in the proposed conversion;”<sup>37</sup>
- [w]hether the proposed conversion will harm the public’s interest in trust property given, devised, or bequeathed to the existing hospital for charitable, educational, or religious purposes located or administered in this state;<sup>38</sup>

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<sup>31</sup> *Id.* at ¶¶ 13-15.

<sup>32</sup> *Id.* at ¶14.

<sup>33</sup> R.I. Gen. Laws § 23-17.14-3(1).

<sup>34</sup> R.I. Gen. Laws § 23-17.14-10(a)(4).

<sup>35</sup> R.I. Gen. Laws § 23-17.14-10(b).

<sup>36</sup> R.I. Gen. Laws § 23-17.14-10(b)(3) and (4).

<sup>37</sup> R.I. Gen. Laws § 23-17.14-10(b)(8).

<sup>38</sup> R.I. Gen. Laws § 23-17.14-10(b)(1).

- [w]hether a trustee or trustees of any charitable trust located or administered in this state will be deemed to have exercised reasonable care, diligence, and prudence in performing as a fiduciary in connection with the proposed conversion;<sup>39</sup>
- [w]hether the proposed conversion contemplates the appropriate and reasonable fair market value;<sup>40</sup>
- [w]hether the proposed conversion was based upon appropriate valuation methods including, but not limited to, market approach, third-party report, or fairness opinion;<sup>41</sup>
- [w]hether the proposed conversion is proper under chapter 36 of title 6 ('Rhode Island Antitrust Act');<sup>42</sup> and
- [w]hether the proposed conversion "[a]ssure[s] the viability of a safe, accessible and affordable healthcare system that is available to all."<sup>43</sup>

The identified criteria provided the Attorney General the requisite lens with which to view the record and make a determination whether to approve, approve with conditions, or disapprove the Proposed Transaction.

The Attorney General's authority under the HCA includes the authority to "adopt rules and regulations to accomplish the purpose of this chapter."<sup>44</sup> This authority is relevant to the Attorney General's construction of the HCA provisions discussed above and elsewhere in this Decision. The construction of various HCA provisions is also provided with an awareness that Rhode Island law "accord[s] great deference to an agency's interpretation of its rules and regulations and its governing statutes, provided that the agency's construction is neither clearly erroneous nor unauthorized."<sup>45</sup>

## II. Discussion

Analysis of the Proposed Transaction under the HCA requires this Office to determine (1) whether the Proposed Transaction is proper under Rhode Island's antitrust laws, (2) whether

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<sup>39</sup> R.I. Gen. Laws § 23-17.14-10(b)(2).

<sup>40</sup> R.I. Gen. Laws § 23-17.14-10(b)(14).

<sup>41</sup> R.I. Gen. Laws § 23-17.14-10(b)(15).

<sup>42</sup> R.I. Gen. Laws § 23-17.14-10(b)(22).

<sup>43</sup> R.I. Gen. Laws § 23-17.14-3(1).

<sup>44</sup> R.I. Gen. Laws § 23-17.14-32(b).

<sup>45</sup> *Endoscopy Assocs., Inc. v. R.I. Dep't of Health*, 183 A.3d 528, 533 (R.I. 2018). As the seat of the Office of Health Care Advocate, the Attorney General also has the power "[t]o take all necessary and appropriate action . . . to secure and insure compliance with the provisions of title[] 23," which includes the HCA. R.I. Gen. Laws § 42-9.1-2(a)(5).

the merged Lifespan/CNE entity would be financially viable, and (3) whether the Parties realistically can achieve the claimed benefits of the Proposed Transaction.

As described more fully in Section II.A of this Decision, the Proposed Transaction would have significant anticompetitive effects – in terms of cost, quality, access, and labor for nurses in Rhode Island – and is improper under Rhode Island’s antitrust laws. This finding alone is enough to deny the application under the HCA. As set forth in Section II.B, the Proposed Transaction also threatens the financial viability of the two systems and would leave them facing greater financial peril than they already face. As described in Section II.C, the Parties have failed to provide a detailed plan regarding how the two systems would integrate and how that integration would result in the benefits the Parties claim will be achieved. Furthermore, as described in Section II.D, because the risks are great, and because the Attorney General cannot afford to give the Proposed Transaction a trial run, the Parties’ approach to this transaction warrants scrutiny and underscores the need for caution. Finally, as described in Section II.E, conditions and regulation cannot cure the anticompetitive harms created by the Proposed Transaction or the shortfalls in the transaction’s financial integration and planning.

**A. The Proposed Transaction is not proper under the Rhode Island Antitrust Act.**

To determine whether the Proposed Transaction is proper under the antitrust laws of the state, the Attorney General has reviewed the economic data, evidence from market participants, and the Parties’ own documents and testimony. The Attorney General has applied analytical techniques widely accepted by courts – including those in the Horizontal Merger Guidelines issued by the United States Department of Justice and the United States Federal Trade Commission<sup>46</sup> – to evaluate the likely competitive effects of the Proposed Transaction. The results establish that the Proposed Transaction is likely to substantially reduce competition throughout relevant healthcare markets. The Proposed Transaction is likely to substantially reduce competition in the markets for both commercial and Medicare inpatient hospital services. In addition, the Attorney General is concerned that the Proposed Transaction is likely to substantially reduce competition in outpatient surgical markets, the market for inpatient psychiatric care, and the labor market for nurses. The consolidation of the Parties’ Accountable Care Organizations also raises competitive concerns.

The Proposed Transaction would result in a virtual monopoly in multiple markets. A combined Lifespan/CNE system would account for over 80% of all Rhode Island discharges of commercially insured patients receiving inpatient general acute care (“GAC”) hospital services –

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<sup>46</sup> The Horizontal Merger Guidelines, which “describe the principal analytical techniques and the main types of evidence on which” the DOJ and the FTC “usually rely to predict whether a horizontal merger may substantially lessen competition,” do not have the force of law. U.S. Dept of Justice & Fed. Trade Comm’n, Horizontal Merger Guidelines § 1 (2020), (“Merger Guidelines”), <https://www.justice.gov/atr/horizontal-merger-guidelines-08192010>. However, they “are often used as persuasive authority when deciding if a particular acquisition violates anti-trust laws.” *Chicago Bridge & Iron Co. N.V. v. FTC*, 534 F.3d 410, 431, n.11 (5th Cir. 2008); *United States v. Anthem, Inc.*, 855 F.3d 345, 349 (D.C. Cir. 2017) (the Guidelines are “a helpful tool, in view of the many years of thoughtful analysis they represent, for analyzing proposed mergers.”).

a wide range of medical and surgical treatments requiring a hospital admission that patients would expect a community hospital to provide. The Proposed Transaction also would produce an extraordinarily high concentration in the market for inpatient GAC hospital services provided to Medicare beneficiaries in Rhode Island, where a combined Lifespan/CNE system would have a market share of 70%. By comparison, Massachusetts' largest health system – Mass General Brigham (formerly known as Partners) – has around 27% of the statewide market for commercial inpatient general GAC services.<sup>47</sup> In Connecticut, a coalition of healthcare organizations, consumer groups, and unions objected to and intervened, unsuccessfully, in the 2016 acquisition of New London's main hospital by the Yale New Haven Health System because it would result in Connecticut's largest system controlling 31% of the statewide inpatient GAC services market share.<sup>48</sup> Not only is the level of concentration resulting from the Lifespan/CNE transaction far beyond the levels in these other New England states, the increase is higher than any of the last 11 proposed hospital mergers that the FTC has sought to block in the last 18 years. By eliminating head-to-head competition between Lifespan and CNE in these markets, the Proposed Transaction is likely to increase Rhode Islanders' healthcare costs and would eliminate the competitive pressures that have pushed both systems to make substantial investments in improving the quality of, and access to, their services.

The likely competitive harm is not limited to the markets for inpatient GAC hospital services. The Attorney General is concerned that the Proposed Transaction is likely to substantially reduce competition in several other markets, likely leading to higher prices, lower quality, and reduced access.

- *Outpatient surgery markets.* For the ten most intensive outpatient procedure specialties, a merged Lifespan/CNE would have a market share greater than 60% for four specialties. For seven of the ten most intensive outpatient procedure specialties, the Proposed Transaction would result in concentration that is presumptively anticompetitive under the Merger Guidelines.
- *Market for inpatient behavioral health services.* A merged Lifespan/CNE system would account for 79% of behavioral health discharges for commercially insured patients under 65 in Rhode Island. The increase in concentration is presumptively anticompetitive under the Merger Guidelines.
- *ACO competition.* The Parties' three Accountable Care Organizations ("ACOs") would account for 81% of commercial lives "attributed" to Rhode Island ACOs. Consolidation

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<sup>47</sup> Massachusetts Health Policy Commission, Review of The Proposed Merger of Lahey Health System; CareGroup and its Component Parts, Beth Israel Deaconess Medical Center, New England Baptist Hospital, and Mount Auburn Hospital; Seacoast Regional Health Systems; and Each of their Corporate Subsidiaries into Beth Israel Lahey Health; and The Acquisition of the Beth Israel Deaconess Care Organization by Beth Israel Lahey Health; and The Contracting Affiliation Between Beth Israel Lahey Health and Mount Auburn Cambridge Independent Practice Association (Sep. 27, 2018) at 45. The Review also finds that Mass General Brigham has 21.6% of all Massachusetts acute care hospital beds (p. 28) and 26.9% of the statewide market for commercial outpatient care (p. 45).

<sup>48</sup> Connecticut Health Policy Project et al., *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, (Dec. 2015) at 8.

of the Parties’ ACOs would reduce the Parties’ incentives to improve the patient experience and to work with insurers on innovative payment mechanisms that would reduce the overall cost of care.

- *Labor market for nurses.* The Parties would employ 67% of the full-time registered nurses employed by Rhode Island hospitals. The Parties’ ordinary-course documents demonstrate that they compete with each other in the labor market for nurses. The elimination of this competition is likely to result in lower wages, worse benefits, and limited options for nurses.

These concerns further support the Attorney General’s conclusion that the Proposed Transaction is not proper under the Rhode Island Antitrust Act.

**1. Background**

**a. The hospital landscape in Rhode Island**

Lifespan is the largest healthcare provider in Rhode Island. It operates four hospitals: Rhode Island Hospital (“RIH”), a general acute care hospital in Providence that houses Hasbro Children’s Hospital (“Hasbro”); the Miriam Hospital (“Miriam”), a general acute care hospital in Providence; Newport Hospital (“Newport”), a general acute care hospital in Newport; and Emma Pendleton Bradley Hospital (“Bradley”), a behavioral health hospital in East Providence.

CNE is the second largest healthcare provider in Rhode Island. It operates three hospitals: Kent County Memorial Hospital (“Kent”), a general acute care hospital in Warwick; Women & Infants Hospital of Rhode Island (“W&I”), a specialty women’s hospital in Providence; and Butler Hospital (“Butler”), a behavioral health hospital in Providence.

There are six other non-public hospitals in Rhode Island. CharterCARE Health Partners operates two general acute care hospitals: the Roger Williams Medical Center, located in Providence, and Our Lady of Fatima Hospital (“Fatima”), located in North Providence. Prime Healthcare, which operates hospitals across 14 states, operates two not-for-profit hospitals in Rhode Island: Landmark Medical Center, a GAC hospital located in Woonsocket, and the Rehabilitation Hospital of Rhode Island located in North Smithfield. South County Health operates South County Hospital, a GAC hospital in Wakefield. The Yale New Haven Health System owns Westerly Hospital, a GAC hospital located in Westerly.

The following table shows the bed capacities of the ten Rhode Island hospitals that provided inpatient GAC services.

**Figure 2: General acute care hospital landscape in Rhode Island<sup>49</sup>**

System	Hospital	Staffed beds
Lifespan	Rhode Island Hospital	682
	Miriam	247

<sup>49</sup> Pflum Report Figure 2. 2017-2019 data is used to smooth out small year-to-year fluctuations that may occur in the ordinary course. Data for 2020 and 2021 were not available. However, because of the



	Newport	104
CNE	Kent County	306
	Women & Infants	247
CharterCARE	Fatima Hospital	125
	Roger Williams	86
Prime	Landmark Medical Center	140
Yale	Westerly	93
South County	South County	91

Measured by staffed beds, Lifespan’s RIH is the largest hospital in Rhode Island and CNE’s Kent is the second largest hospital. CNE’s W&I and Lifespan’s Miriam, with the same number of staffed beds, are the third and fourth largest hospitals in the state. A merged Lifespan/CNE system not only would control the four largest hospitals in Rhode Island but also would account for 75% of all staffed beds at Rhode Island hospitals that provide inpatient GAC services.

The Parties’ operations in Rhode Island extend beyond hospitals. Lifespan operates a behavioral health organization, ambulatory care centers, and laboratory testing sites. CNE operates behavioral health centers/organizations; a nurse, home health, and hospice agency; a private duty nursing service; a wellness center; laboratory testing sites; and an express care center. In August 2021, CNE was granted permission to establish an ambulatory surgery center in Providence.<sup>50</sup> Lifespan and CNE each have affiliated Accountable Care Organizations and physician groups.<sup>51</sup>

**b. The benefits of competition and the role antitrust laws play in protecting competition**

Robust competition benefits consumers and workers. Economic theory and empirical studies have demonstrated that, across a range of industries, including health care, competition leads to lower prices and higher quality. Competition also can lead to a greater diversity of goods and services and drives innovation.<sup>52</sup> Competition benefits workers; when businesses compete to attract workers, they do so by increasing pay and improving working conditions. Conversely, when there is insufficient competition, businesses have less incentive to act in the interest of consumers and workers. Instead, dominant businesses can and do use their market

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COVID pandemic, data concerning shares and the distribution of inpatient services rendered in those years are not likely to be as indicative of future competition as are the data just prior to the pandemic. *Id.* ¶ 123 n.255.

<sup>50</sup> Health Services Council, *Report of the Health Services Council on the Application of Care New England Health System for a Certificate of Need to Establish a Freestanding Ambulatory Surgery Center in Providence*, Aug. 3, 2021 at 1.

<sup>51</sup> Pflum Report ¶¶ 23, 25 & 40-41.

<sup>52</sup> R.S. Pindyck, and D.L. Rubinfeld, *Microeconomics*, Pearson, 8th Ed. (2013); Pflum Report ¶¶ 212 & 238-39.

power to charge higher prices and offer fewer and lower-quality products and services to consumers and to lower worker pay.<sup>53</sup> Lack of competition also can stifle innovation.<sup>54</sup>

Antitrust laws protect competition and, by extension, the consumers and workers who benefit from competition. In recognition of the importance of competition, the General Assembly enacted the Rhode Island's Antitrust Act ("RIAA"), the purpose of which is:

[t]o promote the unhampered growth of commerce and industry throughout the state by prohibiting unreasonable restraint of trade and monopolistic practices, inasmuch as these have the effect of hampering, preventing, or decreasing competition. It is intended that, as a result, the prices of goods and services to consumers will be fairly determined by free market competition in activities affecting trade or commerce in this state, including the manufacturing, distribution, financing, and service sectors of the economy . . . .<sup>55</sup>

Rhode Island is not an outlier in recognizing the importance of competition and the necessity of protecting it. The federal antitrust laws, which the RIAA was designed to complement,<sup>56</sup> prohibit mergers whose effect "may be substantially to lessen competition, or to tend to create a monopoly"<sup>57</sup> and make unlawful agreements in restraint of trade.<sup>58</sup> Most states have their own antitrust laws. Massachusetts and Connecticut have enacted antitrust laws similar to the RIAA to protect their own economies and residents from the harms of anticompetitive conduct.<sup>59</sup>

Although competition is important in all industries, it is especially important in health care due to the nature of the services provided and the significant role health care plays in the economy of Rhode Island and the household economies of Rhode Island residents. As the COVID-19 pandemic has brought into sharp focus, healthcare services are critical to the physical well-being of every Rhode Islander. Over the last two years, the healthcare industry has served almost every resident through testing, vaccinations, and care related to COVID-19, while also addressing the myriad other health needs of residents during the pandemic. Moreover, the healthcare industry has an enormous impact on Rhode Island's economy. Not only does Rhode

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<sup>53</sup> Pindyck, Part 3: Market Structure and Competitive Strategy; Pflum Report ¶ 5.

<sup>54</sup> R. De Bondt, J. Vandekerckhove, *Reflections on the Relation Between Competition and Innovation*, J Ind Compet Trade 12, 7-19 (2012), [https://www.researchgate.net/publication/225191358\\_Reflections\\_on\\_the\\_Relation\\_Between\\_Competition\\_and\\_Innovation](https://www.researchgate.net/publication/225191358_Reflections_on_the_Relation_Between_Competition_and_Innovation).

<sup>55</sup> R.I. Gen. Laws § 6-36-2(a)(2).

<sup>56</sup> R.I. Gen. Laws § 6-36-2 (a)(1); 15 U.S.C. § 18.

<sup>57</sup> 15 U.S.C. § 18.

<sup>58</sup> 15 U.S.C. § 1.

<sup>59</sup> Mass. Antitrust Act, Gen. Laws, Part I, Title XV, Ch. 93, § 1, *et seq.*; Conn. Antitrust Act, Gen. Statutes, §§ 35-14, *et seq.*

Island spend billions of dollars a year on healthcare,<sup>60</sup> but the healthcare sector is the biggest employer in the state, employing approximately 70,000 Rhode Islanders – or approximately one out of every seven workers.<sup>61</sup>

Health care has become increasingly expensive for consumers. Last year the Rhode Island Health Care Cost Trends Steering Committee announced that from 2018 to 2019 per capita healthcare spend went up 4.1%, resulting in \$8,949 in medical spending per covered Rhode Islander.<sup>62</sup> This increase exceeded the 3.2% cost growth target established by the Steering Committee. Moreover, employee contributions to employer sponsored insurance premiums in Rhode Island have grown nearly three times faster than personal income from 2001 to 2021.<sup>63</sup> Rhode Island’s experience mirrors national trends as well. A 2021 survey found that the average annual premium for family coverage increased 47% between 2011 and 2021, increasing from \$15,073 to \$22,221.<sup>64</sup> Similarly, the average worker’s contribution toward family premiums increased 44.6% from \$4,129 in 2011 to \$5,969 in 2021.<sup>65</sup> In comparison, the consumer price index, which reflects general price inflation, increased by only 19% during the same period.<sup>66</sup>

Hospital mergers are a driver of increased healthcare costs. As described in greater detail in Section II.A.4.d.3 below, economic studies show that hospitals that face less competition tend to charge higher prices, which ultimately are passed along to consumers in the form of higher premiums and greater out-of-pocket costs. More often than not, higher prices are not buying better care; those price increases often are not accompanied by improvements in the quality of care. To the contrary, studies have shown that quality of care often suffers after a merger, to the detriment of patients.

Recognizing the potential harms of hospital consolidation, in 2020 the General Assembly amended the Hospital Conversions Act to authorize the Attorney General to review proposed hospital mergers for compliance with the Rhode Island Antitrust Act. As one of the sponsors of

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<sup>60</sup> Office of the Health Insurance Commissioner and the Executive Office of Health and Human Services, *Rhode Island Health Care Cost Trends Collaborative Project Report to the Legislature*, Dec. 2020, <http://www.ohic.ri.gov/documents/2021/January/Annual%20Cost%20Trends%20Report%202020.pdf>.

<sup>61</sup> Employment by Occupation Table, <https://dlt.ri.gov/media/13661/download?language=en>; Industries at a Glance: Social Assistance: NAICS 624 (bls.gov).

<sup>62</sup> Alexa Gagosz, *Health care has become less affordable in Rhode Island*, Boston Globe (April 29, 2021).

<sup>63</sup> Rhode Island Health Care Cost Trends Steering Committee (April 29, 2021). <http://www.ohic.ri.gov/documents/2021/April/Cost%20Trends/steering%20committee%20meeting%202021%204-29%20for%20sharing.pdf>.

<sup>64</sup> Kaiser Family Foundation, *2021 Employer Health Benefits Survey*, Nov. 10, 2021, at Fig. 6 <https://www.kff.org/report-section/ehbs-2021-section-6-worker-and-employer-contributions-for-premiums/>

<sup>65</sup> *Id.*

<sup>66</sup> U.S. Bureau of Labor Statistics, *Consumer Price Index Historical Tables for U.S. City Average*, December 12, 2021, [https://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical\\_us\\_table.htm](https://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical_us_table.htm).

the amendment observed, ensuring that hospital mergers will not result in the loss of competition protects Rhode Island and its residents:

Like many industries, hospitals have experienced a great deal of consolidation in the last several decades. Antitrust laws are meant to protect the public from situations where a single entity has too much control in a segment or region. Compliance with those laws is an important piece of the puzzle that the state should be considering whenever the conversion of a hospital is proposed. . . . This bill will provide a meaningful review of antitrust issues, which ultimately protects patients and the critical health care industry as a whole.<sup>67</sup>

The amendment's other sponsor agreed: "What this boils down to is protecting the quality of health care in Rhode Island. We want to make sure that we don't allow a situation where one corporation controls the majority of our state's hospitals and slashes the resources available to patients here. This will help ensure that patients can access the facilities they need when they need them."<sup>68</sup>

The benefits of competition are not hypothetical. As discussed below, the Attorney General's review has produced evidence that the head-to-head competition between Lifespan and CNE has motivated each to make investments that benefit Rhode Islanders, including investments to raise the quality of clinical care, to improve the patient experience and access to services and doctors, and to innovate through new technology and recruitment of nationally renowned doctors into the state. If the Proposed Transaction were approved, the competitive pressure Lifespan and CNE put on each other to improve the quality of, and access to, care would disappear.

## 2. Legal standard

The Hospital Conversions Act directs the Attorney General to consider "[w]hether the proposed conversion is proper" under the Rhode Island Antitrust Act.<sup>69</sup> Therefore, the HCA instructs the Attorney General to assess whether a proposed conversion could result in the competitive harms the state's antitrust laws seek to prevent in order to "assure the viability of a safe, accessible and affordable healthcare system that is available to all."<sup>70</sup> A proposed conversion that is unlawful under the RIAA is necessarily improper.<sup>71</sup>

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<sup>67</sup> Press Release, State of Rhode Island General Assembly, Assembly adds antitrust review for proposed hospital conversions (July 16, 2020).

[https://www.rilegislature.gov/pressrelease/\\_layouts/RIL.PressRelease.ListStructure/Forms/DisplayForm.aspx?List=c8baae31%2D3c10%2D431c%2D8dcd%2D9dbbe21ce3e9&ID=370996&Web=2bab1515%2D0dcc%2D4176%2Da2f8%2D8d4beebdf488](https://www.rilegislature.gov/pressrelease/_layouts/RIL.PressRelease.ListStructure/Forms/DisplayForm.aspx?List=c8baae31%2D3c10%2D431c%2D8dcd%2D9dbbe21ce3e9&ID=370996&Web=2bab1515%2D0dcc%2D4176%2Da2f8%2D8d4beebdf488).

<sup>68</sup> *Id.*

<sup>69</sup> R.I. Gen. Laws §23-17.14-10(b)(22).

<sup>70</sup> R.I. Gen. Laws 1956 § 23-17.14-3(1).

<sup>71</sup> Even if a conversion does not reach the threshold of illegality under the RIAA, it still may be improper because the anticompetitive effects of the conversion nonetheless would put Rhode Islanders' access to quality and affordable health care in jeopardy. Because the Attorney General has concluded that the

The RIAA prohibits any “contract, combination, or conspiracy in restraint of . . . trade or commerce,”<sup>72</sup> “any attempt to establish a monopoly for the purpose of excluding competition or controlling, fixing, or maintaining prices,”<sup>73</sup> and any “contract for the supplying of commodities or furnishing of services . . . where the effect of the contract . . . may be to lessen competition or tend to create a monopoly. . . .”<sup>74</sup> Because the RIAA was enacted to “complement” federal antitrust laws,<sup>75</sup> it specifically directs that its provisions be interpreted “in harmony with judicial interpretations of comparable federal antitrust statutes insofar as practicable, except where provisions of this chapter are expressly contrary to applicable federal provisions as construed.”<sup>76</sup>

The comparable federal antitrust statutes are the Sherman Antitrust Act and the Clayton Antitrust Act. Section 1 of the former provides that “[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce . . . is declared to be illegal”;<sup>77</sup> Section 7 of the latter prohibits mergers whose effects “may be substantially to lessen competition, or to tend to create a monopoly.”<sup>78</sup> The U.S. Supreme Court has interpreted “may be” in Section 7 to mean that the analysis necessarily focuses on “probabilities, not certainties.”<sup>79</sup> This focus on probabilities “requires not merely an appraisal of the immediate impact of the merger upon competition, but a prediction of its impact upon competitive conditions in the future.”<sup>80</sup> Although the texts of Sherman Act’s Section 1 and Clayton Act’s Section 7 differ, they judge the lawfulness of a merger using the same standard: is it likely to substantially lessen competition?<sup>81</sup>

[REDACTED]

[REDACTED]<sup>82</sup> Accordingly, the Attorney

Proposed Transaction is unlawful under the RIAA, this Decision does not and need not separately consider whether it would be improper even if it were lawful.

<sup>72</sup> R.I. Gen. Laws § 6-36-4.

<sup>73</sup> R.I. Gen. Laws § 6-36-5.

<sup>74</sup> R.I. Gen. Laws § 6-36-6.

<sup>75</sup> R.I. Gen. Laws § 6-36-2(a)(1).

<sup>76</sup> R.I. Gen. Laws § 6-36-2(b); *Auburn News Co. v. Providence Journal Co.*, 659 F.2d 273, 278 (1st Cir. 1981); *ERI Max Entm’t, Inc. v. Streisand*, 690 A.2d 1351, 1353 n.1 (R.I. 1997).

<sup>77</sup> 15 U.S.C. § 1.

<sup>78</sup> 15 U.S.C. § 18.

<sup>79</sup> *Brown Shoe Co. v. United States*, 370 U.S. 294, 323 (1962).

<sup>80</sup> *United States v. Philadelphia Nat’l Bank*, 374 U.S. 321, 362 (1963) (internal quotation marks omitted); *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1389 (7th Cir. 1986) (“Section 7 does not require proof that a merger or other acquisition has caused higher prices in the affected market. All that is necessary is that the merger create an appreciable danger of such consequences in the future.”).

<sup>81</sup> *United States v. Rockford Mem’l Corp.*, 898 F.2d 1278, 1282 (7th Cir. 1990) (“[b]oth statutes as currently understood prevent transactions likely to reduce competition substantially.”).

<sup>82</sup> C-R-CNE-LS64-0078003 ([REDACTED]); C-R-CNE-LS64-0078002 ([REDACTED])

General evaluates the lawfulness of the Proposed Transaction under the RIAA by analyzing whether its effects “may be substantially to lessen competition.”<sup>83</sup>

**3. The Proposed Transaction would eliminate the significant competition between Lifespan and CNE.**

Because the Attorney General must evaluate the loss of competition that may result from a proposed merger, any existing competition between the merging parties is highly relevant. In the context of the Proposed Transaction, the Attorney General must determine whether and to what extent Lifespan and CNE currently compete with each other. The greater the current competition between the two, the greater the loss of competition resulting from the Proposed Transaction.

The record establishes that the Parties engage in significant competition with each other.

[REDACTED]

[REDACTED]. In short, the record leaves no doubt that, were the Parties to merge, the loss of competition would be substantial.

a. [REDACTED]

One of the most reliable sources of information regarding the extent of competition between two merging parties – and a source routinely cited by reviewing courts – is the parties’ own internal documents.<sup>84</sup> [REDACTED]

[REDACTED]

[REDACTED]; C-R-CNE-LS64-0078006 ([REDACTED]).

<sup>83</sup> 15 U.S.C. § 18. Generally, a claim under Section 7 is analyzed using a burden shifting framework that allows each side to rebut the other’s case for why the proposed merger is likely or not likely to result in a substantial lessening of competition, with the ultimate burden of persuasion resting on the plaintiff. *See, e.g., Saint Alphonsus Med. Ctr. - Nampa, Inc. v. Saint Luke’s Health Sys.*, 778 F.3d 775, 783 (9th Cir. 2015). Here, the Parties took the opportunity – in the form of advocacy papers and communications with the Attorney General, among other things – to present their arguments why the Proposed Transaction is not likely to substantially lessen competition, and the Attorney General has considered them.

<sup>84</sup> *See, e.g., FTC v. Hackensack Meridian Health, Inc.*, No. CV 20-18140, 2021 WL 4145062, at \*21 (D. N.J. Aug. 4, 2021) (“*Hackensack*”) (“Defendants’ ordinary course documents and testimony also demonstrate that HMH and Englewood are competitors.”); Merger Guidelines § 2.2 Sources of Evidence (“The most common sources of reasonably available and reliable evidence are the merging parties . . . .”); *id.* § 2.2.1 Sources of Evidence - Merging Parties.

[REDACTED]

Brown University, the Parties' partner in the creation of the proposed integrated academic health system, also has concluded that Lifespan and CNE are major competitors. Dr. Jack Elias, Dean of Medicine and Biology and Senior Vice President for Health Affairs for Brown University, is uniquely positioned to assess the nature of the relationship between the Parties. He was tapped by Brown's President to serve as a special adviser focusing solely on the merger of Lifespan and CNE.<sup>96</sup> According to Dr. Elias, Lifespan and CNE are competing "all over the place"<sup>97</sup> and the two systems "are actually competing with each other rather than working together with each other."<sup>98</sup>

<sup>85</sup> Letter from Lifespan to Rhode Island Attorney General (March 29, 2021) at 2.  
<sup>86</sup> LIFESPAN00038696.  
<sup>87</sup> [REDACTED] LIFESPAN00530148; LIFESPAN000030639.  
<sup>88</sup> [REDACTED] LIFESPAN00530148; [REDACTED].  
<sup>89</sup> [REDACTED] LIFESPAN00043936.  
<sup>90</sup> LIFESPAN\_ORIG005179 at -5195 ([REDACTED]).  
<sup>91</sup> LIFESPAN02250641 [REDACTED].  
<sup>92</sup> Gelinas Dec. 23, 2021 Tr. Ex. 1.  
<sup>93</sup> *Id.* Ex. 10 at LIFESPAN06694370; *id.* 150:1-12.  
<sup>94</sup> FTC-CNE-02483140 at -141.  
<sup>95</sup> FTC-CNE-00002750 at -756; [REDACTED].  
<sup>96</sup> Alexa Gagosz, Boston Globe, "Dr. Jack Elias on how the Lifespan-CNE merger will change the health care and business landscape in R.I." (April 15, 2021).  
<sup>97</sup> Elias Feb. 8, 2022 Tr. 55:4-6.  
<sup>98</sup> *Id.* 24:23-25:1.

**b. Lifespan and CNE hospitals compete against each other in numerous service lines.**

Numerous internal documents, as well as extensive testimony obtained by the Attorney General, demonstrate that Lifespan hospitals compete with CNE hospitals in a broad range of service lines. [REDACTED]

<sup>99</sup>

In particular, the record demonstrates close competition between Kent Hospital and Rhode Island Hospital. [REDACTED]

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<sup>106</sup>

<sup>99</sup> Finucane Jan. 18, 2022 Tr. 38:10-12.

<sup>100</sup> FTC-CNE-00486268 at -277.

<sup>101</sup> [REDACTED]

<sup>102</sup> [REDACTED]

<sup>103</sup> [REDACTED]

<sup>104</sup> [REDACTED]

<sup>105</sup> [REDACTED]

<sup>106</sup> See, e.g., LIFESPAN02376622 at -623, -625 ([REDACTED]).



[REDACTED] <sup>107</sup> [REDACTED] <sup>108</sup>

[REDACTED] <sup>109</sup>  
[REDACTED] <sup>110</sup>  
[REDACTED] <sup>111</sup>  
[REDACTED] <sup>112</sup> Other CNE and Lifespan facilities compete with each other as well.  
[REDACTED] <sup>113</sup>

Below is a more in-depth discussion of examples of service lines in which the record establishes that Lifespan and CNE compete.

**(1) Cardiology**

Kent and RIH (and, to a lesser extent, Miriam) have competed with each other for cardiology market share for years. [REDACTED], the Parties' responses to each other's actions also illustrate their competition in cardiology. When Kent noticed an opportunity to perform more complex, high-revenue heart surgeries, it developed an affiliation with cardiologists at Brigham & Women's Hospital to practice locally<sup>114</sup> and built new laboratories for those

<sup>107</sup> See, e.g., LIFESPAN01790603 at -605; [REDACTED]

<sup>108</sup> [REDACTED]

<sup>109</sup> LIFESPAN04239060 at -081.

<sup>110</sup> [REDACTED] FTC-CNE-00896149.

<sup>111</sup> [REDACTED]

<sup>112</sup> LIFESPAN04239010 at -022. [REDACTED]

<sup>113</sup> LIFESPAN06669178 [REDACTED]

<sup>114</sup> Brigham Clinical & Research News, "Q&A: Expanded Access to Care, Beyond Boston," (Jul. 17, 2019) BWHClinicalAndResearchNews.org/2017/07/19/qa-expanded-access-to-care-beyond-boston/.

procedures.<sup>115</sup> Care New England saw its market share for those cardiac services rise relative to Lifespan's and, subsequently, Lifespan's Cardiovascular Institute ("LCVI") added new physicians and "established a call center to help patients contact providers and arrange services in an even more efficient and timely manner."<sup>116</sup>

[REDACTED] 117  
[REDACTED] 118  
[REDACTED] 119  
[REDACTED] 120  
[REDACTED] 121  
[REDACTED] 122

[REDACTED]

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<sup>115</sup> Kent Hospital, "*Kent Hospital Opens New Cardiac Catheterization Lab Honoring Dr. Robert Baute, Past President, Paved Way for Program*," (Oct. 2016) [KentRI.org/news/kent-hospital-opens-new-cardiac-catheterization-lab-honoring-dr-robert-baute-past-president-paved-way-for-program](http://KentRI.org/news/kent-hospital-opens-new-cardiac-catheterization-lab-honoring-dr-robert-baute-past-president-paved-way-for-program).

<sup>116</sup> Lifespan, "*Annual Report Fiscal Year 2016*," (May 24, 2017) [Issuu.com/lifespanmc/docs/lifespan\\_2016\\_annual\\_report](http://Issuu.com/lifespanmc/docs/lifespan_2016_annual_report) at 11.

<sup>117</sup> LIFESPAN00760037 at -049.

<sup>118</sup> Gelinas Dec. 23, 2021 Tr. Ex. 19 at LIFESPAN00450954 at -958, -962, -964; LIFESPAN04238401 at -402, -410 ([REDACTED]).

<sup>119</sup> [REDACTED]

<sup>120</sup> [REDACTED]  
<sup>121</sup> [REDACTED]  
<sup>122</sup> [REDACTED]

[REDACTED] 123  
[REDACTED] 124  
[REDACTED] 125  
[REDACTED] 126

The STEMI (ST-elevation myocardial infarction)<sup>127</sup> market exemplifies competition between Lifespan and CNE in cardiology. [REDACTED]  
[REDACTED] 128  
[REDACTED] 129  
[REDACTED] 130

[REDACTED] 131  
[REDACTED] 132

[REDACTED]

<sup>123</sup> LIFESPAN06437609 at -610.

<sup>124</sup> LIFESPAN06437609 at -611.

<sup>125</sup> [REDACTED] LIFESPAN00552513.

<sup>126</sup> [REDACTED] LIFESPAN00371916; [REDACTED].

<sup>127</sup> [REDACTED]

<sup>128</sup> FTC-CNE-00302389 at -390.

<sup>129</sup> FTC-CNE-00302389 at -389.

<sup>130</sup> LIFESPAN02396896 at -397.

<sup>131</sup> [REDACTED] LIFESPAN00053423.

<sup>132</sup> [REDACTED].

[REDACTED].<sup>133</sup> For example, Lifespan posted billboard advertisements near Kent Hospital with the slogan “Keep Cardiac Care Close to Home” – a reference to Kent’s affiliation with Brigham & Women’s.<sup>134</sup> [REDACTED]

[REDACTED]<sup>135</sup>

[REDACTED]<sup>136</sup>

[REDACTED]<sup>137</sup>

[REDACTED]

[REDACTED]<sup>138</sup>

As Dr. Fanale explained in an interview, the “Partners’ collaboration on cardiology at Kent has in fact led to more procedures remaining in Rhode Island.”<sup>139</sup>

## (2) Oncology

Substantial record evidence demonstrates that Lifespan and CNE compete in oncology.

[REDACTED]<sup>133</sup>

<sup>134</sup> Souza Jan. 20, 2021 Tr. 125:5-11 (“Rhode Island Hospital, or Lifespan, believes – uses usually the phrase, let’s keep cardiac care close to home and keep it in Providence and at Rhode Island Hospital. They usually use it against CNE because CNE at Kent Hospital, their cardiac program is, again, affiliated with Brigham & Women’s, or Partners Healthcare, which is up in Boston.”); 158:18-24 (Lifespan advertises the phrase “Keep Cardiac Care Close to Home” via a billboard on I-95, close to Kent Hospital).

<sup>135</sup> Finucane Jan. 18, 2022 Tr. 157:15-158:3; 159:22-160:1.

<sup>136</sup> *Id.* Ex. 13 at AM\_048794.

<sup>137</sup> *Id.*

<sup>138</sup> Fanale Dec. 30, 2021 Tr. Ex. 12 at FTC-CNE-008660999-100; *id.* 79:15-18 ([REDACTED]).

<sup>139</sup> Ted Nesi, *Brown's president is alarmed about Care New England – and says you should be, too*, WPRI.com, Feb. 2, 2018, <https://www.wpri.com/news/eyewitness-news-investigates/browns-president-is-alarmed-about-care-new-england-and-says-you-should-be-too/>.

[REDACTED] 140 [REDACTED] 141  
[REDACTED] 142 [REDACTED] 143

[REDACTED] 144 [REDACTED] 145  
[REDACTED] 146 [REDACTED] 147

Dr. Elias, Brown University’s Dean of Medicine, confirmed that Lifespan and CNE are competing for cancer market share. In the context of Lifespan and Brown’s efforts to create a NCI (National Cancer Institute)-designated cancer center, Dr. Elias testified that, “without the merger, you’re committing both institutions [Lifespan and CNE] to continuing to not work together with each other but to compete with each other and to try to get market share away from

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140 [REDACTED] LIFESPAN00547782 at Slide 6; *see id.* at Slide 2.  
141 LIFESPAN00952873 at -875; *see also* Gelinis Dec. 23, 2021 Tr. Ex. 5 at LIFESPAN00887188 ([REDACTED]).  
142 [REDACTED].  
143 Gelinis Dec. 23, 2021 Tr. Ex. 4 at LIFESPAN00447347 ([REDACTED]).  
144 [REDACTED].  
145 FTC-CNE-00120819 at Slides 30-31. [REDACTED].  
146 [REDACTED].  
147 [REDACTED].

each other.”<sup>148</sup> Similarly, Dr. Elias stated that “right now” Lifespan and CNE are competing for cancer market share, and that “you can’t change how you practice until the merger takes place. You’ve got to keep competing with each other until we get appropriate approvals for the process. So, yeah, they’re going to have to keep competing with each other until they’re able to come together.”<sup>149</sup>

### (3) Orthopedics

[REDACTED] <sup>150</sup>  
[REDACTED] <sup>151</sup>

### (4) Other service lines

The record also demonstrates that the Parties compete in a number of other service lines. Examples include:

- *General Medicine:* [REDACTED] <sup>152</sup>
- *Emergency Medicine:* [REDACTED] <sup>153</sup>
- *Medical Surgical:* [REDACTED] <sup>154</sup>  
[REDACTED] <sup>155</sup>  
[REDACTED] <sup>156</sup>

<sup>148</sup> Elias Feb. 8, 2022 Tr. 53:11-16.

<sup>149</sup> *Id.* 54:15-55:3.

<sup>150</sup> FTC-CNE-00834042 at Slide 3.

<sup>151</sup> LIFESPAN03382494 at -495.

<sup>152</sup> *See, e.g.*, FTC-CNE-00229580 at Row 5.

<sup>153</sup> FTC-CNE-00973597 at Slide 14.

<sup>154</sup> LIFESPAN00460190 at -206.

<sup>155</sup> FTC-CNE-00067825 at -826.

<sup>156</sup> LIFESPAN07025093 at -118.

- *Spine*: Lifespan’s RIH, Newport, and Miriam house the Norman Prince Spine Institute,<sup>157</sup> and [REDACTED].<sup>158</sup>  
[REDACTED]  
[REDACTED]<sup>159</sup> Today, CNE offers orthopedic spine surgery.<sup>160</sup>
- *Gastroenterology*: [REDACTED]  
[REDACTED].<sup>161</sup>
- *Bariatrics (i.e., treatment of obesity)*: [REDACTED]  
[REDACTED].<sup>162</sup>

**c. Other providers view Lifespan and CNE as competitors.**

Other hospital systems view Lifespan and CNE as competitors.<sup>163</sup> Partners Healthcare (now Mass General Brigham) – who bid to acquire CNE in 2018 – identified RIH as Kent’s “largest competitor”<sup>164</sup> and confirmed that Lifespan “directly competes” with W&I: “Women and Infants is seeking to differentiate with a women’s oriented strategy... . However, Lifespan is directly competing on a women’s health oriented approach through its Women’s Medicine Collaborative.”<sup>165</sup>

The CEO of Landmark Hospital in Woonsocket testified that Lifespan and CNE are each other’s closest competitors.<sup>166</sup> He explained that, for most inpatient GAC services, the principal choices for patients are Kent, RIH, or Miriam, though the competition is primarily between Kent

<sup>157</sup> Lifespan, *Normal Prince Spine Institute*, <https://www.lifespan.org/centers-services/norman-prince-spine-institute>.

<sup>158</sup> [REDACTED].

<sup>159</sup> FTC-CNE-00126760 at -761.

<sup>160</sup> Care New England, *Neck and Spine Care*, <https://www.carenewengland.org/services/spine-care/>.

<sup>161</sup> Gelinas Dec. 23, 2021 Tr. Ex. 19 at LIFESPAN00450967, -969.

<sup>162</sup> [REDACTED].

<sup>163</sup> CharterCARE declined to speak publicly on the record regarding the Proposed Transaction.

<sup>164</sup> MGBCNE\_0000014 at -023 (“Kent’s medical cardiology and EP market share in its PSA/SSA nearly doubles that of its largest competitor, RIH”).

<sup>165</sup> MGBCNE\_0000384 at -392.

<sup>166</sup> Souza Jan. 20, 2022 Tr. 128:3-9.

and RIH.<sup>167</sup> Competition between Lifespan and CNE is particularly “heated” in cardiac services.<sup>168</sup> RIH and Kent also compete in the cancer service line<sup>169</sup> and RIH and Miriam compete with Kent in the joint replacement service line.<sup>170</sup> Finally, Landmark observed that Lifespan has attempted – so far, unsuccessfully – to compete with CNE in women’s health and maternity services. RIH has “stolen physicians from Women & Infants to try to get a women’s program going,” but the program has not yet “taken off.”<sup>171</sup>

The CFO of South County Health, which operates South County Hospital in Wakefield, agrees that “Lifespan and CNE strongly compete against each other, and this competition benefits patients.”<sup>172</sup> “While each system offers some services that are unique to them . . . the vast majority of services are provided by both CNE and Lifespan,” and “[t]here are significant overlaps in the services offered by the two systems, including at Lifespan’s Rhode Island Hospital and Miriam Hospital, and CNE’s Kent Hospital . . . .”<sup>173</sup> The service overlaps include “general medicine, general surgery, orthopedic, cardiac, vascular, spine, neurology, and obstetrics (offered at Newport Hospital, as well as CNE’s Kent Hospital and Women and Infants Hospital).”<sup>174</sup> Rhode Island residents benefit from the competition between Lifespan and CNE. “Lifespan and CNE compete to attract patients through, among other things, marketing and expansion efforts, quality, access, convenience, and patient satisfaction.”<sup>175</sup>

**4. The Proposed Transaction is likely to substantially reduce competition in the market for inpatient GAC hospital services sold to commercial insurers.**

The likely harm to competition for inpatient GAC services is particularly pronounced. The concentration in the market for inpatient GAC services that would result from the Proposed Transaction renders it presumptively unlawful under the Merger Guidelines, no matter how the inpatient GAC market is defined. Standard economic analyses performed by Dr. Pflum, the expert healthcare economist retained by the Attorney General, are consistent with the documents and testimony of market participants, including the Parties, demonstrating that Lifespan and CNE compete with each other in this market. Both the record and Dr. Pflum’s empirical analysis demonstrate that the extraordinarily high market concentration that would result from the Proposed Transaction, and the elimination of competition between the Parties, would increase the ability of the Parties to negotiate higher rates with insurers, with increased costs passed on to

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<sup>167</sup> *Id.* 128:23-129:6; 160:4-14.

<sup>168</sup> *Id.* 124:21-125:11.

<sup>169</sup> *Id.* 159:9-11; 159:17-22.

<sup>170</sup> *Id.* 159:9-11; 159:23-160:3.

<sup>171</sup> *Id.* 125:21-25.

<sup>172</sup> Declaration of Tom Breen ¶ 5.

<sup>173</sup> *Id.*

<sup>174</sup> *Id.*

<sup>175</sup> *Id.* ¶ 7.



consumers. The record also shows how the Proposed Transaction would eliminate vital quality, access, and other non-price competition between Lifespan and CNE.

**a. Inpatient GAC hospital services sold to commercial insurers and provided to their adult members in Rhode Island is a relevant market in which to evaluate the likely competitive effects of the Proposed Transaction.**

An antitrust analysis of a proposed merger begins with defining the relevant market in which the merger may lessen competition.<sup>176</sup> There are two components to the market: the product market and the geographic market.<sup>177</sup> The product market consists of all goods or services that consumers view as close substitutes.<sup>178</sup> “The general question is whether two products can be used for the same purpose, and if so, whether and to what extent purchasers are willing to substitute one for the other.”<sup>179</sup>

Here, one of the relevant product markets is the set of overlapping inpatient GAC services – services offered by both Lifespan and CNE – sold to commercial insurers and provided to their adult members.<sup>180</sup> As described earlier, inpatient GAC services consist of a wide range of medical and surgical services that require a hospital admission. These services may be elective or emergency in nature. Some common examples include labor and delivery, thoracic surgery, treatment of serious infections, and hip replacement surgery.<sup>181</sup> In hospital merger cases, parties routinely have agreed, and courts have accepted, that inpatient GAC services are a cluster of services constituting a relevant product market.<sup>182</sup>

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<sup>176</sup> *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995).

<sup>177</sup> *Id.*

<sup>178</sup> *Brown Shoe*, 370 U.S. at 325 (“The outer boundaries of a product market are determined by the reasonable interchangeability of use [by consumers] or the cross-elasticity of demand between the product itself and substitutes for it”).

<sup>179</sup> *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 565 (6th Cir. 2014) (internal quotation marks and citation omitted).

<sup>180</sup> Consistent with limiting the market to overlapping services, Dr. Pflum limits the market definition to adults. Pflum Report ¶¶ 79 & 93. This limitation is favorable to the Parties because, with the only pediatrics hospital in Rhode Island, Lifespan treats alone over 80% of Rhode Island children (excluding newborns). *Id.* ¶ 86.

<sup>181</sup> Pflum Report ¶ 95. Because inpatient GAC services include a broad range of services, one service is not generally substitutable for one another (*e.g.*, labor and delivery and thoracic surgery). However, it is appropriate to analyze the services together because the competitive conditions are generally similar across services. Such aggregation is called a “cluster market” and its use has been widely accepted by courts in analyzing hospital mergers. *See id.* ¶ 96.

<sup>182</sup> *See FTC v. Advocate Health Care Network*, 841 F.3d 460, 468 (7th Cir. 2016) (collecting cases).

A relevant geographic market is an area where the consumer may look for the goods and services in the product market.<sup>183</sup> Put slightly differently, it is “where, within the area of competitive overlap, the effect of the merger on competition will be direct and immediate.”<sup>184</sup> The scope of the geographic market must “correspond to the commercial realities of the industry” being considered and “be economically significant.”<sup>185</sup> Here, the relevant geographic market is Rhode Island. The effect of the proposed merger will be direct and immediate for insurers serving members residing in Rhode Island because the entire state is the nexus of competition between the hospitals of Lifespan and CNE: all of the hospitals of Lifespan and CNE are in Rhode Island, they compete primarily with each other in Rhode Island and against other Rhode Island hospitals, and the record overwhelmingly establishes that patients prefer to receive inpatient GAC services close to where they live.

[REDACTED] .186

[REDACTED] .187

[REDACTED] .188

[REDACTED]. Dr. Pflum finds that Rhode Islanders overwhelmingly prefer receiving treatment at a Rhode Island hospital. He finds that, for commercially insured residents of Rhode Island, 71% seeking elective care and 81% requiring emergency care travel 30 minutes or less to their chosen hospital; 87% of Medicare patients requiring emergency care travel 30 minutes or less to their chosen hospital.<sup>189</sup> Patients who travel for a longer time usually do so for more specialized care.<sup>190</sup> For example, Rhode Island residents that go to Boston hospitals for inpatient GAC services tend to have more complex conditions.<sup>191</sup> Among commercially insured Rhode Island residents, 87% are

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<sup>183</sup> *Gordon v. Lewiston Hosp.*, 423 F.3d 184, 212 (3d Cir. 2005) (geographic market “is that area in which a potential buyer may rationally look for the goods or services he seeks.”).

<sup>184</sup> *Philadelphia Nat’l Bank*, 374 U.S. at 357.

<sup>185</sup> *Brown Shoe*, 370 U.S. at 324 (footnote and internal quotation marks omitted).

<sup>186</sup> [REDACTED]

<sup>187</sup> Gelinis Dec. 23, 2021 Tr. 48:4-14.

<sup>188</sup> Robbins Jan. 10, 2022 Tr. 50:6-20; *see also id.* Ex. 1, FTC-CNE-00418485 at Slide 3.

<sup>189</sup> Pflum Report ¶ 106 & Figure 7.

<sup>190</sup> *Id.* ¶ 107.

<sup>191</sup> *Id.*

discharged from a Rhode Island hospital while only 13% are discharged from a Massachusetts hospital.<sup>192</sup> Even when discharges are case-weighted – *i.e.*, greater weight is placed on more complicated and intensive services – over 82% of Rhode Island residents are discharged from a Rhode Island hospital.<sup>193</sup> Accordingly, Blue Cross Blue Shield of Rhode Island – by far, the largest insurer in the state – testifies that it would not be able to successfully market a health plan to Rhode Island residents if the plan did not include any Rhode Island hospitals.<sup>194</sup>

Moreover, Rhode Island and federal law impose network adequacy rules that require insurers to provide a network of providers accessible to insured members. Rhode Island requires that covered services be “accessible without unreasonable delay,”<sup>195</sup> meaning that the providers cannot be too far from where the member lives. In addition, the federal government sets maximum time and distance standards for services covered by Medicare Advantage plans.<sup>196</sup>

Finally, Rhode Island satisfies the hypothetical monopolist test, a common method used by courts and the FTC, and relied upon here by the Attorney General, to determine a relevant geographic market.<sup>197</sup> Under this test, a geographic area is a relevant market if a hypothetical monopolist controlling all relevant services in that area could profitably implement a small but significant and non-transitory price increase (“SSNIP”) because the additional profit from customers who chose to buy within the region outweighs the losses from those who buy from outside the region.<sup>198</sup> In other words, even if a monopoly raised prices, more people would pay that increase rather than forego the product or service. A Rhode Island market satisfies this test if insurers would accept a SSNIP rather than exclude all Rhode Island hospitals from the networks they use to sell insurance to residents of Rhode Island.<sup>199</sup>

Rhode Island insurers would accept a SSNIP. BCBSRI testifies that a plan that did not include any Rhode Island hospitals would not be commercially viable.<sup>200</sup> In addition, a “willingness to pay” (“WTP”) analysis, a standard analysis which estimates the increased bargaining leverage of a hypothetical monopolist, reinforces the BCBSRI testimony. To determine the leverage created by a hypothetical monopolist, Dr. Pflum examined the difference

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<sup>192</sup> *Id.* ¶ 108 & Figure 8.

<sup>193</sup> *Id.*

<sup>194</sup> Declaration of Chris Bush (“Bush Decl.”) ¶ 5.

<sup>195</sup> R.I. Gen. Laws, § 27-18.8-3(c)(1); 230-20-30 R.I. Code R. § 9.7.

<sup>196</sup> 42 C.F.R. 422.116.

<sup>197</sup> *FTC v. Sanford Health*, 926 F.3d 959, 963 (2019) (the hypothetical monopolist test “is commonly used in antitrust actions to define the relevant market.”); Merger Guidelines §§ 4.1 & 4.2.

<sup>198</sup> *FTC v. Penn State Hershey Med. Ctr.* 838 F.3d 327, 338 (3rd Cir. 2016) (“*Hershey*”).

<sup>199</sup> *Hershey*, 838 F.3d at 346 (“the Government was not required to show that payors would accept a price increase rather than excluding the merged Hershey/Pinnacle entity from their networks; it was required to show only payors would accept a price increase rather than excluding *all* of the hospitals in the Harrisburg area [the proposed geographic market]. That is the inquiry under the hypothetical monopolist test.”).

<sup>200</sup> Bush Decl. ¶ 5.

between the WTP of a hypothetical monopolist and the sum of the individual WTP of the separate Rhode Island hospital systems.<sup>201</sup> Dr. Pflum concludes that an insurer's willingness to pay for the services of a hypothetical monopolist of all Rhode Island hospitals increases by 43% when compared with the sum of the insurer's willingness to pay for the services of the individual hospitals that currently exist in Rhode Island. Academic research shows that a WTP difference of this magnitude is associated with large price increases, implying that an insurer would likely pay a SSNIP to a hypothetical monopolist of all Rhode Island hospitals rather than offer a plan that excludes all of them.<sup>202</sup> In fact, Dr. Pflum estimates that a 43% increase in WTP is associated with a 24% increase in price based on Rhode Island hospital prices.<sup>203</sup>

**b. The Proposed Transaction would result in a market share and concentration that far exceed the threshold over which the merger is presumptively anticompetitive.**

Courts use basic metrics – market shares and what is known as the Herfindahl-Hirschman Index (“HHI”) – to determine whether a merger should be presumed anticompetitive. These two metrics are related: HHI is calculated as the sum of the squares of market shares of each market participant.<sup>204</sup> A post-merger market share of 30% gives rise to the presumption of illegality.<sup>205</sup> The Merger Guidelines classify a market as unconcentrated if the HHI is below 1,500, moderately concentrated if it is between 1,500 and 2,500, and highly concentrated if it is above 2,500.<sup>206</sup> A merger is “presumed to be likely to enhance market power” if it would increase the HHI by more than 200 points and result in a highly concentrated market.<sup>207</sup> Applying the Merger Guidelines’ standards, courts have found that mergers that cause a greater than 200 point increase in the HHI and result in a post-merger HHI of more than 2,500 are presumptively

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<sup>201</sup> Pflum Report ¶ 111.

<sup>202</sup> *Id.*

<sup>203</sup> *Id.*

<sup>204</sup> P. Areeda & H. Hovenkamp, *Antitrust Law* ¶ 930a (4th ed. 2019) (“Areeda”) (“The HHI estimates market concentration by summing the squares of the market shares of every firm in the market. Thus a market with five firms of share  $A = 30$ ,  $B = 30$ ,  $C = 20$ ,  $D = 10$ ,  $E = 10$ , would have an HHI of  $900 + 900 + 400 + 100 + 100$ , or 2400”); Merger Guidelines § 5.3. Courts commonly use HHI to calculate market concentration. *See, e.g., Hershey*, 838 F.3d at 346 (“Market concentration is measured by the Herfindahl-Hirschman Index (‘HHI’).”); *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 716 (D.C. Cir. 2001) (“Market concentration, or the lack thereof, is often measured by the Herfindahl-Hirschman Index (HHI).”).

<sup>205</sup> *United States v. Philadelphia Nat’l Bank*, 374 U.S. 321, 364 (1963) (“Without attempting to specify the smallest market share which would still be considered to threaten undue concentration, we are clear that 30% presents that threat.”); *see also FTC v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069, 1078 (N.D. Ill. 2012) (finding that 59.4% and 64.2% post-merger market shares “far surpass the threshold found to be presumptively unlawful in *Philadelphia National Bank*.”).

<sup>206</sup> Merger Guidelines § 5.3.

<sup>207</sup> *Id.* § 5.3. Under the Guidelines, mergers that result in even lesser market concentrations “potentially raise significant competitive concerns and often warrant scrutiny.” *Id.*

illegal.<sup>208</sup> Such transactions “potentially raise significant competitive concerns and often warrant scrutiny.”<sup>209</sup> Based on both of these metrics, the merger of Lifespan and CNE flies past the threshold for the presumption of illegality.

The Merger Guidelines prescribe two methods to compute market shares, depending on whether the market is defined around the location of sellers or around the location of buyers. When the geographic market is defined around the location of suppliers – *i.e.*, all hospitals in Rhode Island – the Merger Guidelines prescribe computing shares for those suppliers based on their sales, whether or not the buyers are in the market.<sup>210</sup> This means shares should be computed as the shares among Rhode Island hospitals based on these hospitals’ discharges, regardless of whether the patient resides in Rhode Island or traveled from out of state. Under this approach, Dr. Pflum finds that a combined Lifespan/CNE system would have a post-merger market share of 80% of overlapping inpatient GAC services sold to commercial insurers and provided to their adult members at Rhode Island hospitals. This share well exceeds the Supreme Court’s 30% market share threshold for a presumption of illegality. Moreover, Dr. Pflum predicts the merger to increase the HHI by 3,184 points, from a starting HHI of 3,315 to a post-merger HHI of 6,499 points. Thus, the Proposed Transaction is presumed likely to enhance market power as it would increase the HHI by an amount nearly 16 times greater than 200 points, resulting in a highly concentrated market far exceeding the 2,500 threshold.<sup>211</sup>

The projected 3,184 increase in the HHI when the market is defined as the set of overlapping inpatient GAC services sold to commercial insurers and provided to their adult members at hospitals in Rhode Island is exceedingly high. It would represent the largest increase in HHI among the last 11 proposed hospital mergers that the FTC has sought to block since 2004, as illustrated in the following chart:

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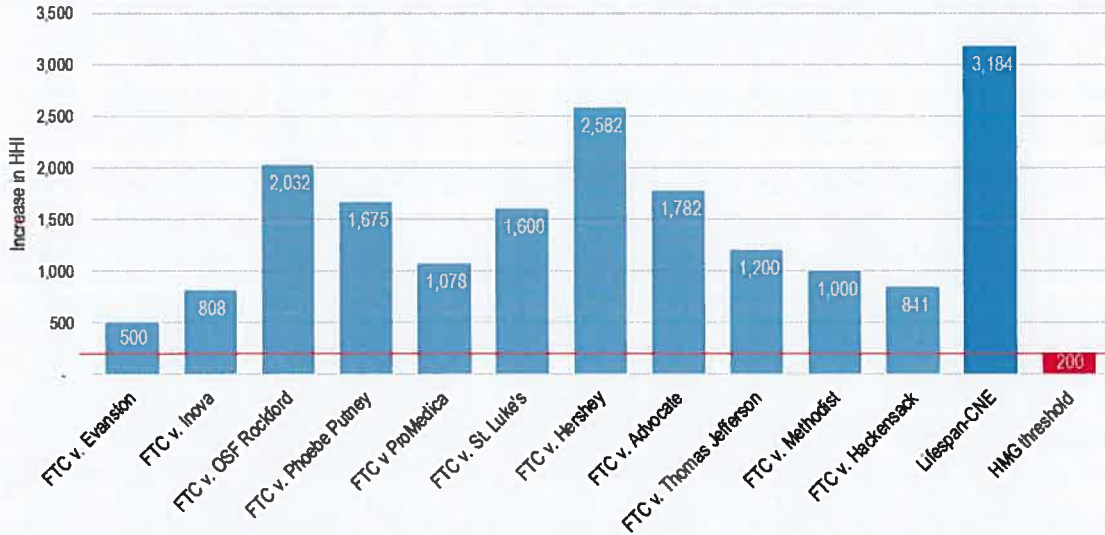
<sup>208</sup> See, e.g., *Hershey*, 838 F.3d at 347 (“The Government can establish a prima facie case simply by showing a high market concentration based on HHI numbers.”); *ProMedica*, 749 F.3d at 568 (describing the Merger Guidelines’ 200 increase in HHI as the threshold for the “presumption of illegality”).

<sup>209</sup> *Id.* § 5.3.

<sup>210</sup> *Id.* § 4.2.1.

<sup>211</sup> Pflum Report ¶ 123 & Figure 11.

**Figure 14. The Proposed Transaction will increase the HHI by more than the estimated increase in all hospital mergers challenged by the FTC in the last 18 years<sup>212</sup>**



The Merger Guidelines also prescribe that market shares be computed based on all sellers that supply customers when the geographic market is defined around the location of consumers.<sup>213</sup> Applied to this merger, that means shares are computed for all hospitals that commercially insured adult Rhode Island residents go to for treatment, whether or not the hospital is in Rhode Island. Even under this alternative approach, where the geographic market is defined around the location of Rhode Island patients instead of the location of Rhode Island hospitals, the merger is presumptively anticompetitive. Dr. Pflum concludes that a CNE and Lifespan merger would result in a post-merger share of 70.0% of all inpatient GAC discharges of commercially insured Rhode Island residents and would increase the HHI by 2,449 points, from a pre-merger HHI of 2,588 to a post-merger HHI of 5,038.<sup>214</sup>

Finally, the same presumption of harm to competition remains even when the definition of the relevant market is adjusted by expanding the geographic market to [REDACTED] the “MARI” region<sup>215</sup> – consisting of the state of Rhode Island and surrounding 19 towns in Massachusetts – and by narrowing the product market by excluding obstetrics from the cluster of inpatient GAC services.<sup>216</sup>

<sup>212</sup> *Id.* ¶ 127 & Figure 14

<sup>213</sup> Merger Guidelines § 4.2.2.

<sup>214</sup> Pflum Report ¶ 123 & Figure 12.

<sup>215</sup> Gelinas Dec. 23, 2021 Tr. 37:2-39:10.

<sup>216</sup> Pflum Report Figure 49 at Appendix D-1.

**Figure 49: Market shares and HHIs in alternative geographic and product markets<sup>217</sup>**

Geographic market	Product market	Concentration			
		Combined share	HHI		
			Pre	Post	Change
Rhode Island hospitals	All overlapping adult inpatient GAC	79.8%	3,315	6,499	3,184
Rhode Island patients	All overlapping adult inpatient GAC	70.0%	2,588	5,038	2,449
MARI hospitals	All overlapping adult inpatient GAC	65.4%	2,337	4,474	2,136
MARI patients	All overlapping adult inpatient GAC	52.4%	1,610	2,981	1,372
Rhode Island hospitals	Overlapping adult Inpatient GAC, excluding labor and delivery	75.0%	3,855	5,821	1,966
Rhode Island patients	Overlapping adult inpatient GAC, excluding labor and delivery	63.7%	2,769	4,267	1,498
Threshold over which a merger is presumed to be likely to enhance market power:				2,500	200

In short, regardless of how the geographic market is defined, the Proposed Transaction would be presumed illegal because the merger would increase the HHI by more than 200 points and result in a highly concentrated market.<sup>218</sup>

**c. Economic analysis establishes that Lifespan and CNE hospitals compete with each other in the market for inpatient GAC hospital services.**

The Parties have asserted that the services each system provides are unique and highly differentiated, and the services provided by one are not substitutes for the services provided by the other. While each system does possess certain relatively specialized hospitals (for example, W&I is the top provider of obstetrics, while RIH is the only Rhode Island provider of certain highly specialized and technical care known as tertiary and quaternary services), the Parties overstate the degree of differentiation between their services [REDACTED]. Nonetheless, to empirically test the degree of competition between Lifespan and CNE, Dr. Pflum performs two standard economic analyses regarding service line overlap and diversions between the two systems. Consistent with the record evidence discussed above in Section II.A.3, both analyses demonstrate that Lifespan and CNE engage in head-to-head competition in numerous service areas.

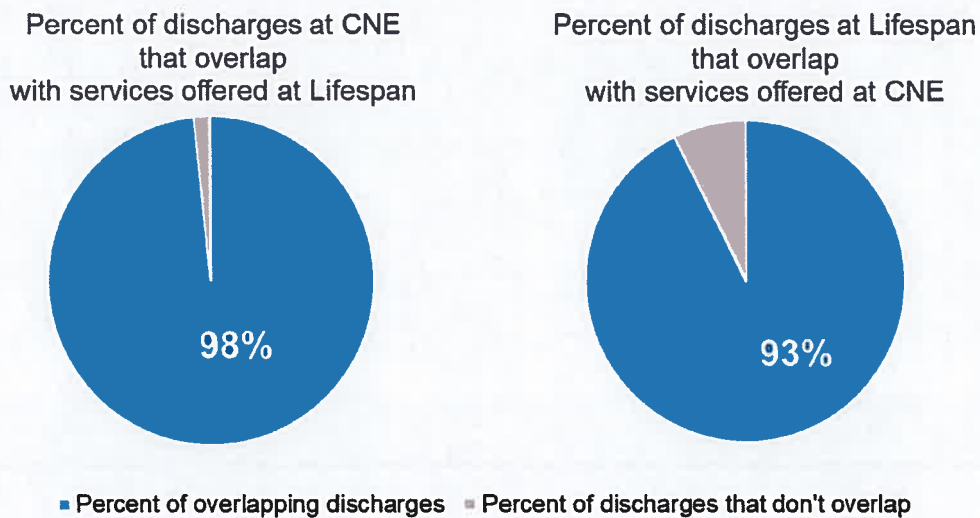
<sup>217</sup> *Id.*

<sup>218</sup> *Hershey*, 838 F.3d at 347 (merger was presumptively anticompetitive where the increase in HHI was 2,582 and the post-merger HHI was 5,984); *Saint Alphonsus Med. Ctr.*, 778 F.3d at 786 (merger was presumptively anticompetitive where the increase in HHI was 1,607 and the post-merger HHI was 6,219); *ProMedica*, 749 F.3d at 568 (“[t]he merger here blew through those barriers in spectacular fashion,” where HHI in the GAC market would increase by 1,078 to 4,391 and the HHI in the obstetrical services market would increase by 1,323 to 6,854.).

(1) Service line overlap

While there is some degree of differentiation between the services provided by certain Lifespan hospitals and certain CNE hospitals, Dr. Pflum’s analysis demonstrates significant overlap in the services offered by the two systems. In fact, Lifespan and CNE compete head-to-head for the large majority of their discharges – well over 90% of their services on a volume-adjusted basis.<sup>219</sup> Ninety-eight percent of CNE’s discharges of Rhode Island patients are for services provided at Lifespan hospitals and 93% of Lifespan’s discharges of Rhode Island patients are for services provided at CNE hospitals.<sup>220</sup>

Figure 21: Lifespan and CNE largely offer the same set of inpatient GAC services<sup>221</sup>



The overlap in services is especially pronounced in the case of CNE’s Kent Hospital (the second largest hospital in Rhode Island) and Lifespan’s Rhode Island Hospital (the largest hospital in Rhode Island) and The Miriam Hospital. All three offer a broad array of GAC services. During the 2017 to 2019 period, 93% of discharges of Rhode Island patients at Kent involved services that were offered at RIH and/or Miriam.<sup>222</sup> Conversely, 92% of discharges at RIH and Miriam involved services that were offered at Kent.<sup>223</sup>

<sup>219</sup> Pflum Report ¶ 229 & Figure 21.

<sup>220</sup> *Id.*

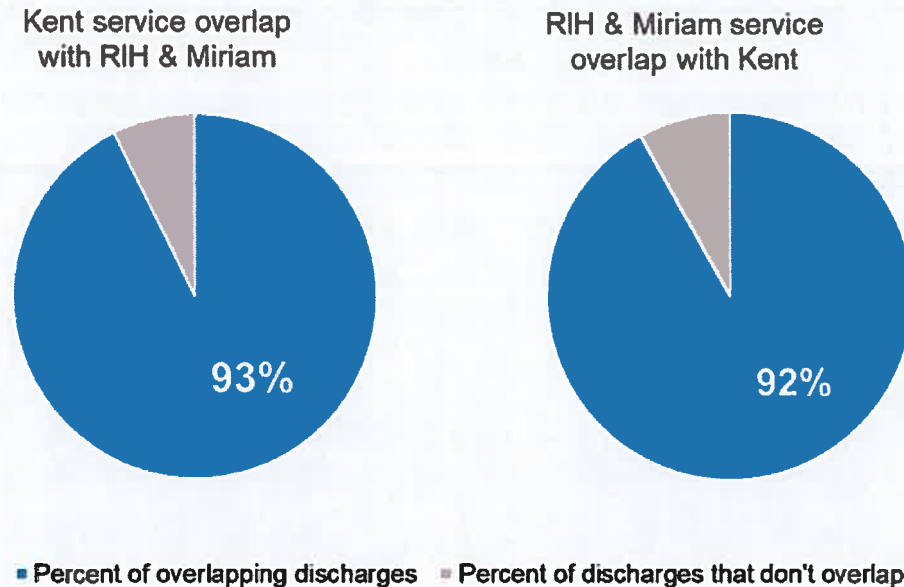
<sup>221</sup> *Id.*

<sup>222</sup> *Id.* ¶ 233 & Figure 26.

<sup>223</sup> *Id.*



**Figure 26. CNE’s Kent hospital and Lifespan’s RIH and Miriam hospitals offer largely overlapping inpatient GAC services<sup>224</sup>**



Dr. Pflum also examines these overlapping services between Kent and RIH/Miriam at a more granular level by analyzing the service overlap within each “major diagnostic category” (“MDC”).<sup>225</sup> Among the 11 MDCs that collectively accounted for nearly 90% of the volume at Kent, RIH and/or Miriam offered all (100%) of the services that Kent offered for each MDC, except for obstetrics.<sup>226</sup> About 90% of the discharges at RIH and Miriam were for services that Kent also offered.<sup>227</sup> The lowest service overlap is associated with the nervous system category, where 72% of the discharges of RIH and Miriam were for services that Kent offered.<sup>228</sup>

## (2) Diversion analysis

Not only do Lifespan and CNE mostly provide the same services, but economic analysis by Dr. Pflum shows that Lifespan and CNE are competitors for those services. Diversion ratios, which the FTC commonly uses to analyze hospital competition, also demonstrate the head-to-head competition between Lifespan and CNE. Diversion ratios are calculations that quantify

<sup>224</sup> *Id.*

<sup>225</sup> Major diagnostic categories represent groups of diagnoses that are for the same organ system (*e.g.*, respiratory system) or for which the patient’s disease or condition have a common cause (*e.g.*, infectious and parasitic diseases and disorders).

<sup>226</sup> *Id.* ¶ 234 & Figure 27.

<sup>227</sup> *Id.*

<sup>228</sup> *Id.*



CNE hospitals is 44%.<sup>236</sup> These ratios demonstrate that RIH and Kent, the two largest hospitals in the state, are competing head-to-head for the patients residing in the large population centers between the two hospitals.<sup>237</sup>

**d. The Proposed Transaction is likely to substantially reduce price competition.**

The record demonstrates not only that Lifespan and CNE compete with each other, but also how the loss of that competition would reduce price competition. The healthcare industry is different from other industries in that the consumers – the insured patients who use hospital services – do not pay the hospital other than co-pays or other similar charges.<sup>238</sup> Because of this unique feature, the healthcare market is described as having two stages of competition.<sup>239</sup> In the first stage, hospitals compete to be included in an insurer’s network of providers.<sup>240</sup> In the second stage, hospitals compete to attract patients.<sup>241</sup> Although stage one is focused on insurers and stage two is focused on patients, the two stages are interrelated in that patient “behavior affects the relative bargaining positions of insurers and hospitals as they negotiate rates.”<sup>242</sup>

The Parties have publicly argued that “with few exceptions, Lifespan and Care New England offer [sic] do not compete on the basis of clinical services rather they present complementary health care services” for commercial insurers in Rhode Island.<sup>243</sup>

[REDACTED]

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As demonstrated in the preceding sections, the Attorney General’s review has demonstrated that the Parties’ premise is wrong. Documents, testimony, and empirical evidence all establish that Lifespan and CNE hospitals compete with each other in numerous services lines. The Parties’ argument is faulty for additional reasons. First, although there is some degree of differentiation between the services offered by certain Party hospitals, because of the

<sup>236</sup> *Id.* ¶ 148.

<sup>237</sup> *Id.*

<sup>238</sup> *Hackensack*, 2021 WL 4145062, at \*16.

<sup>239</sup> *Hershey*, 838 F.3d at 342; *see also Saint Alphonsus Med. Ctr.*, 778 F.3d at 784 n.10 (two-stage model is the “accepted model”).

<sup>240</sup> *Hershey*, 838 F.3d at 342.

<sup>241</sup> *Id.*

<sup>242</sup> *Hershey*, 838 F.3d 327 at 342.

<sup>243</sup> *Frequently Asked Questions*, HealthierRI.com/faq (accessed Feb. 7, 2022).

[REDACTED]

245 [REDACTED]

substantial overlap in services, insurers still have been able to use the rates of one system, or market rates reflecting the rates of one system, to obtain price concessions in negotiations with the other system. Moreover, the record demonstrates that a merged Lifespan/CNE – with its overwhelming market share – would have greater bargaining power than the two systems currently have as separate entities. Dr. Pflum agrees in his expert report:

I conclude that the Proposed Transaction is likely to enhance the combined system's bargaining leverage *vis-à-vis* insurers and substantially reduce competition to attract and serve Rhode Island patients—commercial, Medicare, and other.<sup>246</sup>

Thus, as detailed below, the Proposed Transaction is likely to lessen competition in stage one of hospital competition where hospitals compete for inclusion in the insurer networks.

**(1) The Proposed Transaction would increase the Parties' bargaining leverage in negotiations with insurers.**

The reduction in competition caused by the Proposed Transaction would increase the Parties' already significant bargaining leverage in contract negotiations with commercial insurers. Blue Cross Blue Shield of Rhode Island ("BCBSRI") – which accounts for 70% of commercially insured lives in Rhode Island<sup>247</sup> – illustrates this dynamic.

BCBSRI explains that Lifespan and CNE "offer many of the same services for both inpatient and outpatient care" and "are each other's primary competitors."<sup>248</sup> Competition between Lifespan and CNE "has enabled BCBSRI to negotiate lower rates on behalf of Rhode Island residents."<sup>249</sup> For example, BCBSRI has been able to use prevailing market rates, reflecting CNE's lower rates, to negotiate lower rates from Lifespan in connection with certain services.<sup>250</sup> As another example of the benefits to Rhode Island residents of the competition between Lifespan and CNE, BCBSRI has also been able to secure lower rates from Lifespan in a narrow network product featuring Lifespan that excludes CNE.<sup>251</sup> The merger "would eliminate competition between Lifespan and CNE that has historically increased service offerings and reduced rates."<sup>252</sup> With a "lack of competitors to keep the merged system in check," the Proposed Transaction "would give the merged entity increased leverage in negotiations with

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<sup>246</sup> Pflum Report ¶ 134.

<sup>247</sup> *Id.* ¶ 65.

<sup>248</sup> Bush Decl. ¶ 6.

<sup>249</sup> *Id.* ¶ 8.

<sup>250</sup> *Id.* [REDACTED]

<sup>251</sup> Bush Decl. ¶ 9.

<sup>252</sup> *Id.* ¶ 10.

BCBSRI.”<sup>253</sup> Thus, the largest insurer in Rhode Island rejects the Parties’ theory that the separate existence of the two systems is irrelevant to negotiations and that the Proposed Transaction will not increase the Parties’ bargaining leverage.

Similarly, PACE Organization of Rhode Island (“PACE-RI”), a “statewide, non-profit 501(c)(3) health plan for frail elders with low income who want to continue living in their own homes,” has expressed serious concerns about the Proposed Transaction and the effect that decreased competition between CNE and Lifespan would have on hospital rates.<sup>254</sup> PACE-RI opposes the merger because “[w]ith decreased competition, [PACE-RI] expect[s] that a unified [Lifespan-CNE] hospital system would require PACE-RI to pay increased rates across all hospitals, something that would cost PACE-RI, and in turn the government, hundreds of thousands of dollars in extra fees each year.”<sup>255</sup>

BCBSRI expresses other concerns regarding the harm to competition that would result from the Proposed Transaction. In light of the significant discrepancies in prices for the same services at different facilities, BCBSRI expresses concern that “a merged Lifespan-CNE may shift volume to its higher-cost facilities.”<sup>256</sup> In addition, because “competitive pressure has pushed Lifespan and CNE to improve quality and expand service offerings,” BCBSRI expresses concern that a merger would reduce incentives to make quality improvements and to participate in innovative products.<sup>257</sup>

**(2) Economic analysis shows that the merger would lead to price increases.**

Dr. Pflum’s analysis shows that the Proposed Transaction would increase the Parties’ bargaining leverage and that such increase is associated with a 9% price increase relative to what insurers would pay absent the merger. Dr. Pflum uses “willingness to pay” (“WTP”) analysis, a standard analysis often used in hospital mergers to estimate the increase in the merged system’s bargaining leverage resulting from the merger.<sup>258</sup> Dr. Pflum looks at the difference between the WTP of the proposed merged hospital system and the sum of the individual WTP of CNE and Lifespan.<sup>259</sup> Dr. Pflum finds that, for Rhode Island patients, the WTP for a combined Lifespan/CNE system is 16.2% higher than the sum of the WTP for each of the two systems.<sup>260</sup>

Put differently, the value that the merged Lifespan/CNE adds to an insurer’s network from the perspective of a Rhode Island resident is 16.2% higher than the value that Lifespan and

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<sup>253</sup> *Id.* ¶ 13.

<sup>254</sup> Letter from PACE-RI to RIAG (Feb. 9, 2022).

<sup>255</sup> *Id.*

<sup>256</sup> Bush Decl. ¶ 14.

<sup>257</sup> *Id.* ¶ 15.

<sup>258</sup> Pflum Report ¶ 156.

<sup>259</sup> *Id.* ¶ 158.

<sup>260</sup> *Id.* ¶ 160.

CNE separately add to an insurer's network.<sup>261</sup> As Dr. Pflum explains, this will have real consequences:

[T]he estimated 16.2 percent increase in WTP generated by the Proposed Transaction corresponds with an 8.9 percent increase in price. This positive relationship between prices and WTP in Rhode Island is further confirmed by the observation that prices for [insurers] generally move together, *i.e.*, when a system has a higher price with one insurer, it has a relatively higher price with all insurers.<sup>262</sup>

Consistent with the testimony of BCBSRI, this increase in WTP reflects the increased bargaining leverage of a merged Lifespan/CNE system resulting from the elimination of competition between Lifespan and CNE.

**(3) The economic literature confirms that the Proposed Transaction's elimination of head-to-head competition between Lifespan and CNE is likely to increase Rhode Islanders' healthcare costs without any offsetting improvement in the quality of care or access to care.**

There is a general academic consensus that mergers of hospitals tend to result in increased hospital prices. [REDACTED]

[REDACTED]<sup>263</sup> In 2020, the Medicare Payment Advisory Commission reported the same conclusion to the U.S. Congress: the "preponderance of the research suggests that hospital consolidation leads to higher prices for commercially insured patients."<sup>264</sup> Professor Martin Gaynor of Carnegie Mellon University – one of the leading scholars in the field of competition and antitrust policy in healthcare markets – came to the same conclusion in his recent testimony before the U.S. Senate Committee on the Judiciary Subcommittee on Competition Policy, Antitrust, and Consumer Rights:

There are many studies of hospital mergers. These studies look at many different mergers in different places in different time periods and find substantial increases in price resulting from mergers in concentrated markets. . . . Price increases on the order of 20 or 30 percent are common, with some increases as high as 65 percent. . . . Overall, these studies consistently show that when hospital consolidation is between close competitors it raises prices, and by substantial amounts. Consolidated hospitals that are able to charge higher prices due to reduced competition are able to do so on an ongoing basis, making this a permanent rather than a transitory problem. Moreover, there is no difference

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<sup>261</sup> *Id.*

<sup>262</sup> *Id.* ¶ 162.

<sup>263</sup> [REDACTED]

<sup>264</sup> MedPac, *March 2020 Report to the Congress: Medicare Payment Policy*, Mar. 13, 2020, at 468, [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/mar20\\_entirereport\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_entirereport_sec.pdf).

between not-for-profit and for-profit hospitals in the extent to which they raise prices due to increased market power.<sup>265</sup>

Professor Gaynor further explained that the inflated prices resulting from hospital mergers are ultimately borne by consumers in the form of higher premiums, increased out-of-pocket expenses, and/or reduced benefits and lower wages:

[T]he burden of higher provider prices falls on individuals, not insurers or employers . . . . Insurers facing higher provider prices increase their premiums to employers. Employers then pass those increased premiums on to their workers, either in the form of lower wages (or smaller wage increases) or reduced benefits (greater premium sharing, greater cost sharing, or less extensive coverage). . . . Employers may also respond to these increases in their costs of employing workers by reducing workers' hours or the number of workers. A recent study . . . finds that "hospital mergers lead to a \$521 increase in hospital prices, a \$579 increase in hospital spending among the privately insured population and a . . . \$638 reduction in wages."<sup>266</sup>

Dr. Pflum's analysis shows that this pattern of mergers resulting in higher prices that are passed along to consumers is expected to hold true for the Proposed Transaction. Dr. Pflum also finds that increased insurer spending on inpatient medical care translates directly into higher premiums for Rhode Island employers and residents.<sup>267</sup> Analyzing data from Rhode Island's Office of the Health Insurance Commissioner, Dr. Pflum shows that a one-percent increase in an insurer's inpatient medical expense is associated with a larger-than-one-percent increase in premiums passed on to consumers.<sup>268</sup> As Dr. Pflum explains in his report:

Consistent with OHIC's statement [that commercial payers pass along price increases to consumers in the forms of higher premiums and out-of-pocket medical expenses], statistical analysis of the premium increases shows that a one percentage point increase in an insurer's inpatient medical expense is associated with a statistically significant increase in the OHIC-approved premium of more than one percentage point. That is, when insurers' costs increase, those increases are passed on to their members through higher premiums.<sup>269</sup>

Nor can Rhode Islanders expect better quality of care in return for their increased spending. To the contrary, the academic consensus is that quality suffers or, at best, remains the

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<sup>265</sup> Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solution*, May 19, 2021, at 9-10 (citations omitted), [https://www.judiciary.senate.gov/imo/media/doc/Gaynor\\_Senate\\_Judiciary\\_Hospital\\_Consolidation\\_May\\_19\\_2021.pdf](https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf); see also Pflum Report § VI.A (discussing literature and coming to the same conclusion as Professor Gaynor).

<sup>266</sup> Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solution*, at 6-7 (citations omitted).

<sup>267</sup> Pflum Report ¶ 198.

<sup>268</sup> *Id.* ¶ 199.

<sup>269</sup> *Id.*

same following a merger. As Professor Gaynor told the Senate Committee, “the strongest scientific studies” show “that the lack of competition can cause serious harm to the quality of care received by patients, even substantially increasing the risk of death.”<sup>270</sup>

There are compelling reasons to conclude that the Proposed Transaction, too, would result in the stagnation or decline in the quality of care. As discussed below, the merger also is likely to result in the diminishment of innovation, patient convenience, and access.

**e. The Proposed Transaction also would eliminate vital quality, access, and other non-price competition.**

As described in the preceding section, the healthcare market is considered to have two stages of competition. The preceding section demonstrates that the Proposed Transaction would increase the Parties’ bargaining leverage in the first stage. In the second stage, hospitals compete to attract patients.<sup>271</sup> Because patients “are largely insensitive to healthcare prices” due to insurance,<sup>272</sup> hospitals compete on non-price factors such as the quality of care they provide, ease of access to a local facility, or simply how easy it is to make an appointment.<sup>273</sup> The Parties’ “complementarity” argument also fails because it largely ignores the effects that the Proposed Transaction is likely to have in the second stage of hospital competition where hospitals compete for patient volume based primarily on non-price factors such as quality, convenience, and innovation.

Antitrust law is not concerned solely with price effects. In *United States v. Continental Can Co.*, the United States Supreme Court observed that rivalry on non-price terms “may not be price competition but it is nevertheless meaningful competition” that Section 7 protects.<sup>274</sup> Similarly, the Merger Guidelines explain that an antitrust analysis must consider the non-price effects of a proposed transaction. That is because “[e]nhanced market power can also be manifested in non-price terms and conditions that adversely affect customers, including reduced product quality, reduced product variety, reduced service, or diminished innovation. Such non-price effects may coexist with price effects, or can arise in their absence.”<sup>275</sup> Here, the evidence

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<sup>270</sup> Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solution* at 6, 11; see also Pflum Report Section VI.A.2 (discussing literature and coming to the same conclusion as Professor Gaynor).

<sup>271</sup> *Id.*

<sup>272</sup> *Id.*

<sup>273</sup> *FTC v. Advocate Health Care Network*, 841 F.3d 460, 465 (7th Cir. 2016) (second stage competition focuses “primarily on non-price factors like convenience and reputation for quality”). Although stage one is focused on insurers and stage two is focused on patients, the two stages are interrelated in that patient “behavior affects the relative bargaining positions of insurers and hospitals as they negotiate rates.” *Hershey*, 838 F.3d 327 at 342.

<sup>274</sup> 378 U.S. 441, 456 (1964).

<sup>275</sup> Merger Guidelines § 1.



shows that the Proposed Transaction will likely produce non-price effects – *i.e.*, diminution of quality, service, access, and innovation – that will adversely affect Rhode Island patients.<sup>276</sup>

Approval of the Proposed Transaction would mean the end of the head-to-head competition between Lifespan and CNE and, with it, the end of the economic incentive for either system to make investments to improve quality of care or customer service because of competitive pressure from the other system. Given that a merged Lifespan/CNE entity would account for over 80% of all Rhode Island discharges of commercially insured patients receiving inpatient GAC hospital services, it would face no significant competition from the remaining Rhode Island hospitals and thus would have little economic reason to make improvements to attract patients. This means that, following a merger, Rhode Islanders are less likely to benefit in the ways they did when CNE and Lifespan were competing with each other for quality, innovation, patient convenience, and access.

**(1) The Proposed Transaction would eliminate competition between Lifespan and CNE to improve the quality of the health care they provide.**

As described in the preceding sections, [REDACTED] other providers, and the largest insurer in Rhode Island view Lifespan and CNE as competitors. Not surprisingly, the record also demonstrates that, to draw additional patients, the two systems monitor each other's quality and service offerings, and each system responds in a way that enhances its own competitive position. Often, the response takes the form of investments that result in improved quality, expanded service offerings, and/or greater patient convenience and access. In other words, the competition between Lifespan and CNE for patients produces real benefits for Rhode Island patients in the quality, choice, and convenience of healthcare services. But the Proposed Transaction would eliminate this competition and, with it, the benefits that redound to patients.

[REDACTED]

[REDACTED]

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<sup>276</sup> See *Hackensack*, 2021 WL 4145062, at \*24 (in granting a preliminary injunction against a proposed hospital merger, observing that the merger “would also likely eliminate competition on a non-price level” because loss of competition between the merging parties “would remove an incentive for both entities to continue improve quality metrics and offer innovative medical technology.”).

<sup>277</sup> [REDACTED].

[REDACTED]  
278

[REDACTED]  
[REDACTED]. In 2014, Kent started using robots that employ ultraviolet light to sterilize rooms between patient stays and lower the risk of healthcare-associated infections.<sup>279</sup>

[REDACTED]  
280

[REDACTED]  
281

**(2) The Proposed Transaction would eliminate competition between Lifespan and CNE to make investments that improve patient services and access.**

The Merger Guidelines observe that “[c]ompetition often spurs firms to innovate” and regulators “may consider whether a merger is likely to diminish innovation competition by encouraging the merged firm to curtail its innovative efforts below the level that in the absence of the merger.”<sup>282</sup> Here too, the record demonstrates competition between Lifespan and CNE has pushed each to make investments to improve patient services and convenience.

One such example is in the cardiology/cardiovascular service line. As described in Section II.A.3.b.1, competition between RIH and Kent for cardiology market share motivated Kent to expand its cardiology offerings by building cardiac catheterization laboratories. Kent also made it easier for patients to access those offerings. [REDACTED]

278 [REDACTED]

<sup>279</sup> Rhode Island Medical Journal, *Kent and Memorial Hospitals Using Germ-Zapping Robots to Fight Infection* (Jun. 2014).

280 [REDACTED]

281 [REDACTED]

<sup>282</sup> Merger Guidelines § 6.4.

[REDACTED] 283  
[REDACTED] 284  
[REDACTED] 285

[REDACTED] 286  
[REDACTED] 287  
[REDACTED] 288  
[REDACTED] 289  
[REDACTED] 290

The thoracic service line provides another illustration of competition between Lifespan and CNE driving the Parties to develop, expand, and improve their services. Thoracic surgery focuses on the chest area, including the treatment of lung and esophageal cancer.

[REDACTED] 291  
[REDACTED] 292  
[REDACTED] 293

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283 [REDACTED] LIFESPAN00760049; see also LIFESPAN02396896 at -097 ([REDACTED]).

284 *Id.* at LIFESPAN00760049.

285 *Id.* at LIFESPAN00760050.

286 *Id.* at LIFESPAN00760051.

287 *Id.*

288 [REDACTED] LIFESPAN00760051.

289 [REDACTED].

290 [REDACTED].

291 [REDACTED].

292 [REDACTED].

293 [REDACTED].

[REDACTED] 294  
[REDACTED] 295

296 Because of this competition, Rhode Island is now home to a “world-class” physician specializing in minimally invasive robotic surgeries that “have the advantage of reduced pain and bleeding, minimal scarring, and fewer complications” for patients.<sup>297</sup> A merger between the Parties would eliminate the competition that has pushed the two systems to expand and innovate.

Lifespan’s application to expand its obstetrics offerings at RIH provides another example of competition motivating the Parties to expand their service offerings.

[REDACTED] 298  
[REDACTED] 299

[REDACTED] 300  
[REDACTED] 301  
[REDACTED] 302

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294 [REDACTED] LIFESPAN03731940.

295 [REDACTED] LIFESPAN03731940.

296 [REDACTED]

297 Press Release, Lifespan, Lifespan expands thoracic care, hires world-class surgeon Abbas El-Sayed Abbas, MD (July 14, 2021), <https://www.lifespan.org/news/lifespan-expands-thoracic-care-hires-world-class-surgeon-abbas-el-sayed-abbas-md>; Press Release, Brown Surgical Associates, World Class Surgeon, Abbas, Tapped to Take Reins of Brown Surgical Associates’ Thoracic Surgery Division (Jun. 24, 2021), <https://www.brownsurgicalassociates.org/2021/06/24/world-class-surgeon-abbas-abbas-tapped-to-take-reins-of-brown-surgical-associates-thoracic-surgery-division/>.

298 [REDACTED]

299 [REDACTED]

300 [REDACTED]  
[REDACTED] LIFESPAN ORIG007633 [REDACTED]

301 [REDACTED]

302 [REDACTED]

Therefore, in 2016, Lifespan attempted to win over W&I patients by filing a Certificate of Need application with the Rhode Island Department of Health to expand its obstetrics offerings; Lifespan re-filed the application in 2017.<sup>304</sup> In advocating for approval of the application, Lifespan argued that because CNE handles 87% of the deliveries for Rhode Island residents, people “in Rhode Island have very few alternatives when it comes to where they will deliver their babies” and that “[a]lternatives to Women & Infants and the Care New England system are needed to address the current monopoly regarding obstetrics services.”<sup>305</sup> Lifespan further represented to the Rhode Island Department of Health that, “[b]y providing another option” to people in and around Providence, “patients will have real choice regarding their care, and payors will be able to negotiate more competitive rates,” and that RIH believed that “increased competition will result in reduced prices.”<sup>306</sup> Although Lifespan ultimately abandoned its application (following an objection by CNE),<sup>307</sup> the fact that Lifespan was prepared to invest tens of millions of dollars<sup>308</sup> to create an expanded obstetrics unit that it believed would lower costs and offer more choice to Rhode Islanders demonstrates the potential benefits of competition, which would be lost were the Parties to merge.<sup>309</sup>

The Parties also have responded to competition from each other by focusing on improving patient convenience and access in other ways. For example:

- [REDACTED]

310

- [REDACTED]

<sup>303</sup> LIFESPAN ORIG007633 at Slide 3 ([REDACTED]).

<sup>304</sup> Certificate of Need Application at 3.

<sup>305</sup> *Id.* at 12, 26.

<sup>306</sup> *Id.* at 27.

<sup>307</sup> Letter from Mark Marcantano, President and COO of Women & Infants, to Rhode Island Department of Health (Mar. 31, 2017) at 1.

<sup>308</sup> Certificate of Need Application, Lifespan, submitted to Rhode Island Department of Health (Jan. 17, 2017) at 3. at 1.

<sup>309</sup> [REDACTED] FTC-CNE-00006952 at -069.

<sup>310</sup> [REDACTED] FTC-CNE-00227333-334 [REDACTED].

[REDACTED] 311

• [REDACTED] 312

• [REDACTED] 313

Competition also has spurred regulatory compliance, resulting in greater transparency for patients. [REDACTED] 314

The Parties also have acknowledged that competition pushes them to make changes that benefit patients. [REDACTED] 315  
[REDACTED] 316  
[REDACTED] 317  
[REDACTED] 318  
[REDACTED] 319

The Proposed Transaction would eliminate the head-to-head competition between Lifespan and CNE that produces real benefits for Rhode Island patients, whether they have commercial insurance, obtain coverage on the individual market, or utilize Medicare or Medicaid, and for plan sponsors, including small businesses. Because a merged entity with an inpatient GAC market share of 80% would face little competition for patients, it would have no

311 [REDACTED]

312 [REDACTED]

313 LIFESPAN07393094.

314 Iannoni Jan. 12, 2022 Tr. 178:8-179:11.

315 [REDACTED]

316 [REDACTED]

317 LIFESPAN\_ORIG007633 at -636.

318 LIFESPAN\_ORIG007633 at -643.

319 FTC-CNE-00866098 at -100.

incentive to make the investments that Lifespan and CNE, as separate entities, have previously made or contemplated making to improve the quality of their services, add services lines, and increase patient safety, convenience, and access.

**f. Entry by another hospital or other market participant would not be timely, likely, or sufficient to offset the harm to competition likely to result from the Proposed Transaction.**

The anticompetitive effects of the Proposed Transaction are reinforced by the high barriers to entry. When entry barriers are high, the reduced competition caused by a proposed merger is unlikely to be ameliorated by new competition from outsiders.<sup>320</sup> Conversely, “[i]f entry barriers are low, the threat of outside entry can significantly alter the anticompetitive effects of the merger by deterring the remaining entities from colluding or exercising market power.”<sup>321</sup> Here, the Parties have presented no evidence that market entry by other hospitals or healthcare service providers will be “timely, likely, and sufficient in its magnitude, character, and scope to deter or counteract the competitive effects” of the proposed merger.<sup>322</sup>

The barriers to entry for inpatient GAC services in Rhode Island are high. Rhode Island requires that healthcare providers obtain a certificate of need to build or relocate a hospital, to add new units or departments (*e.g.*, obstetrics and trauma units, cardiac surgery departments), or even to add patient beds to an existing unit.<sup>323</sup> Obtaining a certificate is a time-consuming process. In the case of the two applications involving new construction for inpatient or general outpatient care that were filed in Rhode Island since 2007, approval for each took 14 months.<sup>324</sup> Moreover, the actual construction of a new facility or the renovation of an existing facility hospital also is time consuming. Some recent hospital constructions have taken four or five years.<sup>325</sup> These hurdles would not only prevent a competitor from making a “timely” entry, but may preclude entry altogether.

**5. The Proposed Transaction is likely to substantially reduce competition in the market for inpatient GAC hospital services for Medicare beneficiaries.**

The Proposed Transaction is unlawful under the RIAA for the independent reason that it is likely to substantially lessen competition in the inpatient GAC hospital services market for Medicare beneficiaries in Rhode Island. The Medicare market in Rhode Island is significant.

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<sup>320</sup> See *FTC v. H.J. Heinz Co.*, 246 F.3d at 717.

<sup>321</sup> *H.J. Heinz Co.*, 246 F.3d at 717 n.13; see also Merger Guidelines § 9.

<sup>322</sup> See Merger Guidelines § 9; *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 52-53 (D.D.C. 2017) (citing cases applying Merger Guidelines to guide the analysis concerning entry).

<sup>323</sup> See R.I. Gen. L. 216-RICR-40-10-22, *Determination of Need for New Health Care Equipment and New Institutional Health Services* at § 22.4(B); see also State of Rhode Island Dep’t of Health, *Health Systems, Forms: Certificate of Need*, [https://health.ri.gov/programs/detail.php?pgm\\_id=1012#](https://health.ri.gov/programs/detail.php?pgm_id=1012#).

<sup>324</sup> Pflum Report ¶ 172.

<sup>325</sup> *Id.* ¶ 174.

Medicare (traditional Medicare and Medicare managed care) accounts for about 45% of inpatient discharges in Rhode Island.<sup>326</sup> Therefore, the Proposed Transaction's effects on competition in the Medicare market are of particular concern.

While there is no price competition in the Medicare market – because prices are set by the government – hospitals do compete on non-price dimensions to attract patients. As demonstrated above in Section II.A.4.e, this “stage-two” competition between Lifespan and CNE benefits patients, including Medicare patients, by spurring innovation and improvements to quality, access, and service offerings. The Proposed Transaction is likely to substantially reduce this competition not only in the commercial inpatient GAC market, but also in the market for inpatient GAC services provided to Medicare beneficiaries.

**a. Inpatient GAC hospital services provided to Medicare beneficiaries in Rhode Island is a relevant market in which to evaluate the likely competitive effects of the Proposed Transaction.**

The cluster of overlapping inpatient GAC services provided to Medicare beneficiaries by Rhode Island hospitals is a relevant market in which to evaluate the likely competitive effects of the Proposed Transaction.<sup>327</sup> As with inpatient GAC services sold to commercial health plans and provided to their members, outpatient services are properly excluded from the inpatient GAC cluster; they are not generally interchangeable with inpatient care and the decision to treat a given condition on an inpatient or outpatient basis is generally based on clinical considerations.<sup>328</sup> The geographic market also is properly defined as Rhode Island, especially in light of the strong aversion of Medicare beneficiaries to traveling outside of Rhode Island for care.<sup>329</sup> Among Rhode Island residents covered by Medicare, 94.3% are discharged from a Rhode Island hospital while only 5.7% are discharged from a Massachusetts hospital.<sup>330</sup> Accordingly, Dr. Pflum concludes that a hypothetical monopolist of all Rhode Island hospitals would be able to profitably impose a SSNIP – or, since Medicare beneficiaries choose hospitals based on quality differences and not price differences, a small but significant and non-transitory decrease in quality.<sup>331</sup>

**b. The Proposed Transaction would result in a market share and concentration that far exceed the threshold over which the merger is presumptively anticompetitive.**

The Proposed Transaction would further concentrate an already highly concentrated inpatient GAC Medicare market. A combined Lifespan/CNE system would have a post-merger

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<sup>326</sup> *Id.* ¶ 95.

<sup>327</sup> *Id.* ¶¶ 100-101.

<sup>328</sup> *Id.* ¶ 102.

<sup>329</sup> *Id.* ¶ 105-106 & Figure 7.

<sup>330</sup> *Id.* ¶ 108 & Figure 8.

<sup>331</sup> *Id.* ¶ 113.



market share of 69.7% of all overlapping inpatient GAC services provided to Medicare beneficiaries at Rhode Island hospitals.<sup>332</sup> The Proposed Transaction is estimated to increase the HHI by 1,631 points, from a starting HHI of 3,502 to a post-merger HHI of 5,132 points.<sup>333</sup> As in the market based on commercially insured patients, the market based on Medicare patients is already classified as highly concentrated before the merger.<sup>334</sup> The change in HHI predicted to result from the proposed merger is over eight times greater than the 200-point increase threshold over which a merger is “presumed to be likely to enhance market power.”<sup>335</sup>

**c. Lifespan and CNE compete with each other in the inpatient GAC market for Medicare beneficiaries.**

Diversions analysis demonstrates the competition between Lifespan and CNE in the inpatient GAC market for Medicare beneficiaries. While diversions from Miriam and Newport to CNE are lower in the Medicare market than in the commercial market (reflecting the preference of Medicare beneficiaries to receive care close to home and the proximity of non-CNE hospitals), diversion analysis shows that CNE hospitals are substitutes for RIH. In addition, diversion analysis shows that Lifespan is, by far, the closest substitute for CNE’s hospitals. If Medicare patients were to switch away from CNE hospitals, 75% of the switching Kent patients and 61% of the switching W&I patients would choose a Lifespan hospital.<sup>336</sup> As in the market for inpatient GAC services sold to commercial insurers, the Proposed Transaction would eliminate this competition. As in the market for inpatient GAC services sold to commercial insurers, the merger also would eliminate vital quality, access, and other non-price competition in the market for inpatient GAC services provided to Medicare beneficiaries.

**6. The Attorney General is concerned that the Proposed Transaction is likely to substantially reduce competition in other relevant markets.**

The Attorney General’s investigation has identified several other areas in which the Proposed Transaction raises serious anticompetitive concerns. Those concerns are set out in detail in the Pflum Report, and they are briefly summarized here to show that the anticompetitive effects of the Proposed Transaction would extend beyond the markets for inpatient GAC services. Indeed, the anticompetitive effects would reverberate throughout the entire healthcare landscape of Rhode Island.

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<sup>332</sup> *Id.* ¶ 131 & Figure 19.

<sup>333</sup> *Id.*

<sup>334</sup> Merger Guidelines § 5.3 (“Highly Concentrated Markets: HHI above 2500”).

<sup>335</sup> As the Merger Guidelines explain, the “presumption may be rebutted by persuasive evidence showing that the merger is unlikely to enhance market power.” Merger Guidelines § 5.3.

<sup>336</sup> Pflum Report ¶ 145 & Figure 22.

**a. The Attorney General is concerned that the Proposed Transaction is likely to substantially reduce competition in outpatient surgery markets.**

Outpatient surgery markets in Rhode Island are significant. Revenues from outpatient surgery services represented [REDACTED] total commercial revenue from hospital services for 2019.<sup>337</sup> For this reason, the potential harm to competition also is significant.

**(1) Outpatient surgery services in Rhode Island are relevant markets in which to evaluate the likely competitive effects of the Proposed Transaction.**

Outpatient surgery services, also referred to as “ambulatory” surgery, are surgical procedures that are performed in an operating room but do not require an overnight stay in a hospital.<sup>338</sup> Such services are not included within the cluster product market of inpatient GAC services because outpatient surgical services generally are not a substitute for inpatient care.<sup>339</sup> The decision to treat a patient in an inpatient versus outpatient setting is typically guided by clinical considerations and not price differences, meaning that insurers and their members will not (because they cannot) substitute towards outpatient care in response to an increase in the price of inpatient care, and vice versa.<sup>340</sup> In addition, the competitive conditions in terms of the number and composition of competitors and the barriers to entry substantially differ between the inpatient and outpatient care settings.<sup>341</sup> Moreover, the competitive conditions vary across different outpatient surgery services. For example, procedures at an outpatient otolaryngology (commonly known as ear, nose, and throat, or “ENT”) facility, such as a tonsillectomy, require a small restricted operating room with general anesthesia capabilities, particular surgical tools, and a short-term recovery area. Alternatively, a dermatology facility may only require unrestricted examination rooms with basic equipment for biopsies and local anesthesia administration.<sup>342</sup> For these reasons, the clusters of outpatient surgeries associated with a specific service line (*i.e.*, a specific organ system) are relevant product markets in which to assess the competitive effects of the Proposed Transaction.<sup>343</sup>

As with inpatient GAC services, the appropriate relevant geographic market in which to analyze the effects of the Proposed Transaction is Rhode Island. As discussed in Section II.A.4.a above, Dr. Pflum finds that most commercially insured patients who reside in Rhode Island receive routine care close to where they work or live and generally do not travel outside of

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<sup>337</sup> Pflum Report ¶ 297.

<sup>338</sup> *Id.* ¶¶ 98, 296.

<sup>339</sup> *Id.* ¶ 98.

<sup>340</sup> *Id.*

<sup>341</sup> *Id.* ¶ 300.

<sup>342</sup> *Id.*

<sup>343</sup> *Id.* ¶¶ 300-301.

Rhode Island to receive that care.<sup>344</sup> A hypothetical monopolist of all outpatient surgery providers in Rhode Island would be able to profitably impose a significant and non-transitory price increase because a commercial insurer's only alternative would be to send all patients to outpatient surgical facilities located outside the state (or require the patient to pay much more out of pocket for out-of-network care).<sup>345</sup> Such an insurance product would not meet network adequacy requirements and would be substantially less attractive than products that included in-state outpatient options.<sup>346</sup> Therefore, under the Merger Guidelines' hypothetical monopolist test, Rhode Island is an appropriate relevant geographic market in which to evaluate the Proposed Transaction.<sup>347</sup>

**(2) The Proposed Transaction would result in market shares and concentrations that far exceed the threshold over which the merger is presumptively anticompetitive.**

The Proposed Transaction would significantly increase concentration in outpatient surgery markets. Outpatient surgeries performed in an operating room generally require anesthesia or sedation and are not a substitute for other less invasive outpatient procedures, such as blood draws, that can be performed in a physician's office or other settings.<sup>348</sup> For the ten most intensive outpatient procedure specialties,<sup>349</sup> a merged Lifespan/CNE would have a market share greater than 60% for four specialties. For the ten most intensive outpatient procedure specialties, the Proposed Transaction is expected to increase HHI by substantially more than 200 points for seven specialties, and the post-merger HHI measure is above 2,500 for seven specialties.<sup>350</sup> These market shares, increases in HHI, and post-merger HHIs establish that the merger is presumptively anticompetitive.<sup>351</sup>

**(3) Lifespan and CNE compete with each other in outpatient surgery markets.**

Dr. Pflum's diversion analysis demonstrates the head-to-head competition in outpatient surgeries between CNE and Lifespan. If outpatient surgery services at Lifespan hospitals were to become unavailable to Rhode Island patients, 25% of RIH patients, 27% of Miriam patients, and 16% of Newport patients would switch to a CNE hospital.<sup>352</sup> The diversions are

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<sup>344</sup> *Id.* ¶ 106.

<sup>345</sup> *Id.* ¶ 302.

<sup>346</sup> *Id.* ¶ 302.

<sup>347</sup> *Id.* ¶ 303.

<sup>348</sup> *Id.* ¶ 301.

<sup>349</sup> Dr. Pflum analyzes surgeries that account for 97% of these more intensive surgeries on a work RVU basis. *Id.* ¶ 305.

<sup>350</sup> *Id.* ¶ 305.

<sup>351</sup> *Id.*

<sup>352</sup> *Id.* ¶ 306 & Figure 37.

significantly higher within specific service lines. For example, nearly 50% of RIH's and Miriam's patients would switch to a CNE hospital for surgeries related to hemic & lymphatic and integumentary specialties (e.g., lymph node removals and mastectomies); over 80% of RIH's and Miriam's patients would switch to a CNE hospital for surgeries related to the female reproductive system (e.g., hysterectomies).<sup>353</sup> Similarly, if outpatient services at CNE hospitals were to become unavailable to Rhode Island patients, 36% of Kent patients and 30% of W&I patients would switch to a Lifespan hospital.<sup>354</sup> Again, the diversions are much higher within specific service lines. For example, the diversions to a Lifespan hospital are over 50% for either Kent or W&I (usually both) in over seven specialties including cardiovascular, digestive, endocrine, eye and ocular adnexa, female genital, hemic & lymphatic, and integumentary.<sup>355</sup> These diversion figures confirm that the Proposed Transaction would substantially lessen competition in outpatient surgery markets.

Dr. Pflum's WTP analysis also demonstrates the competition between Lifespan and CNE in outpatient surgery markets. As discussed above in Section II.A.4.a, the WTP of a merger is driven by the degree of service and geographic overlap for the merging hospitals. The WTP for a merged Lifespan/CNE system for outpatient surgeries is 19.4% higher than the sum of the WTP for each of the two systems.<sup>356</sup> The result is similar in the MARI area. For MARI patients, the increase in WTP is 19.3%.<sup>357</sup> These significant WTP increases result from the elimination of competition between the two systems.

[REDACTED]

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[REDACTED]<sup>359</sup> Lifespan subsequently hired a "leading expert in breast oncology and clinical research" from HCA Healthcare in Kansas City to serve as director of the breast oncology at the Lifespan Cancer Institute.<sup>360</sup> [REDACTED]

<sup>353</sup> *Id.*

<sup>354</sup> *Id.*

<sup>355</sup> *Id.*

<sup>356</sup> *Id.* ¶ 309.

<sup>357</sup> *Id.* ¶ 309.

<sup>358</sup> [REDACTED] FTC-CNE-00227333.

<sup>359</sup> LIFESPAN00952873 at -875.

<sup>360</sup> Lifespan, *Lifespan Cancer Institute Appoints National Expert to Director of Breast Oncology*, July 23, 2021, <https://www.lifespan.org/news/lifespan-cancer-institute-appoints-national-expert-director-breast-oncology>.

[REDACTED]<sup>361</sup> The Proposed Transaction would eliminate this non-price competition and price competition in outpatient surgery markets.

**b. The Attorney General is concerned that the Proposed Transaction is likely to substantially reduce competition in the market for inpatient behavioral health services.**

The Parties' dominant share in the inpatient behavioral health market raises serious concerns. Once again, the Proposed Transaction would result in market share and concentration that far exceeds the threshold over which the Proposed Transaction is presumptively anticompetitive. And, once again, Dr. Pflum's empirical analysis as well as the record demonstrate that the Proposed Transaction would eliminate competition between the Parties, to the detriment of Rhode Islanders in need of behavioral health care.

**(1) The market for inpatient behavioral health services sold to commercial insurers and provided to their members in Rhode Island is a relevant market in which to evaluate the likely competitive effects of the Proposed Transaction.**

Inpatient behavioral health care is a market distinct from inpatient GAC hospital services, for several reasons. First, broadly speaking, inpatient behavioral health care is not a substitute for inpatient GAC care.<sup>362</sup> In response to a significant and non-transitory price increase by a hypothetical monopolist of all inpatient GAC services and of all inpatient behavioral health services, insurers and/or patients will not substitute one cluster of services for the other.<sup>363</sup>

[REDACTED]  
[REDACTED]<sup>364</sup> Third, although inpatient GAC hospitals can have a behavioral health inpatient unit and/or a substance abuse unit, they often do not. Among the inpatient GAC hospitals in Rhode Island, only Kent, Landmark, and RIH have a material number of inpatient admissions for behavioral health care.<sup>365</sup> [REDACTED]

[REDACTED]<sup>366</sup> As a result, the competitive conditions in terms of the number

<sup>361</sup> LIFESPAN01005741 at -742.

<sup>362</sup> Pflum Report ¶ 313.

<sup>363</sup> *Id.* ¶ 315.

<sup>364</sup> *Id.* ¶ 313.

<sup>365</sup> *Id.*

<sup>366</sup> *Id.*

and composition of competitors and the barriers to entry substantially differ between the inpatient GAC and inpatient behavioral health care settings.<sup>367</sup>

As with inpatient GAC services, the relevant geographic market in which to analyze the effects of the proposed merger is Rhode Island. Around 97% of commercially insured patients who reside in Rhode Island receive inpatient behavioral health care within Rhode Island.<sup>368</sup> A hypothetical monopolist of all inpatient behavioral health services in Rhode Island would be able to profitably impose a SSNIP because a commercial insurer's only alternative to accepting the SSNIP would be to send patients to facilities located outside the state for all inpatient behavioral health services or to force enrollees to pay much more out of pocket for out-of-network care to receive care within Rhode Island.<sup>369</sup> Therefore, Rhode Island is an appropriate relevant geographic market in which to evaluate the Proposed Transaction.

**(2) The Proposed Transaction would result in a market share and concentration that far exceed the threshold over which the merger is presumptively anticompetitive.**

Once again, the Proposed Transaction would result in extraordinary market share and concentration. A merged Lifespan/CNE system would account for 79% of behavioral health discharges for commercial patients under 65 in Rhode Island.<sup>370</sup> The corresponding HHIs are exceedingly high. In an already highly concentrated behavioral health market, the estimated change in HHI is 2,835, resulting in a post-merger HHI of 6,345 points.<sup>371</sup> The market share, increase in HHI, and post-merger HHI establish that the merger is presumptively anticompetitive.

**(3) Lifespan and CNE compete with each other in the market for inpatient behavioral health services.**

The record plainly demonstrates head-to-head competition between Lifespan and CNE in behavioral health.

<sup>372</sup> [REDACTED]

<sup>373</sup> [REDACTED]

<sup>374</sup> [REDACTED]

<sup>367</sup> *Id.* ¶¶ 313-314.

<sup>368</sup> *Id.* ¶ 315.

<sup>369</sup> *Id.*

<sup>370</sup> *Id.* ¶ 319.

<sup>371</sup> *Id.*

<sup>372</sup> [REDACTED]

<sup>373</sup> Marran Jan. 13, 2022 Tr. 59:18-60:22.

<sup>374</sup> *Id.* 83:1-7; 84:18-22; 134:22-25.

Dr. Pflum's diversion analyses underscore the competitive concern. If Lifespan hospitals were to become unavailable to Rhode Island patients, 97% of Bradley patients, 72% of RIH patients, 30% of Miriam patients, and 61% of Newport patients would switch to a CNE hospital.<sup>376</sup> If CNE hospitals were to become unavailable to Rhode Island patients, 46% of Butler patients and 43% of Kent patients would switch to a Lifespan hospital.<sup>377</sup> The substitution patterns show that Butler is by far the closest substitute for Bradley, RIH, and Newport, and is the third closest substitute for Miriam.<sup>378</sup> RIH is the closest substitute for Butler and Kent.<sup>379</sup> The elimination of this competition would leave Rhode Island with a single dominant behavioral health provider, to the detriment of behavioral health patients at a time when the COVID-19 pandemic has compounded widespread concerns regarding behavioral health.

**c. The Attorney General is concerned that the Proposed Transaction is likely to substantially reduce ACO competition .**

The Parties' control of three Accountable Care Organizations – Integra (CNE), Lifespan Health Alliance (Lifespan), and Coastal Medical (Lifespan) – also raises competitive concerns. An ACO is a collection of physicians, physician groups, and hospitals who work together to coordinate the care for attributed patients.<sup>380</sup> About half of all commercial medical spending in Rhode Island is for patients who have a primary care physician in one of those three ACOs – *i.e.*, for patients “attributed” to one of those three ACOs.<sup>381</sup> ACOs are incentivized to provide high-value care through “shared savings” with insurers based on the ACO's performance with respect to medical expense per member targets.<sup>382</sup>

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In so doing, ACOs compete to improve the patient experience, including by improving care coordination, quality, and access so that patients prefer to receive their care from physicians and

<sup>375</sup> *Id.* 143:20-144:8.

<sup>376</sup> Pflum Report ¶ 321 & Figure 41.

<sup>377</sup> *Id.*

<sup>378</sup> *Id.* ¶ 320.

<sup>379</sup> *Id.*

<sup>380</sup> *Id.* ¶ 325.

<sup>381</sup> *Id.* ¶ 323 & Figure 42.

<sup>382</sup> *Id.* ¶ 326.

<sup>383</sup> *Id.* ¶¶ 324 & 326.

hospitals within the ACO.<sup>384</sup> Patients benefit from this competition,<sup>385</sup>

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The Parties' three ACOs would dominate the ACO market in Rhode Island. Together, they would account for 81% of all Rhode Island patients assigned to one of the seven ACOs in Rhode Island.<sup>388</sup> With little competitive pressure to reduce leakage – since the ACO competition would be greatly reduced – incentives to improve the patient experience also would be greatly reduced.<sup>389</sup> There is a substantial risk that the patient experience would suffer as a result.

In addition, ACO concentration is likely to reduce innovation. Another mechanism that an ACO may use to increase its patient attribution is by working with insurers on innovative payment mechanisms that reduce the overall cost of care in exchange for increased patient volume. Because it would already have control over 80% of attributed lives, a merged Lifespan/CNE would have little incentive to work with payors to develop innovative payment arrangements to gain patient volume. Accordingly, BCBSRI has expressed concern that the Proposed Transaction would result in less incentive to innovate.<sup>390</sup>

Finally, non-Party providers who are excluded from the Parties' ACOs may find themselves unable to compete. South County Health expresses the concern that, if non-Party providers are excluded, "patients could be steered within the Lifespan/CNE network and patients would lose [South County] and other providers as a choice."<sup>391</sup> In other words, excluded providers would find it difficult to overcome the Parties' efforts to maximize "care retention." Such exclusion creates barriers to entry and raises competing providers' costs if they must build out referral networks that they did not need to assemble but-for the merger.<sup>392</sup>

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<sup>384</sup> *Id.* ¶¶ 326-327.

<sup>385</sup> *Id.* ¶¶ 326, 329.

<sup>386</sup> [REDACTED] FTC-CNE-00521536.

<sup>387</sup> [REDACTED]; Pflum Report ¶ 328.

<sup>388</sup> *Id.* ¶ 323 & Figure 42. Patients are assigned to an ACO based on who their primary care physician is, and ACOs are accountable for the cost and quality of the care of their assigned patients. Assigned patients are referred to as "attributed" by insurers and ACOs. *Id.* ¶ 325.

<sup>389</sup> *Id.* ¶ 329.

<sup>390</sup> *See* Bush Decl. ¶ 17.

<sup>391</sup> Declaration of Tom Breen ¶ 14.

<sup>392</sup> Pflum Report ¶ 332.



**d. The Attorney General is concerned that the Proposed Transaction is likely to substantially reduce competition in the labor market for nurses.**

The Proposed Transaction risks an increase in hospital monopsony power that would decrease wages and compensation for nurses. Monopsony power is the market power of buyers of goods and services, such as labor, to drive down prices below competitive levels.<sup>393</sup> Currently, pandemic-related staffing shortages are disrupting healthcare markets across the U.S., leaving hospital administrators struggling to fill open positions.<sup>394</sup> But antitrust analysis requires the Attorney General to look beyond the labor conditions created by the pandemic when analyzing a transaction that will change the face of Rhode Island's healthcare landscape for decades. The economic literature confirms that, in more concentrated markets, monopsony power in the market for nurses enables hospitals to suppress wages and/or increase nurses' workloads.<sup>395</sup>

Rhode Island would be such a concentrated market. CNE and Lifespan, if combined, would become the largest employer in Rhode Island and the largest employer of nurses.<sup>396</sup> The merged entity would dominate the market for nurses, accounting for 67% of full-time registered nurses employed by Rhode Island hospitals and 52% of full-time registered nurses employed by hospitals in the broader "MARI" region.<sup>397</sup> The post-merger HHIs and increases in HHIs for both markets far exceed the presumptively anticompetitive thresholds in the Merger Guidelines.<sup>398</sup>



<sup>393</sup> *Id.* ¶ 334.

<sup>394</sup> Andrew Jacobs, *Nursing in Crisis: Staff Shortages Put Patients at Risk*, New York Times, Aug. 21, 2021, <https://www.nytimes.com/2021/08/21/health/covid-nursing-shortage-delta.html>; Centers for Disease Control, *Strategies to Mitigate Healthcare Personnel Staffing Shortages*, Jan. 21, 2022, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>; Alexa Gagosz, *R.I health care leaders warn of 'crisis level' staffing shortages in nursing homes, hospitals*, Boston Globe, Nov. 17, 2021. <https://www.bostonglobe.com/2021/11/17/metro/ri-health-care-leaders-warn-crisis-level-staffing-shortages-nursing-homes-hospitals/>.

<sup>395</sup> Pflum Report ¶ 343.

<sup>396</sup> *Id.* ¶ 334.

<sup>397</sup> *Id.* ¶ 342 & Figure 43.

<sup>398</sup> *Id.* ¶ 342.

<sup>399</sup> Abbott Feb. 3, 2022 Tr. 126:1-4.

<sup>400</sup> *Id.* 127:23-128:1.

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402 [REDACTED]

403 LIFESPAN07422721 at -722.

404 Abbott Feb. 3, 2022 Tr. 111:16-24 ([REDACTED]). [REDACTED]

405 [REDACTED] FTC-CNE-00111816.

FTC-CNE-00042082 at -083 [REDACTED].

406 Abbott Feb. 3, 2022, Tr. 161:17-22.

407 LIFESPAN02874247 at -248.

[REDACTED] <sup>408</sup> [REDACTED] <sup>409</sup>

- [REDACTED] <sup>410</sup>

- [REDACTED] <sup>411</sup>

[REDACTED] <sup>412</sup>  
[REDACTED] <sup>413</sup>

[REDACTED] <sup>414</sup> By eliminating this competition, the Proposed Transaction would reduce the choices currently available to nurses.

[REDACTED]  
Moreover, the pandemic and its acute demands on Rhode Island's healthcare system are expected to be temporary. The merger, by contrast, is permanent.<sup>415</sup> [REDACTED]  
[REDACTED]

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<sup>408</sup> LIFESPAN02414057.

<sup>409</sup> *Id.*

<sup>410</sup> LIFESPAN02640947 at -048.

<sup>411</sup> LIFESPAN01018045 at Slide 7.

<sup>412</sup> FTC-CNE-00820438.

<sup>413</sup> *Id.*

<sup>414</sup> Abbott Feb. 3, 2022 Tr. 158:15-25.

<sup>415</sup> Pflum Report ¶ 340.

The Attorney General acknowledges the support for the Proposed Transaction expressed by four labor unions representing employees working at Lifespan and CNE hospitals, and recognizes the impressive work by those unions and their leadership to secure agreements from the Parties to the benefit of their members. The Attorney General has a significant advantage in evaluating the Proposed Transaction that others do not: access to mountains of confidential information obtained from the Parties – tested by the Attorney General’s questions to the Parties and answered by them under oath – and the insights of independent, nationally renowned experts in the field. As a result, the Attorney General remains concerned that, in the labor market for nurses, a merger of Lifespan and CNE will give the combined entity monopsony power to decrease compensation, reduce benefits, and degrade working conditions.

7. **The Parties’ arguments in favor of the Proposed Transaction are not persuasive and are contradicted by the record.**
  - a. **The OHIC hospital rate cap cannot prevent the anticompetitive effects of the Proposed Transaction.**

The Office of the Health Insurance Commissioner (“OHIC”) was established in 2004 to regulate the health insurance industry.<sup>417</sup> In 2010, OHIC implemented a set of Affordability Standards for commercial insurers that were designed to achieve “stable, predictable, affordable rates for high quality, cost efficient health insurance products.”<sup>418</sup> Among other things, the Affordability Standards impose what is referred to as a hospital rate increase cap (the “hospital rate cap” or “rate cap”), which prohibits an insurer from agreeing to hospital rates that, on average, exceed OHIC guidelines regarding annual increases unless the insurer obtains OHIC’s prior approval.<sup>419</sup>

<sup>420</sup> The rate cap, along with other regulatory measures taken by OHIC, has had a positive effect on the health insurance market and made insurance more affordable and accessible to Rhode Islanders than it would otherwise be; the accolades that OHIC has received for accomplishing what other states’ regulators could not are well deserved.<sup>421</sup> But despite the salutary effect of OHIC’s efforts,

<sup>416</sup> FTC-CNE-01600397.

<sup>417</sup> R.I. Gen. Laws § 42-14.5-2.

<sup>418</sup> 230 R.I. Code R. 20-30-4.9 and 4.10.

<sup>419</sup> 230 R.I. Code R. 20-30-4.10-(D)(6)€.

<sup>420</sup>

<sup>421</sup> See, e.g., Aaron Baum, et al., *Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers*, Health Affairs, Feb. 2019.

[REDACTED]. In a working paper issued in June 2021 analyzing policy considerations raised by the Proposed Transaction, OHIC concluded that its regulations “are insufficient by themselves to adequately mitigate the risks to affordability resulting from higher prices that could materialize following the proposed merger of CNE and Lifespan” and opined that regulators, including the Attorney General, should evaluate “the likely price effects of the proposed merger of CNE and Lifespan assuming an unregulated environment.”<sup>422</sup>

OHIC’s conclusion was informed, in part, by two characteristics of the hospital rate cap — its mutability and limited scope. OHIC observed that, “[a]s a regulatory requirement, the OHIC hospital rate increase cap could be overridden statutorily at a future date. This means that there can be no assurance that it will exist as a permanent feature of the regulatory landscape.”<sup>423</sup>

[REDACTED]

[REDACTED]<sup>424</sup>  
[REDACTED]<sup>425</sup>  
[REDACTED]<sup>426</sup>  
[REDACTED]<sup>427</sup> A combined Lifespan/CNE, representing the largest private employer in the state, could apply extraordinary political pressure on OHIC.<sup>428</sup> Indeed, South County Health expresses concern that “the merged entity would have the political power to do away with OHIC regulations altogether” or, alternatively, “OHIC’s rules would be modified to meet the needs of a merged entity.”<sup>429</sup>

Pressure from hospitals significantly smaller than a combined Lifespan/CNE system already has resulted in OHIC modifying the hospital rate cap. Certain non-Party hospitals complained that the cap penalized those facilities that charged lower rates at the time the Affordability Standards were first implemented because the same percentage-based cap applied

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<sup>422</sup> Rhode Island Office of the Health Insurance Commissioner, *The Care New England and Lifespan Proposed Merger: Policy Considerations Related to the State of Rhode Island Office of the Health Insurance Commissioner’s Statutory Purpose* (June 2021) at 23-24.

<sup>423</sup> *Id.*

<sup>424</sup> [REDACTED] FTC-CNE-00854412.

<sup>425</sup> [REDACTED].

<sup>426</sup> [REDACTED] LIFESPAN00796387.

<sup>427</sup> LIFESPAN00495588.

<sup>428</sup> The Attorney General does not suggest that any such speech could be the basis of liability. [REDACTED]

<sup>429</sup> Declaration of Tom Breen ¶ 14.



[REDACTED] <sup>437</sup> [REDACTED]

<sup>438</sup> Thus, even if, as the Parties would have it, the hospital rate cap prevents anticompetitive pricing for hospital services, it could not stop the merged Lifespan/CNE entity from exercising its increased market power to extract high prices for services provided by its non-hospital facilities such as ambulatory surgery centers.

[REDACTED] <sup>439</sup> [REDACTED] <sup>440</sup> [REDACTED] <sup>441</sup> [REDACTED]

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<sup>437</sup> Robbins Jan. 10, 2022 Tr. Ex. 5 at FTC-CNE-0000464.

<sup>438</sup> *Id.* at FTC-CNE-0000457.

<sup>439</sup> [REDACTED]; LIFESPAN00803165.

<sup>440</sup> [REDACTED] LIFESPAN00825795 [REDACTED]

[REDACTED] LIFESPAN00811732 [REDACTED]

LIFESPAN00375310 [REDACTED]

<sup>441</sup> [REDACTED].

[REDACTED] 442 [REDACTED]  
[REDACTED] 443

Finally, even if the OHIC regulations could prevent the anticompetitive price effects of the Proposed Transaction, OHIC does not, and cannot, regulate all non-price dimensions of competition that hospitals invest in to attract and retain patients. These unregulated service areas include the type of services a hospital offers, a hospital's performance, and innovation.

[REDACTED] 444  
[REDACTED] 445 As Dr. Pflum explains, OHIC is unable to regulate all dimensions of hospital competition that the Proposed Transaction would eliminate.<sup>446</sup>

**b. The Parties overstate the differentiation between the two systems.**

[REDACTED] 447

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442 [REDACTED]  
Iannoni Jan. 12, 2022 Tr. 141:10-16 ( [REDACTED]  
[REDACTED] ); [REDACTED]

443 [REDACTED]

444 [REDACTED]

445 Iannoni Jan. 12, 2022 Tr. 184:5-8.

446 Pflum Report ¶ 205.

447 [REDACTED]



[REDACTED]

As an initial matter, some of the differentiation between the services offered by CNE and Lifespan was artificially created by an agreement between Rhode Island Hospital and Women & Infants that was designed to restrain competition. In 1983, RIH and W&I entered into a ground lease agreement as landlord and tenant, respectively.<sup>448</sup> The agreement provides that, in return for a \$100 yearly rent, W&I may operate its hospital on the campus owned by RIH and on which RIH also operates.<sup>449</sup> There is a caveat, however. Under the lease, which runs to December 31, 2085, W&I is prohibited from offering any services that are not related to “maternity, obstetrics, gynecological and infant patients.”<sup>450</sup> As a result, W&I has been and still is precluded from expanding its services to compete with RIH and other Lifespan hospitals that provide a wider range of hospital services.

[REDACTED]<sup>451</sup> Thus, the Parties’ argument to justify the merger on the ground of differentiated services rests on an anticompetitive environment that they themselves created.

Notwithstanding the limitation imposed on W&I by the ground lease, there is significant competition between the two systems’ service offerings, as the record and Dr. Pflum’s analyses demonstrate. In addition to the service-line and diversion analyses discussed above in Section II.A.4.c, Dr. Pflum’s willingness-to-pay analysis also demonstrates the competition between Lifespan and CNE, as well as the corresponding increase in bargaining leverage that would result from the elimination of this competition. Willingness to pay accounts for the degree to which the hospitals overlap geographically and with respect to service offerings.<sup>452</sup> Two examples illustrate this point. A hypothetical merger of Lifespan and Kent – hospitals that have a high degree of geographic and service overlap – would result in a WTP of 20.6%.<sup>453</sup> However, a merger of W&I and Lifespan – hospitals that have a high degree of geographic overlap, but a lower degree of service overlap – would result in a WTP of only 3.9%.<sup>454</sup> As discussed above in Section II.A.4.d.2, the WTP of the proposed merger of the two systems is 16.2%. This relatively high WTP demonstrates that Lifespan and CNE overlap significantly in the services they are providing patients and in the geographies from which they are drawing patients.

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<sup>448</sup> Ground Lease” between Rhode Island Hospital (landlord) and Women & Infants Hospital of Rhode Island (tenant) for the Land Underlying the Women & Infants Hospital of Rhode Island Building (Nov. 1, 1983).

<sup>449</sup> *Id.* at 7.

<sup>450</sup> *Id.* at 6.

<sup>451</sup> [REDACTED]

<sup>452</sup> Pflum Report ¶ 159.

<sup>453</sup> *Id.* ¶ 268.

<sup>454</sup> *Id.* ¶ 269.

[REDACTED]. At stage one – where hospitals compete for inclusion in insurers’ networks – the overlap in service offerings and the competition between the two systems explain how insurers have used the rates of one system, or market rates reflecting the rates of one system, to negotiate lower rates with the other, and why the Proposed Transaction will increase the merged entity’s bargaining leverage.<sup>455</sup> Dr. Pflum’s empirical analyses also demonstrate why there would be harm to competition at stage two [REDACTED]. At stage two, hospitals compete to attract patients based primarily on non-price factors such as quality of services and convenience. As to stage-two competition, the fact that there may be some degree of differentiation between the services offered by CNE and Lifespan makes little difference because CNE and Lifespan engage in head-to-head competition in numerous service areas, as Dr. Pflum’s service overlap, diversion, and willingness-to-pay analyses all establish. With respect to those service areas, the record establishes that competition has incentivized each to innovate and improve its quality of care, expand its services lines, and make care more accessible. The Proposed Transaction would eliminate this competition, to the detriment of Rhode Islanders.

**c. The Proposed Transaction cannot be justified based on the Parties’ claimed efficiencies.**

The Parties have claimed that the Proposed Transaction will produce certain “efficiencies.” The law is unsettled regarding whether and how claims of post-merger efficiencies should be considered when determining the lawfulness of a proposed merger, with the U.S. Supreme Court expressing doubt that efficiencies can be used as a defense to an illegal merger.<sup>456</sup> But to the extent that federal courts have considered efficiencies when evaluating the competitive harm of a hospital merger, they have required the merging parties to show that the alleged efficiencies: (1) “offset the anticompetitive concerns in highly concentrated markets”; (2) are “merger-specific, meaning, they must be efficiencies that cannot be achieved by either company alone”; and (3) are “verifiable, not speculative.”<sup>457</sup> Likewise, the Merger Guidelines provide that claims of efficiencies must be merger specific and will not be considered “if they are vague, speculative, or otherwise cannot be verified by reasonable means.”<sup>458</sup> Moreover, “the greater the potential adverse competitive effect of a merger, the greater must be the cognizable efficiencies, and the more they must be passed through to customers.”<sup>459</sup>

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<sup>455</sup> The BCBSRI declaration also demonstrates the [REDACTED]

[REDACTED]. Bush Decl. ¶ 13.  
[REDACTED]. See Pflum Report § VII.C.2.

<sup>456</sup> See *Saint Alphonsus Med. Ctr.*, 778 F.3d at 789, citing *Brown Shoe Co. v. United States*, 370 U.S. 294, 344 (1962) and *FTC v. Proctor & Gamble Co.*, 386 U.S. 568, 580 (1967).

<sup>457</sup> *Hershey*, 838 F.3d at 348-49 (internal quotation marks and citations omitted).

<sup>458</sup> Merger Guidelines § 10.

<sup>459</sup> *Id.*

The federal courts and regulators thus have set an exceedingly high bar.<sup>460</sup> This standard takes into account the reality that claimed efficiencies may prove illusory because businesses, even if well intentioned, may be mistaken in their predictions about the benefits of a merger, run into unforeseen financial obstacles, or simply choose to change course.<sup>461</sup> More fundamentally, the high bar reflects the policy decision by Congress to preserve our traditionally competitive economy even if some benefits may flow from an otherwise illegal merger.<sup>462</sup>

The Rhode Island General Assembly made a similar policy decision when it enacted the RIAA to “complement” the federal antitrust laws and to “promote the unhampered growth of commerce and industry throughout the state” by prohibiting conduct that have the effect of “hampering, preventing, or decreasing competition.”<sup>463</sup> Accordingly, for purposes of the present decision, the Attorney General will apply a standard similar to those used by federal courts: namely, for efficiencies to outweigh the potential competitive harm, they must be particularized, merger-specific, and fully offset the risks a transaction presents to the viability of affordable, accessible, quality care for Rhode Islanders. Where, as here, the anticompetitive risks associated with a transaction are immense and the harm from lost competition is likely irreversible, that bar is high. The Parties do not clear it.

The only cost-savings identified by the Parties were contained in an “Efficiencies Report” created by Deloitte.<sup>464</sup> As discussed below in Section II.B.3.c, Deloitte identified [REDACTED]

[REDACTED]. These claimed efficiencies do not alleviate the Attorney General’s concern regarding the anticompetitive effects of the proposed merger.

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<sup>460</sup> Areeda ¶ 970a (“while efficiencies are commonly asserted as a defense, they are rarely found sufficient to undermine a prima facie case against a merger.”); *FTC v. ProMedica Health Sys.*, 2011 WL 1219281, at \* 57 (N.D. Ohio Mar. 29, 2011) (“No court in a 13(b) proceeding, or otherwise, has found efficiencies sufficient to rescue an otherwise illegal merger.”); Merger Guidelines §10 (“[E]fficiencies almost never justify a merger to monopoly or near-monopoly.”).

<sup>461</sup> See, e.g., *FTC v. H.J. Heinz Co.* 246 F.3d at 721 (“given the high concentration levels, the court must undertake a rigorous analysis of the kinds of efficiencies being urged by the parties in order to ensure that those ‘efficiencies’ represent more than mere speculation and promises about post-merger behavior”); Merger Guidelines § 10 (“Efficiencies are difficult to verify and quantify, in part because . . . efficiencies projected reasonably and in good faith by merging firms may not be realized”).

<sup>462</sup> *Philadelphia Nat’l Bank*, 374 U.S. at 371 (“Congress determined to preserve our traditionally competitive economy. It therefore proscribed anticompetitive mergers, the benign and the malignant alike, fully aware, we must assume, that some price might have to be paid.”); see also *Saint Alphonsus Med. Ctr.*, 778 F.3d at 792 (“the Clayton Act does not excuse mergers that lessen competition or create monopolies simply because the merged entity can improve its operations.”); Merger Guidelines § 10 (“the antitrust laws give competition, not internal operational efficiency, primacy in protecting customers.”).

<sup>463</sup> R.I. Gen. Laws § 6-36-2 (a)(1).

<sup>464</sup> Efficiency projections generated for litigation or for antitrust review, rather than through the “usual business planning process” undertaken by entities evaluating a prospective merger, will be viewed with skepticism. Merger Guidelines ¶ 10, Efficiencies; see also *Hackensack*, 2021 WL 4145062, at \*27 (giving “little weight” to an Optimization Plan that, “[r]ather than providing Defendants with a comprehensive plan to implement, . . . reads as a sales pitch to justify the merger after the fact.”).

As an initial matter, the Parties have not demonstrated that the alleged cost-saving efficiencies will offset anticompetitive effects of the Proposed Transaction. To satisfy this criterion, the Parties must “demonstrate that the intended acquisition would result in significant economies and that these economies ultimately would benefit competition and, hence, consumers.”<sup>465</sup> This can be achieved through evidence that the post-merger prices will be no higher than the pre-merger prices.<sup>466</sup> The Deloitte report [REDACTED]

[REDACTED] <sup>467</sup> The Deloitte report [REDACTED]

[REDACTED] <sup>468</sup> [REDACTED] <sup>469</sup> Moreover, the claimed efficiencies are speculative. The efficiencies must be “verifiable, not speculative”<sup>470</sup> and must amount to “more than mere speculation and promises about post-merger behavior.”<sup>471</sup> As discussed below in Section II.B.3.c, the Deloitte report [REDACTED]

[REDACTED]. Finally, as discussed below in Section II.B.3.c, [REDACTED]

Although only the Deloitte report purports to quantify any efficiencies, the Parties have claimed other potential benefits of the Proposed Transaction, including a number of potential initiatives identified in a report prepared by the Chartis Group. As discussed in Section II.C.3.b below, [REDACTED]

[REDACTED]. At the same time, as discussed in Section II.B.4 below, in light of the significant concerns regarding the financial feasibility of a merged Lifespan/CNE system, it is unclear how the merged system could afford to execute these initiatives. In short, the claimed benefits from the initiative are unsubstantiated, speculative, and likely financially infeasible. Accordingly, the Parties’ future plans, however laudable, cannot overcome the substantial competitive harm that is likely to result from the Proposed Transaction.

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<sup>465</sup> *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1223 (11th Cir. 1991); see also *Hershey*, 838 F.3d at 350 (“An efficiencies analysis requires more than speculative assurances that a benefit enjoyed by the Hospitals will also be enjoyed by the public. The hospitals must demonstrate that benefits . . . will be passed on to consumers.”); *Hackensack*, 2021 WL 4145062, at \*29 (“Defendants provide no evidence that the cost-savings from service optimization between the prior merger entities was passed through to payors. . . . [T]he Court doubts that any cost savings . . . will be passed through to payors.”).

<sup>466</sup> Areeda ¶ 971a.

<sup>467</sup> Ahern Nov. 17, 2021 Tr. 103:13-104:3.

<sup>468</sup> *Id.* 81:2-8.

<sup>469</sup> Burns Report at 63.

<sup>470</sup> *Hershey*, 838 F.3d at 348-49.

<sup>471</sup> *H.J. Heinz Co.*, 246 F.3d at 721.

**B. The Proposed Transaction cannot be approved where the evidence shows it is not financially feasible.**

When reviewing a hospital conversion application, the Attorney General must determine whether the applicant's proposal is financially viable. This is especially so when a proposed transaction encapsulates so much of the Rhode Island healthcare market; as discussed in Section II.A above, a merged Lifespan/CNE system would extend to and impact nearly every aspect of Rhode Island's healthcare delivery system. If a merged Lifespan/CNE system were to become financially unstable – either by depleting its cash assets or by defaulting on its debt covenants – virtually the entire Rhode Island healthcare system would be at risk of failing.

To that end, the Attorney General has engaged in a thorough review of the financial implications of the Proposed Transaction. The Attorney General was assisted in its review by Veralon, which, as described in Section I.A.1.b above, is a healthcare finance consulting firm with deep and varied experience in healthcare merger matters, including the Boston-based Beth Israel Leahy merger and past Rhode Island Hospital Conversions Act matters. The Attorney General has determined, based on the information and testimony submitted by the Parties and Veralon's analysis, that the Proposed Transaction is not financially feasible or viable for at least four reasons:

- (1) By simply combining, the Parties would create a new, market-dominating hospital system in a financial condition that risks system failure if faced with even a short-term crisis, poor management, or unanticipated challenges as result of the overall financial uncertainty of the healthcare industry;
- (2) Faced with a concerning financial future for a combined Lifespan/CNE system, the Parties have not developed a particularized, detailed plan to reach ongoing financial stability;
- (3) The Proposed Transaction would require a Lifespan/CNE system to invest [REDACTED] before they can pay for any of the other expenses associated with the merger or begin investing in any of the merger's projected benefits; and
- (4) The Parties have failed to identify or provide a comprehensive estimate of how much it will cost to create their proposed "Academic Health System," including the initiatives identified in the Chartis Report or the other costs associated with integrating two large, complex health systems, nor have they identified with any specificity how they intend to fund those costs.

In other words, the numbers provided by the Parties do *not* tell the Attorney General how a combined entity would fill the gap between (1) their projected income and what is needed to support a healthy combined system and (2) the amount of capital available to Lifespan and CNE and what is actually needed to obtain the benefits they claim will result from combining the systems. [REDACTED]

[REDACTED]

Because, ultimately, these questions remain unanswered, approval of the Proposed Transaction would risk creating a health system without any of the benefits patients currently enjoy from competition between Lifespan and CNE, that is unable to invest in and deliver on the new benefits the Parties claim such a system would deliver, and that would leave the vast majority of Rhode Island's healthcare infrastructure in a single, financially volatile entity.

At bottom, for the Proposed Transaction to be successful, the Transacting Parties need to accomplish two things: (1) reach a healthy operating margin, and (2) find a way to make the investments required to integrate their systems and develop the initiatives they have promised to carry out to benefit Rhode Islanders. The record reveals that there is an unacceptable risk that a combined Lifespan/CNE cannot accomplish either task.

First, [REDACTED]

Second, [REDACTED]. The Proposed Transaction would require substantial investments to combine and integrate these two systems, pay for deferred maintenance, and to fund promised initiatives like the creation of an NCI cancer center, an innovation fund to support technology start-ups, or increasing research capabilities.

[REDACTED]

[REDACTED] there is an unacceptable risk that Rhode Islanders will have to serve as the financial backstop if the transaction proves financially unsuccessful – whether that is in the form of increased cost of care or a government bailout – or pay the intangible price, despite the Parties' promises, of no investments in improving healthcare because such improvements are financially impossible to make.

Recognizing this financial reality, it is unsurprising that the Parties have repeatedly considered the need for state funding in the context of the proposed merger. [REDACTED]

[REDACTED] 472

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[REDACTED] 474

475 The Proposed Transaction would create a health system that is too big to fail [REDACTED] 476

**1. Applicable criteria under the Hospital Conversions Act**

As noted in Section I.B, the overarching purpose of the Attorney General’s review under the HCA is to “[a]ssure the viability of a safe, accessible and affordable healthcare system” for Rhode Island.<sup>477</sup> And the viability of Rhode Island’s hospital system is dependent on the financial security of the State’s hospitals. To that end, the HCA suggests that the Attorney General consider a number of criteria related to the financial implications of the proposed transaction, including:

- (1) Whether the proposed conversion will harm the public’s interest in trust property given, devised, or bequeathed to the existing hospital for charitable, educational, or religious purposes located or administered in this state;
- (2) Whether a trustee or trustees of any charitable trust located or administered in this state will be deemed to have exercised reasonable care, diligence, and prudence in performing as a fiduciary in connection with the proposed conversion;
- (3) Whether the board established appropriate criteria in deciding to pursue a conversion in relation to carrying out its mission and purposes;
- (4) Whether the board considered the proposed conversion as the only alternative or as the best alternative in carrying out its mission and purposes;

<sup>472</sup> Lifespan00505424 ([REDACTED]).

<sup>473</sup> C-R-CNE-LS23-0047743 at -764 (Alvarez & Marsal, *Preliminary Integration Planning Process: Potential Integration of Lifespan & Care New England to Create a New Rhode Island Academic Health System*, Sept. 8, 2020).

<sup>474</sup> Finucane Dec. 22, 2021 Tr. 129:5-10.

<sup>475</sup> Babineau Dec. 21, 2021 Tr. 113:20-114:7; 165:10-14.

<sup>476</sup> Lifespan and Care New England are spending \$30,000 per month for lobbyists in Rhode Island. *The Lifespan/Care New England merger just got a big boost*, Boston Globe, Feb. 2, 2022, <https://www.bostonglobe.com/2022/02/10/metro/lifespanscare-new-england-merger-just-got-big-boost/>.

<sup>477</sup> R.I. Gen. Laws § 23-17.14-3(1).

(8) Whether the board exercised due care in accepting assumptions and conclusions provided by consultants engaged to assist in the proposed conversion;

(14) Whether the proposed conversion contemplates the appropriate and reasonable fair market value; and

(15) Whether the proposed conversion was based upon appropriate valuation methods including, but not limited to, market approach, third-party report, or fairness opinion.

In light of the HCA's purpose and criteria, the Attorney General is directed to examine the financial impact of a proposed conversion, including whether a transaction puts a hospital or system – and thus, its charitable assets – at financial risk, how the Boards of each of the Parties assessed the transaction, and the assumptions and conclusion of consultants who assisted in the proposed conversion.

## **2. The Parties' current financial state**

Given that the Parties' Application proposes a straightforward combination of both systems that postpones changes to the combined entity's operating structure or organization,<sup>478</sup> it is important to view the proposed merger in the context of Lifespan's and CNE's current financial state. That financial state is currently defined by external forces – such as a disadvantageous payer mix and OHIC – which create financial challenges for all Rhode Island hospitals. These conditions make it difficult for Lifespan or CNE to fund the types of promises made by the Parties publicly and in their Application. Nor do the Parties demonstrate whether they will be financially stable once combined, even without implementation of all the stated promises.

### **a. Industry headwinds left unaddressed by the Parties**

Hospitals in Rhode Island and around the country are facing tremendous financial headwinds brought about by a shifting healthcare marketplace. Nationally, hospitals are attempting to grapple with fundamental changes such as:

- Healthcare trending away from higher priced (more profitable) inpatient care which requires overnight stay in a hospital and towards outpatient care;<sup>479</sup>
- Technological progress, like telehealth, that improves access and convenience for patients;<sup>480</sup>

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<sup>478</sup> R-CNE-LS09-0000793

<sup>479</sup> See Rhode Island Office of the Health Insurance Commissioner and the Executive Office of Health and Human Services, *Rhode Island Health Care Cost Trends Collaborative Project Report to the Legislature*, December 2020, <http://www.ohic.ri.gov/documents/2021/January/Annual%20Cost%20Trends%20Report%202020.pdf>.

<sup>480</sup> See Oleg Bestsenny, Greg Gilbert, Alex Harris, and Jennifer Rost, *Telehealth: A quarter-trillion-dollar post-COVID-19-Reality?*, Jul. 9, 2021, <https://www.mckinsey.com/industries/healthcare-systems->



- Changes in the way health insurers structure plans to put more of an emphasis on high quality care, lower cost, prevention, and shared risk;<sup>481</sup> and
- Healthcare worker shortages, and demands for higher wages and flexibility from frontline healthcare workers.<sup>482</sup>

While these improvements in the way we health care is delivered and paid for potentially benefit patients and healthcare workers, to be nimble and competitive, hospital systems must adjust the way they have traditionally operated to meet new market demands while maintaining financial stability. These challenges have only been further exacerbated by the enduring COVID-19 pandemic.<sup>483</sup>

Rhode Island hospitals also face some unique and challenging financial realities, both because OHIC caps hospital rate increases, see Section II.A.7.a above, and because Rhode Island ranks among the states with the highest rates of Medicaid and Medicare coverage in the country.<sup>484</sup> Those programs generally pay hospitals lower rates than commercial insurers like BCBSRI. Because a higher proportion of patients are publicly insured, hospitals like RIH and W&I make less money per patient seen than hospitals like Brigham & Women's in Boston. OHIC's efforts to maintain healthcare affordability mean that Rhode Island hospitals make less from commercially insured patients as compared to states where health care is more expensive. Therefore, it is unrealistic to expect that Rhode Island's hospitals will ever be able to achieve

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and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality; King, Sarah L., Shipman, Scott A. MD, MPH, *Telehealth in Academic Medicine: Roles, Opportunities, and Risks*, Academic Medicine, June 2019, [https://journals.lww.com/academicmedicine/fulltext/2019/06000/telehealth\\_in\\_academic\\_medicine\\_role\\_s,.53.aspx](https://journals.lww.com/academicmedicine/fulltext/2019/06000/telehealth_in_academic_medicine_role_s,.53.aspx).

<sup>481</sup> See Anne M. Lockner, *INSIGHT: The Healthcare Industry's Shift from Fee-for-Service to Value-Based Reimbursement*, Sep. 26, 2018, <https://news.bloomberglaw.com/health-law-and-business/insight-the-healthcare-industrys-shift-from-fee-for-service-to-value-based-reimbursement>.

<sup>482</sup> See American Hospital Association, *Fact Sheet: Strengthening the Health Care Workforce*, Nov. 2021, <https://www.aha.org/fact-sheets/2021-05-26-fact-sheet-strengthening-health-care-workforce>; Yaarit Silverstone, *5 ways to attract and keep frontline workers*, Nov. 29, 2021, <https://www.accenture.com/us-en/blogs/business-functions-blog/attract-frontline-workers>.

<sup>483</sup> See American Hospital Association, *Fact Sheet: Financial Challenges Facing Hospitals and Health Systems as a Result of COVID-19*, Apr. 2020, <https://www.aha.org/fact-sheets/2020-04-24-fact-sheet-financial-challenges-facing-hospitals-and-health-systems-result>.

<sup>484</sup> See Medicaid.gov, *Percentage of Population Enrolled in Medicaid or CHIP by State*, <https://www.medicaid.gov/state-overviews/scorecard/percentage-of-population-enrolled-medicaid-or-chip-state/index.html>; The Henry J. Kaiser Family Foundation, *Medicaid State Fact Sheets*, Oct. 17, 2019, <https://www.kff.org/interactive/medicaid-state-fact-sheets/>; The Henry J. Kaiser Family Foundation, *Medicare Beneficiaries as a Percent of Total Population*, 2018, KFF.org/medicare/state-indicator/medicare-beneficiaries-as-of-total-pop/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

profit margins like hospitals in states where hospital rates are unregulated and health insurance is far more expensive.

However, these challenges are not incompatible with a system's ability to deliver accessible, affordable, high-quality care. For example, Kent Hospital is a financially successful institution that delivers high quality care to its local community.<sup>485</sup> Accordingly, hospital systems will need to anticipate and adequately respond to the changing healthcare marketplace – they will likely need to reengineer their healthcare delivery model to deliver forward-looking and financially sustainable services that lead to high-quality patient outcomes and positive patient experiences.<sup>486</sup>

As discussed in Section II.C, the Parties have not proposed a plan that addresses any of these larger marketplace forces or would create a more agile, adaptable healthcare system. Instead, Lifespan and CNE have proposed a system that keeps their existing structure and business model largely intact.

**b. Key metrics for understanding the financial health of hospital systems**

Although health systems are complex, there are a number of indicators that are useful for measuring the financial health of a hospital system. Veralon took a holistic view of the Parties' respective finances when rendering its opinions, but there are two key metrics that illustrate the financial condition of the Parties and are typically relied upon by ratings agencies when determining a hospital or hospital system's debt capacity: operating margin and days of cash on hand.

The key metric when determining the financial health of a hospital or hospital system is its "operating margin" –the difference between total operating revenue and operating expenses.<sup>487</sup> In other words, operating margin is a hospital or hospital system's profitability from its operations. For purposes of this Decision [REDACTED], "operating margin" shall refer to "proportional profit after considering all expenses required to sustain operations, including paying interest costs and funding depreciation."<sup>488</sup>

<sup>485</sup> Finucane Jan. 18, 2022 Tr. 41:11-14; [REDACTED].

<sup>486</sup> Bill Siwicki, *Here are the Major Issues Facing Healthcare in 2021, according to PwC*, Healthcare IT News, Dec. 16, 2020, <https://www.healthcareitnews.com/news/here-are-major-issues-facing-healthcare-2021-according-pwc>.

<sup>487</sup> Veralon Report 10, 48; See American Hospital Association, *Fact Sheet: Financial Challenges Facing Hospitals and Health Systems as a Result of COVID-19*, Apr. 2020 ("A positive operating margin – that is, more revenue than expenses – is critical for any organization to survive over the long term, including not-for-profit organizations.").

<sup>488</sup> Veralon Report at 10.

[REDACTED] 489

Additionally, “positive margins create the ability to invest in new facilities, treatments, and technologies to better care for patients, and to build reserves to be ready for a future made highly uncertain due to the effects of the COVID-19 pandemic.”<sup>490</sup> [REDACTED]

[REDACTED]<sup>491</sup> Studies also show that there is a strong relationship between hospital margins and quality outcomes – indicating that hospitals with thin margins may not be able to make the investments necessary to improve or maintain quality.<sup>492</sup>

Therefore, if a hospital system is to invest in maintaining and improving quality, expanding services, and improving and innovating how it delivers health care, it needs to reach a “healthy” operating margin. [REDACTED]

[REDACTED] 493  
[REDACTED] 494  
[REDACTED] 495  
[REDACTED] 496  
[REDACTED] 497

Days Cash on Hand (“DCOH”) is a measure of the number of days an organization can support operating expenses if its revenue were to be reduced or eliminated. In other words, “DCOH is a ratio that measures the number of days’ worth of expenses an organization can

<sup>489</sup> Babineau Dec. 21, 2021 Tr. 89:21-90:1; *see also* Wakefield Jan. 5, 2022 Tr. 37:18-38:9 ([REDACTED]).

<sup>490</sup> *See* American Hospital Association, *Fact Sheet: Financial Challenges Facing Hospitals and Health Systems as a Result of COVID-19*, Apr. 2020, <https://www.aha.org/guidesreports/2021-03-22-covid-19-2021-pressure-continues-hospital-margins-report>.

<sup>491</sup> Babineau Dec. 21, 2021 Tr. 89:21-22.

<sup>492</sup> Ly, Jha & Epstein, *The Association Between Hospital Margins, Quality of Care, and Closure or Other Change in Operating Status*, *J Gen Intern Med.*, 2011 Nov; 26(11): 1291–1296, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3208470/>.

<sup>493</sup> C-R-CNE-LS23-0047743 at -768 (Potential Integration of Lifespan & Care New England to Create a New Rhode Island Academic Health System, September 8, 2020); C-R-CNE-LS01-0250773 at -779 ([REDACTED]); Finucane Jan. 18, 2022 Tr. 86:5-7 ([REDACTED]).

<sup>494</sup> Wakefield Jan. 5, 2022 Tr. 40:8-14 ([REDACTED]).

<sup>495</sup> *Id.* at 28:14-23 ([REDACTED]).

<sup>496</sup> Babineau Dec. 21, 2021 Tr. 62:13-24.

<sup>497</sup> Finucane Jan. 18, 2022 Tr. 115:4-8.

cover with its highly liquid assets (i.e., cash and cash equivalents).<sup>498</sup> DCOH is noteworthy because an adequate amount of DCOH ensures that a hospital or hospital system can continue operations in the event of unforeseen circumstances. If a hospital system does not have adequate liquidity, incurring additional debt may be necessary to fund operations. Moreover, there is a direct correlation between DCOH and bond ratings: “As one of the most common indicators of the health of a hospital’s balance sheet and solvency, DCOH requirements are often included as a bond covenant for hospitals and health systems when they issue debt.”<sup>499</sup> A lower bond rating is also correlated with a higher cost of borrowing.

All of these financial indicators are relevant to assessing the Parties’ financial stability going into the Proposed Transaction, and the combined Lifespan/CNE system’s anticipated financial stability once the merger is complete.

**c. CNE’s financial state**

Although CNE delivers important healthcare services to Rhode Islanders, its current financial status raises concerns about a combined Lifespan/CNE entity’s financial viability.

[REDACTED]

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[REDACTED]

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<sup>498</sup> Veralon Report at 10.

<sup>499</sup> *Id.*

<sup>500</sup> *Id.* at 14.

<sup>501</sup> R-CNE-LS01-0119747 at -763 (Rhode Island Academic Healthcare System Stakeholder Briefing prepared by the Chartis Group, October 2021) (Setting out investment commitments of more than ~\$100 million per year by the combined Lifespan/CNE system to advance clinical, research and community programs).

<sup>502</sup> Veralon Report at 21.

<sup>503</sup> *Id.* at 16.

[REDACTED] 504 [REDACTED]

CNE's Historical Reported and Adjusted Operating Margin					
Year	2017	2018	2019	2020	Through 8/31/2021
Reported OM	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Normalized OM	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

[REDACTED] 505 [REDACTED]

[REDACTED] 507 [REDACTED] 508 [REDACTED] 509 [REDACTED] 510 [REDACTED] 511 [REDACTED]

**d. Lifespan's financial state**

Lifespan is already a large Academic Health System and is in relatively financially stable condition.

[REDACTED] 512 [REDACTED] 513 [REDACTED]

<sup>504</sup> *Id.*

<sup>505</sup> *Id.* at 13.

<sup>506</sup> *Id.* at 21.

<sup>507</sup> *Id.*

<sup>508</sup> Fanale Dec. 30, 2021 Tr. 36:6-10.

<sup>509</sup> See Veralon Report at 13-14, 35; C-R-CNE-LS-0129913 ([REDACTED]).

<sup>510</sup> Fanale Dec. 30, 2021 Tr. 32:11-16; see also *id.* 17:21-18:20.

<sup>511</sup> *Id.* 32:17-23.

<sup>512</sup> Wakefield Jan. 5, 2022 Tr. 40:1-14.

<sup>513</sup> *Id.* 40:13-14.

[REDACTED] 514

[REDACTED] 515

[REDACTED] 516

[REDACTED] 517

[REDACTED] 518

[REDACTED] 519

Lifespan's Historical Reported and Adjusted Operating Margin					
Year	2017	2018	2019	2020	2021
Reported OM	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Normalized OM	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

[REDACTED] 520

[REDACTED] 521

[REDACTED] 522

<sup>514</sup> Veralon Report at 23.

<sup>515</sup> *Id.*

<sup>516</sup> *Id.* at 30.

<sup>517</sup> *Id.* at 29.

<sup>518</sup> *Id.* at 26.

<sup>519</sup> *Id.* at 30.

<sup>520</sup> *Id.*

<sup>521</sup> See C-R-CNE-LS22-0047433 at -469 ([REDACTED]).

<sup>522</sup> [REDACTED] C-R-CNE-LS01-0013127 at 129 (The Chartis Group, LLC Integration Report, Oct. 2021 (“Chartis”)).

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Lifespan's Historical Reported and Adjusted DCOH					
Year	2017	2018	2019	2020	2021
Cash and Cash Equivalents Only					
Reported					
Normalized					

524

e. **A Combined Lifespan/CNE system's debt capacity**

Another important factor in evaluating the financial feasibility of the Proposed Transaction is the debt capacity of the combined Lifespan/CNE system.

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C-R-CNE-LS01-0250773 at 14.

524 Veralon Report at 22.

525 Babineau Dec. 21, 2021 Tr. 91:14-92:5.

526 *Id.* 74:19-24; Wakefield Jan. 5, 2022 Tr. 44:3-6, 46:6-13.

527 Supplemental Response S-3 (C-R-CNE-LS-0131564).

. Veralon Report at 39.

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**3. The Parties' proffered financial projections demonstrate an unacceptable risk that the Proposed Transaction is not financially feasible.**

In connection with the Proposed Transaction, the Parties commissioned – and submitted to the Attorney General – a series of financial projections for a combined system. The first two were prepared by consultant Alvarez & Marsal and were submitted to the Parties in September 2020 and April 2021, and included five-year financial projections, potential synergy opportunities, and capital investments associated with the merger.<sup>531</sup> These were submitted to the Attorney General with the Initial Application on April 26, 2021. In October 2021, the Parties submitted a report prepared by Deloitte, which was engaged to summarize the more narrow question of the Proposed Transaction's financial efficiencies [REDACTED].<sup>532</sup> Finally, the Parties submitted an updated five-year financial projection prepared by Ernst & Young on January 14, 2022.<sup>533</sup> These reports presented numerous types of projections, measures, and potential initiatives; however, they failed to quantify what the Parties expect it will cost to effectuate the Proposed Transaction in all its forms or identify where that money will come from.

**a. Alvarez & Marsal's September 2020 board presentation**

In September 2020, Alvarez & Marsal prepared financial projections for a combined Lifespan/CNE system to present to the Board of Directors and executive officers of both Parties

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<sup>528</sup> Supplemental Response S-3 (C-R-CNE-LS-0131563).

<sup>529</sup> *Id.*

<sup>530</sup> *Id.* at C-R-CNE-LS-0131564.

<sup>531</sup> Alvarez & Marsal, *CNE-Lifespan: AHS Five Year Income Statement Pro Forma*, September 2020 (C-R-CNE-LS23-0047719); Alvarez & Marsal, *Preliminary Integration Planning Process: Potential Integration of Lifespan & Care New England to Create a New Rhode Island academic Health System*, September 8, 2020 (C-R-CNE-LS23-0047743) ("September 2020 Presentation"); Alvarez & Marsal, *Pro Forma Update*, April 2021 (C-R-CNE-LS63-077978) ("April 2021 Pro Forma").

<sup>532</sup> See Deloitte, *Care New England and Lifespan Efficiency Report*, October 1, 2021 at 3. (C-R-CNE-LS-0079215, at -216) ("Deloitte Report").

<sup>533</sup> Ernst & Young, *Consolidated Pro-forma*, Jan. 14, 2022 (C-R-CNE-LS01-0250773).



[REDACTED] <sup>534</sup> [REDACTED]

<sup>535</sup> A&M prepared a very limited five-year income statement projection (“pro forma”) that

[REDACTED]

<sup>536</sup> [REDACTED]

<sup>537</sup> [REDACTED]

[REDACTED]

<sup>538</sup> [REDACTED]

<sup>539</sup> [REDACTED]

<sup>540</sup> [REDACTED]

[REDACTED] <sup>541</sup> [REDACTED]

<sup>534</sup> Finucane Jan. 18, 2022 Tr. 90:13-23.

<sup>535</sup> Babineau Dec. 21, 2021 Tr. 70:17-71:8.

<sup>536</sup> September 2020 Presentation at C-R-CNE-LS23-0047769.

<sup>537</sup> *Id.*

<sup>538</sup> *Id.* at C-R-CNE-LS23-0047770.

<sup>539</sup> *Id.* at C-R-CNE-LS23-0047771-772.

<sup>540</sup> Finucane Jan. 18, 2022 Tr. 123:10-125:11.

<sup>541</sup> *Id.* 99:15-20; 129:12-16.

[REDACTED] 542  
[REDACTED] 543  
[REDACTED] 544  
[REDACTED] 545

Therefore, it is possible that A&M is grossly underestimating the investment required before a combined Lifespan/CNE system can even turn to the third bucket – implementing potential growth opportunities.

It is critical that A&M did not identify exactly how the Parties would find the funds for [REDACTED]

[REDACTED] 546 The report includes numerous references to the need for financial funding from the State of Rhode Island, such as the following: the creation of a combined Academic Health System [REDACTED]; the “proposed transaction will benefit from the financial participation of the State of Rhode Island”; and the system can achieve a “positive margin with appropriate support from the State of Rhode Island.”<sup>547</sup>

**b. Alvarez & Marsal’s April 2021 pro forma**

The next financial projection prepared for the Parties was A&M’s April 2021 Pro Forma. [REDACTED] 548  
[REDACTED] 549

<sup>542</sup> September 2020 Presentation at C-R-CNE-LS23-0047772.

<sup>543</sup> *Id.*

<sup>544</sup> *Id.*; Finucane Jan. 18, 2022 Tr. 97:21-98:9. [REDACTED]  
[REDACTED] *Id.* at 98:10-99:14.

<sup>545</sup> See Minutes of the Care New England Finance Committee, Oct. 17, 2019 (C-R-CNE-LS06-0013996-197).

<sup>546</sup> September 2020 Presentation at C-R-CNE-LS23-0047765.

<sup>547</sup> September 2020 Presentation at C-R-CNE-LS23-0047764, -767, -781.

<sup>548</sup> Babineau Dec. 21, 2021 Tr. 155:3-6.

<sup>549</sup> April 2021 Pro Forma at 1 (C-R-CNE-LS63-077979).

[REDACTED] <sup>550</sup>  
[REDACTED] <sup>551</sup>

**c. Deloitte’s October 1, 2021 Report**

After reviewing the September 2020 and April 2021 A&M financial forecasts, the Attorney General was concerned with a combined Lifespan/CNE system’s ability to [REDACTED]. Following a request by Attorney General for a more detailed view of the financial implications of the Proposed Transaction, the Parties retained Deloitte [REDACTED]

[REDACTED] <sup>552</sup>  
[REDACTED] <sup>553</sup>  
[REDACTED] <sup>554</sup>  
[REDACTED] <sup>555</sup>  
[REDACTED] <sup>556</sup>  
[REDACTED] <sup>557</sup>  
[REDACTED] <sup>558</sup>  
[REDACTED] <sup>559</sup>  
[REDACTED] <sup>560</sup>

<sup>550</sup> *Id.* at 9 (C-R-CNE-LS63-077987).  
<sup>551</sup> Babineau Dec. 21, 2021 Tr. 153:24-154:2; April 2021 Pro Forma at 9 (C-R-CNE-LS63-077987), 12 (C-R-CNE-LS63-077990).  
<sup>552</sup> Ahern Nov. 17, 2021 Tr. 51:15-52:13; 79:20-80:4; 92:5-9.  
<sup>553</sup> Babineau Dec. 21, 2021 Tr. 155:15-156:7.  
<sup>554</sup> Deloitte Report at C-R-CNE-LS-0079222. [REDACTED]  
<sup>555</sup> *Id.* at C-R-CNE-LS-0079228. [REDACTED]  
<sup>556</sup> Ahern Nov. 17, 2021 Tr. 70:20-23; 81:18-19.  
<sup>557</sup> Deloitte Report at C-R-CNE-LS-0079222.  
<sup>558</sup> *Id.* at C-R-CNE-LS-0079226.  
<sup>559</sup> Burns Report at 63.  
<sup>560</sup> *Id.*

[REDACTED] <sup>561</sup>

[REDACTED] <sup>562</sup>  
[REDACTED] <sup>563</sup>  
[REDACTED] <sup>564</sup>

[REDACTED] <sup>565</sup>  
[REDACTED] <sup>566</sup>  
[REDACTED] <sup>567</sup> [REDACTED] <sup>568</sup>

<sup>561</sup> Deloitte Report at C-R-CNE-LS-0079223-225.

<sup>562</sup> See at C-R-CNE-LS-0079231 ([REDACTED] <sup>562</sup>); *id.* at C-R-CNE-LS-0079233 ([REDACTED] <sup>563</sup>); *id.* C-R-CNE-LS-0079234 ([REDACTED] <sup>564</sup>); *id.* C-R-CNE-LS-0079235 ([REDACTED] <sup>565</sup>); *id.* C-R-CNE-LS-0079235 ([REDACTED] <sup>566</sup>); *id.* C-R-CNE-LS-0079242 (P [REDACTED] <sup>567</sup>); *id.* C-R-CNE-LS-0079243 ([REDACTED] <sup>568</sup>); Ahern Nov. 17, 2021 Tr. 151:3-8; 158:20-159:9.

<sup>563</sup> Ahern Nov. 17, 2022 Tr. 27:21-28:16; 45:2-6; 102:19-20; 126:3-7; 148:21-149:1; 165:6-10; 195:11-19.

<sup>564</sup> *Id.* 162:15-163:10; 164:1-6; 168:15-169:7.

<sup>565</sup> Deloitte Report at C-R-CNE-LS-0079241; Ahern Nov. 17, 2021 Tr. 176:12-20.

<sup>566</sup> Ahern Nov. 17, 2021 Tr. 178:10-13; 179:4-8; Preibe Jan. 4, 2022 Tr. 36:6-20.

<sup>567</sup> Priebe Jan. 4, 2022 Tr. 37:21-38:15; Kahn Jan. 4, 2022 Tr. 53:1-54:4.

<sup>568</sup> Kahn Jan. 4, 2022 Tr. at 53:1-17.

[REDACTED] <sup>569</sup> [REDACTED] <sup>570</sup>  
[REDACTED] <sup>571</sup>

[REDACTED] <sup>572</sup>  
[REDACTED] <sup>573</sup> [REDACTED] <sup>574</sup>  
[REDACTED] <sup>575</sup>

It is also worth noting that on the same day the Parties submitted the Deloitte Report, they also submitted the Chartis Report. As discussed in Section II.C.3.b below, Chartis

[REDACTED] <sup>576</sup>

**d. The Attorney General’s November 16, 2021 supplemental questions**

Following the Attorney General’s receipt and review of A&M’s and Deloitte’s financial projections in April and October, there remained a number of open questions regarding the financial viability of the Proposed Transaction. The information submitted to the Attorney General as of that point in time raised serious concerns about how the Parties could financially achieve any of the goals they had identified in their Application, the Chartis Report, and their commitments to the public (for example, those found on HealthierRI.com). Although the Parties had a \$125 million commitment from Brown, the only other sources of capital identified by

<sup>569</sup> Deloitte Report at C-R-CNE-LS-0079241.

<sup>570</sup> Priebe Jan. 4, 2022 Tr. 82:16-25; 83:5-14; 85:2-86:6.

<sup>571</sup> *Id.* 118:24-119:10.

<sup>572</sup> *See* Deloitte Report at C-R-CNE-LS-0079230.

<sup>573</sup> Ahern Nov. 17, 2021 91:10-14.

<sup>574</sup> *Id.* 122:2-123:2; 170:4-8.

<sup>575</sup> Reppucci Dec. 22, 2021 Tr. 191:2-7.

<sup>576</sup> Chartis Report at C-R-CNE-LS01-0013129.

A&M were [REDACTED]

To get answers to those questions, on November 16, 2021 the Attorney General and the Rhode Island Department of Health (“RIDOH”) requested that the Parties explain how they intended to make the Proposed Transaction financially work. Specifically, the Attorney General requested information regarding sources of funding for the establishment of the proposed Lifespan/CNE system, the budget for the proposed Lifespan/CNE system, the financial status of the Parties, a specification of the capital commitments necessary to complete the integration process, and an explanation for how the Parties would financially manage the combined system.<sup>577</sup> In addition, the Attorney General requested a financial pro forma demonstrating “how the Transacting Parties will be capable of investing in the [Academic Medical Center] capital and infrastructure over the first 5 years . . . .”<sup>578</sup>

On December 2, 2021, the Parties submitted their responses. [REDACTED]

[REDACTED] 579

[REDACTED] 580

[REDACTED] 581

In sum, these responses left the Attorney General’s questions largely unanswered and compounded the concern regarding the financial feasibility and viability of the Proposed Transaction.

**e. January 14, 2022 Ernst & Young pro forma**

When it finally arrived, the Ernst & Young (“EY”) January 14, 2022 Pro Forma only heightened the Attorney General’s concerns about the financial viability of the Proposed Transaction. [REDACTED]

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<sup>577</sup> Letter from Maria Lenz and Fernanda Lopes to P. Rocha (Nov. 16, 2022) at Exhibit A.

<sup>578</sup> *Id.*

<sup>579</sup> Supplemental Response S-1 (C-R-CNE-LS-0131562); Supplemental Response S-2 (C-R-CNE-LS-0131562); Supplemental Response S-7 (C-R-CNE-LS-0131565).

<sup>580</sup> *Id.* at 1 (C-R-CNE-LS-0131562), 4 (C-R-CNE-LS-0131565).

<sup>581</sup> Supplemental Response S-5 (C-R-CNE-LS-0131564). *Id.* at 3 (C-R-CNE-LS-0131564).

[REDACTED] 582

[REDACTED] 583

[REDACTED] 584

[REDACTED] 585

[REDACTED] 586

[REDACTED] 587

[REDACTED] 588

[REDACTED] 589

[REDACTED] 590

[REDACTED] 591

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582 [REDACTED] Hunerlach Feb. 2, 2022 Tr. 84:18-20; 104:13-105.

583 Hunerlach Feb. 2, 2022 Tr. 72:14-15

584 Hunerlach Feb. 2, 2022 Tr. 70:20-71:7; 95:7-23.

585 *Id.* 66:24-67:22; 68:4-12; 91:9-23; 139:17-24.

586 *Id.* 107:11-15.

587 *E.g.*, Supplemental Response S-2 (C-R-CNE-LS-0131562 at -562).

588 *See* Veralon Report at 35-36.

589 EY Pro Forma at 8 (C-R-CNE-LS01-0250780); Veralon Report at 32.

590 EY Pro Forma at 10 (C-R-CNE-LS01-0250782); Veralon Report at 34.

591 A&M September 8, 2020 Presentation at 26 (C-R-CNE-LS23-0047769).

[REDACTED] 592 [REDACTED]

[REDACTED]

[REDACTED] 593 [REDACTED]

[REDACTED] 594 [REDACTED]

[REDACTED] 595 [REDACTED] 596 [REDACTED]

[REDACTED]

[REDACTED] 597 [REDACTED]

[REDACTED] 598 [REDACTED]

[REDACTED] 599 [REDACTED]

[REDACTED] 600 [REDACTED]

[REDACTED]

[REDACTED] 601 [REDACTED]

<sup>592</sup> Finucane Jan. 18, 2022 Tr. 115:14-117:12.

<sup>593</sup> EY Pro Forma at 9 (C-R-CNE-LS01-0250781); Hunerlach Feb. 2, 2022 Tr. 89:15-18; 93:25-94:5; 94:21-95:2; 106:1-14.

<sup>594</sup> Hunerlach Feb. 2, 2022 Tr. 49:21-50:23.

<sup>595</sup> *Id.* 86:1-18.

<sup>596</sup> *Compare* EY Pro Forma at 9 (C-R-CNE-LS01-0250781) *with* September 2020 Presentation at C-R-CNE-LS23-0047770-771.

<sup>597</sup> EY Pro Forma at 9 (C-R-CNE-LS01-0250781).

<sup>598</sup> *Id.* at 12 (C-R-CNE-LS01-0250784); Hunerlach Feb. 2, 2022 Tr. 91:3-92:4.

<sup>599</sup> Hunerlach Feb. 2, 2022 Tr. 91:3-92:4.

<sup>600</sup> Hunerlach Feb. 2, 2022 Tr. 160:12-161:1.

<sup>601</sup> *Id.* 39:18-40:8; 43:4-44:11.



[REDACTED]

In sum, the multiple reports and analyses provided by A&M, Deloitte, and EY do not demonstrate how the Proposed Transaction can achieve its promised ends. [REDACTED]

[REDACTED]. These are important questions for the Attorney General and, as noted by Veralon:

[G]iven the criticality of these questions to the assessment of the feasibility of the Proposed Transaction and its long-term impact on the Parties' futures, the answers to these questions would be important for each Parties' leadership and governing boards to understand prior to moving forward with such a strategically important decision.<sup>602</sup>

#### 4. Conclusion

It is now nearly ten months since the Parties filed their initial application and three months since that application was deemed complete, and despite the Attorney General's repeated attempts to get answers from the Parties, significant questions remain about the financial feasibility of the Proposed Transaction:

- How will a combined Lifespan/CNE system maintain its financial viability?
- How much will it cost to integrate Lifespan and CNE?
- How much will it cost to fund the initiatives identified by Chartis?
- Does a combined system have the capacity to fund the initiatives identified by Chartis?
- Where will a combined Lifespan/CNE entity find the capital to make those investments and how much do the Parties expect these sources to provide?
- What is the risk that taxpayers will end up footing the bill for the Proposed Transaction?

[REDACTED], the

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<sup>602</sup> Veralon Report at 32.

Attorney General cannot approve an application where an applicant does not answer these basic questions.<sup>603</sup>

[REDACTED]  
[REDACTED] <sup>604</sup> [REDACTED]. It is possible for the Parties to quantify the costs and potential benefits of the initiatives they have already proposed. [REDACTED]

[REDACTED] <sup>605</sup> [REDACTED] <sup>606</sup> [REDACTED]

Without more information, the Attorney General is simply left with the Parties' broad statement of belief that [REDACTED]

[REDACTED] <sup>607</sup> [REDACTED]

[REDACTED] <sup>608</sup> [REDACTED]

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<sup>603</sup> The Attorney General also has significant concerns about shortcomings in the due diligence process. For example, CNE's financial due diligence of Lifespan was extremely limited given the magnitude of the Proposed Transaction. Veralon Report at 42-44.

<sup>604</sup> Supplemental Response S-2 (C-R-CNE-LS-0131562 at -562- 563).

<sup>605</sup> Hunerlach Feb. 2, 2022 Tr. 44:20-46:16.

<sup>606</sup> *Id.* 43:4-49:7.

<sup>607</sup> Supplemental Response S-3 (C-R-CNE-LS-0131562-563).

<sup>608</sup> Term Sheet For New Academic Affiliation Between & Among Brown University, Lifespan & Care New England, February 23, 2001 (C-R-CNE-LS01-0013179at -186); Babineau Dec. 21, 2021 Tr. 201:14-17 ([REDACTED]).

[REDACTED] 609  
[REDACTED] 610  
[REDACTED]

As described by Professor Burns, it is well settled that for a health system to function as an Academic Health System, money must flow from the hospital system to the academic institution.<sup>611</sup> In other words, the success of an AHS requires a funds flow model where hospitals provide sufficient funds to the academic partner to support the promised benefits and outcomes of clinical research, faculty recruitment, and program development. For an Academic Health System to successfully invest in the type of research and clinical improvements the Parties have identified as a goal of the transaction, Brown University would need to have a continual source of revenue coming from the clinical operations of the merged hospital system.

[REDACTED] 612  
[REDACTED] 613  
[REDACTED]

[REDACTED]  
[REDACTED]. Given the merged Lifespan/CNE entity's size and importance to the state, the merged entity cannot afford to falter – instead, as discussed in Section II.A, the merged entity may use that size and power to stabilize its finances through increased healthcare costs or reduce its

<sup>609</sup> Memorandum from Christina Paxson to Peter Neronha, September 24, 2021 at 4; Fanale Dec. 30, Tr. 60:13-23 ([REDACTED]); *see also* Paxson Feb. 10, 2022 Tr. 56:8-23 ([REDACTED]).

<sup>610</sup> Babineau Dec. 21, 2021 Tr 86:18-87:8.

<sup>611</sup> Burns Report at 71.

<sup>612</sup> As explained in Section II.B.2.e above, [REDACTED].

<sup>613</sup> *See* Minutes of the Special Meeting of the Lifespan Corporation Board of Directors, February 17, 2021 (C-R-CNE-LS06-0025666).

investments in healthcare delivery with limited risk of losing market share. Or, as suggested by A&M or Chartis, the merged Lifespan/CNE entity could ask taxpayers to cut a check.

In the end, the Attorney General cannot approve a transaction without knowing whether the Parties have the financial wherewithal to achieve what they propose. The Parties have failed to dispel the Attorney General's evidence-based belief that, financially, the Parties' reach exceeds their grasp.

**C. The Proposed Transaction cannot be approved without the plan for future integration.**

**1. Introduction**

Since first filing their initial HCA Application in April of 2021, and resubmitting their initial HCA Application on October 1, 2021, the Parties have been, as expected, strong advocates for a combined Lifespan/CNE system, and in particular the opportunity to create an Academic Medical Center with Brown University. In communications to both the public and stakeholders, as well as in their submissions as part of their Application, the Parties claim that this merger will bring transformative benefits and that the Parties' firm commitments will result in the development of a healthcare system that will reduce health disparities and address the social determinants of health. The merger, they claim, will result in benefits that include increases in quality and access and decreases in cost, while at the same time establishing Rhode Island's first comprehensive cancer center and transforming Rhode Island into a hub for life sciences research and innovation. Both to the public and to this Office, the claimed benefits of system integration are urged by the Parties as a reason—in fact, a key reason—for the Attorney General to approve the Proposed Transaction.

The Parties' Application, however, does not set forth their plan for the system integration they intend. Instead, the Parties chose to submit their Application for review without having determined or explained how they will accomplish system integration or achieve the benefits they claim will flow from it. [REDACTED]

The submission of an Application that includes a stated intent to integrate these hospital systems without having developed or included a plan to do so is concerning. It is not enough for the Parties to leave the on-the-ground reality of a new system undefined and out of view of regulators, and instead merely engage consultants to "provide guidance as to the potential benefits of integration in connection with the proposed transaction."<sup>614</sup> The Attorney General must evaluate, at least, whether the applicants themselves have realistically grappled with the strengths and weaknesses of their own proposals, including by considering the experience of peer hospital systems and known challenges. In the absence of that work having been done by the Parties and submitted as part of this review, the Attorney General and the public are left entirely blind to this future health system the Parties would create.

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<sup>614</sup> Hospital Conversion Application, resubmitted Oct. 1, 2021 ("HCA Application"), R-CNE-LS-0000001 at -095.

Furthermore, the Parties' decision not to provide an integration plan must be viewed in the context of an Application that seeks approval for a highly anticompetitive merger. As described comprehensively in Section II.A, a combined Lifespan/CNE would constitute a concentration in health care unprecedented in New England by, among other things, accounting for over 80% of all Rhode Island discharges of commercially insured patients receiving inpatient general acute care and employ 67% of all full-time registered nurses employed by the state's hospitals. If allowed, Rhode Islanders would be paying more for health care that is highly likely to cost Rhode Islanders more without improvements in quality.<sup>615</sup>

As noted in the Introduction to this Decision, were the transaction approved, newly created Rhode Island Academic Health Care System ("RIAHCS") would become the corporate parent of Lifespan and CNE.<sup>616</sup> Whether and how system integration would occur would then be left to a committee that would convene after the corporate-level merger.<sup>617</sup> The Parties' decision to delay even the creation of a plan for system integration until there is a corporate-level merger makes any determination of the feasibility of these claimed benefits enormously difficult. Nevertheless, the Attorney General will undertake an analysis of the merger's claimed benefits, by relying in large part on a consultant report – the "Chartis Report" – provided by the Parties. The Attorney General's review of the Chartis Report is conducted with the aid of expert analysis and considers the history and problematic experience of similar combinations throughout the country. As set forth more fully below, it is the determination of the Attorney General that, whether a merger would accomplish or even contribute to the benefits the Parties say will result, or even that the benefits could be achieved financially, is enormously speculative.

## **2. Applicable criteria under the Hospital Conversions Act**

Consistent with the statutory requirements of the HCA process, the Parties in their Application have defined the merger that they propose.<sup>618</sup> At the outset, it is important for the public to understand that the Attorney General must evaluate whether the Proposed Transaction, as described by the Parties, meets the purpose and criteria of the HCA.

The HCA directs the Attorney General to determine whether each applicant hospital system, when deciding to pursue a transaction, established appropriate criteria and considered whether the transaction is the only or best alternative, all in relation to the mission and purpose of each system.<sup>619</sup> In addition, the Attorney General must determine whether each hospital system "exercised due care in accepting assumptions and conclusions provided by consultants

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<sup>615</sup>See Section II.A.

<sup>616</sup>Definitive Agreement By and Between Care New England Health System and Lifespan Corporation dated February 23, 2021, Article 4, R-CNE-LS16-0000807-811).

<sup>617</sup>*Id.*, R-CNE-LS16-0000810.

<sup>618</sup>R.I. Gen. Laws § 23-17.14-6(a)(1).

<sup>619</sup>R.I. Gen. Laws 23-17.14-10(b)(3) ("Whether the board established appropriate criteria in deciding to pursue a conversion in relation to carrying out its mission and purposes"); *id.* subsection (4) ("Whether the board considered the proposed conversion as the only alternative or as the best alternative in carrying out its mission and purposes").

engaged to assist in the proposed conversion.”<sup>620</sup> The HCA only allows the Attorney General to issue a decision reaching one of three conclusions: approval, approval with conditions, or denial.<sup>621</sup> The HCA does not allow the Attorney General to stand in the shoes of the transacting parties and completely reconfigure a proposed transaction to meet the purpose and criteria of the HCA.

In their Application, the Parties set forth an intention to integrate the multiple systems that make up Lifespan and CNE, from clinical service lines to plant operations, from community health obligations to research and medical education; that is, they propose a merger that reaches far beyond the corporate level of merely combining boards of governance and/or administration. In their own words:

By bringing together their complementary services, LS and CNE will offer, under one system, a comprehensive range of specialty and primary care services across the state. This will allow the combined system to coordinate care more effectively and build destination programs around women’s health, cancer, psychiatry/behavioral health, cardiac care and other areas of existing expertise.<sup>622</sup>

In other words, it is the intention of the Parties to accomplish system integration and become one unified healthcare system at every level and together provide better care for Rhode Islanders than each system currently provides independently.

**3. The Attorney General requested but did not receive the system integration plan the Parties plan to implement.**

**a. The Parties considered only a preliminary report on system integration,** [REDACTED].

To better understand the deficiencies in the Parties’ planning efforts, a brief overview of the background and timeline of those efforts is instructive. In June 2020, the Parties engaged Alvarez & Marsal (“A&M”) to [REDACTED].<sup>623</sup> In September of 2020, A&M presented an integration plan and Five Year Income Statement Pro Forma to the Parties.

The presentation to the Parties followed a process conducted for the following purpose:

The Parties have engaged in this Preliminary Integration Planning Period because they believe that a more fully integrated health care system, organized in conjunction with a major, top-tier medical school, could form an essential

<sup>620</sup> R.I. Gen. Laws § 23-17.14-10(b)(8).

<sup>621</sup> R.I. Gen. Laws § 23-17.14-10(a)(4).

<sup>622</sup> Chartis Report, C-R-CNE-LS01-0013130.

<sup>623</sup> See A&M Engagement Letter (dated June 10, 2020), C-R-CNE-LS13-0043281.

foundation for providing high quality and lower cost patient care in a competitive environment.<sup>624</sup>

A&M presented the 90-day preliminary integration planning done by six work streams – Clinical, Research & Academic, Operational, Legal & Regulatory, Budget & Finance and Community Health. Each work stream was composed of five to 14 members.

[REDACTED]

[REDACTED]

[REDACTED]<sup>628</sup> and account for over 80% of all Rhode Island discharges of commercially insured patients receiving inpatient general acute care, are only 56 pages.

**b. The second report on system integration – the Chartis Report – is not a meaningful system integration plan.**

The Parties' Application first submitted in April 2021 included the A&M Report and expressed an intent to integrate their respective systems, but admitted, "[a]t this point, there is

<sup>624</sup> Alvarez & Marsal, "Preliminary Integration Planning Process: Potential Integration of Lifespan & Care New England to Create a New Rhode Island Academic Health System: Report to the CNE and Lifespan Boards of Directors and Brown University Executives" (Sept. 8, 2020) at 5 (C-R-CNE-LS23-0047748).

<sup>625</sup> Babineau Dec. 21, 2021 Tr. 67:3-71:8; Reppucci Dec. 22, 2021 Tr. 257:4-12; *see also id.* Tr. 105:2-106:1; 113:13-114:14.

<sup>626</sup> *See* S2-53, C-R-CNE-LS-0249980; S2-77 C-R-CNE-LS-0249990.

<sup>627</sup> [REDACTED]

<sup>628</sup> *See* Parties' unaudited and audited financial statements provided to the R.I. Attorney General in response to a request dated August 2, 2021, C-CNE-LS-018130 *et seq.*

[sic] not a board approved Integration Plan.”<sup>629</sup> Instead of submitting the plan for system integration, the Parties built into the structure of the Proposed Transaction a delay in developing and approving a system integration plan until after Lifespan and CNE were merged. Put simply, the Parties’ Application expressed an intent that all of the planning with respect to how the two systems would actually merge and integrate would occur after the HCA approval and after the conclusion of the Attorney General’s investigation and review.

The Attorney General identified the absence of a plan as a deficiency in the Application. In fact, during the four months after the Parties submitted their initial HCA Application, the Attorney General pressed them for more fulsome information about the Proposed Transaction. On May 26, 2021, the Attorney General and RIDOH sent a deficiency letter to the Parties, calling their April 2021 Initial Application “overwhelmingly deficient” with a lack of “a realistic plan to meet the resulting entities’ capital needs.”<sup>630</sup> The Attorney General and RIDOH posed 196 deficiency questions to the Parties, including several integration-related questions.<sup>631</sup> In July of 2021, the Parties requested a meeting with the Attorney General seeking feedback on their HCA Application. During this meeting, the Parties were again informed that their Application was deficient because it lacked a final, specific, system integration plan.

Shortly thereafter, in July of 2021, the Parties engaged The Chartis Group LLC “to outline the integration plan that will guide the combination of Care New England and Lifespan, and the relationship between the combined entity and Brown University as their academic partner.”<sup>632</sup> In September of 2021, the Attorney General again advised the Parties of the need for their system integration plan, informing them, “[t]he Agencies cannot fulfill their statutory obligations to evaluate a proposed integrated system without being provided plans for that integration. Put simply, the Agencies cannot evaluate what they cannot see.”<sup>633</sup> On October 1, 2021, the Parties provided the Chartis Report to the Attorney General as part of their resubmitted initial HCA Application, nearly six months after they first filed the HCA Application. In their final Application and in response to a request for the board-approved integration plan for the proposed conversion, the Parties stated the following:

While there is not a board-approved integration plan at this time, as noted in the Executive Summary, the Transacting Parties have jointly engaged Chartis and Deloitte to provide *guidance as to the potential benefits of integration* in connection with the proposed transaction.<sup>634</sup> (emphasis added)

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<sup>629</sup> Response 49, Transacting Parties’ Initial HCA Application submitted April 26, 2021, CNE-LS-000073-74.

<sup>630</sup> Letter from J. Rider and F. Lopes to P. Rocha (May 26, 2021) at 1-2.

<sup>631</sup> *Id.* at Confidential Exhibit A.

<sup>632</sup> *See* Chartis Report, C-R-CNE-LS01-0013127.

<sup>633</sup> Letter from J. Rider and F. Lopes to P. Rocha (Sept. 10, 2021) at 3.

<sup>634</sup> HCA Application, R-CNE-LS-0000095 (emphasis added).



The Chartis Report itself acknowledges that it does not describe the merged system's integration but contemplates a plan to make a future plan that will address issues such as expected cost, quality improvement, and equity:

For each of the final priority initiatives, the parties will develop a comprehensive integration plan that includes a detailed workplan and timeline; estimated improvements in access, quality, cost, and equity; and projected capital needs.

[REDACTED]

<sup>635</sup>

Again, the Parties, through the Chartis Report, only convey a plan to develop the more robust plan after this merger is consummated and outside of this HCA review process. Furthermore, as the Parties have not actually committed to the goals and objectives set forth in the Chartis Report, it is fair to describe them as aspirational.

Setting that threshold issue aside and assuming that these goals did represent concrete commitments, the Chartis Report, similar to the A&M Report, presents in very general terms a long and ambitious list of projected outcomes. The 14 initiatives are described on 15 pages and can be summarized as follows.<sup>636</sup>

- “Unify the Operating Model for Each Clinical Program” [REDACTED];
- “Optimize System-Wide Inpatient Capacity” [REDACTED];
- “Invest in a Unified Set of Information Technology” [REDACTED];
- “Address Unmet Psychiatric/Behavioral Health Needs” with initiatives to knit together CNE and Lifespan programs, including building a brief-stay unit at Butler, centralizing inpatient care at Butler, embedding behavioral health [REDACTED];
- “Transform WIH into a Comprehensive Women’s Hospital,” [REDACTED];

<sup>635</sup> Chartis Report, C-R-CNE-LS01-0013148.

<sup>636</sup> These initiatives are set forth in the Chartis Report, C-R-CNE-LS01-0013130-145.

- “Establish R[hode] I[sland]’s First Comprehensive Cancer Center” [REDACTED];
- “Increase Access to Lower-Cost Care and Accelerate the Transition to Value-Based Payment Models” by working with payors to develop innovative payment models that “can lead to cost reductions and quality improvements for consumers and payors,” [REDACTED];
- “Redirect Appropriate Cases from” RIH’s Hospital Outpatient Department to CNE’s Ambulatory Surgery Center, [REDACTED];
- “Build One to Two Ambulatory Care Centers” [REDACTED];
- “Improve Quality and Decrease Disparities in Healthcare Outcomes” by redesigning quality infrastructure and publicly setting/monitoring quality and cost goals;
- “Expand Services at CNE’s Express Care Center in the Pawtucket/Central Falls Area” to address unmet urgent care, primary care, and behavioral healthcare needs;
- “Invest in Population Health Infrastructure and Addressing the Social Determinants of Health” by committing \$10 million dollars over three years to invest in technologies, capabilities, and programs that improve population health and address social factors that affect health outcomes and by working with Brown’s School of Public Health;
- “Transform RI into a Hub for Life Sciences Research and Innovation” by creating a unified research administration and access to a comprehensive clinical database; offering “world-class scientists”; and serving as catalysts to grow research and innovation, [REDACTED]; and
- “Nurture the Local Healthcare Workforce” by developing new programs that attract physicians and public health professionals to train a diverse healthcare workforce.

This list represents a list of general objectives the Parties themselves acknowledge are only “potential benefits of integration” and contain neither detailed plans nor a description of how the Parties would intend to implement them. [REDACTED]

[REDACTED]. Moreover, the two future co-CEOs of the proposed merged entity – Drs. Babineau and Fanale – provided testimony, under oath, [REDACTED]

[REDACTED] Dr. Babineau admitted that [REDACTED]  
[REDACTED]<sup>637</sup> He further acknowledged that [REDACTED]  
[REDACTED]<sup>638</sup> Dr. Fanale admitted that [REDACTED]  
[REDACTED]<sup>639</sup> Dr. Fanale conceded that [REDACTED]  
[REDACTED]<sup>640</sup> on  
the part of leadership obviously raise significant concerns.

To date, [REDACTED]  
[REDACTED]  
[REDACTED].

**4. The research and national experience demonstrate that hospital consolidation generally does not achieve the results the Parties claim will be achieved here.**

Because the Parties, even with the Chartis Report, do not actually detail how the integration, including the outcomes they claim, will be achieved (systemically, clinically, or financially), the Attorney General looks at the national evidence of the impact of hospital consolidations on quality, access, and cost to determine whether the aspirational efficiencies and goals described in the Chartis Report are realistic and achievable.

The Attorney General's evaluation of the projected outcomes begins with the history of hospital mergers and consolidations. Over the last thirty years, many hospital systems have consolidated and engaged in efforts to accomplish system integration.<sup>642</sup> The results of these efforts have been the subject of careful and convincing research and are relevant to the analysis under the HCA.

In a widely cited statement before a February 2018 hearing in the House Subcommittee on Energy and Commerce Oversight and Investigations, former chief economist at the Federal Trade Commission's Bureau of Competition and Carnegie Mellon professor Martin Gaynor summarized the experience with hospital consolidation and system integration.

<sup>637</sup> Babineau Dec. 21, 2021 Tr. 224:7-10; 74:13-15 ([REDACTED]).

<sup>638</sup> *Id.* at 224:17-19.

<sup>639</sup> Fanale Dec. 30, 2021 Tr. 209:19-210:5; 239:21-24.

<sup>640</sup> *Id.* 163:23-164:5.

<sup>641</sup> *See id.*, Tr. 209:19-24.

<sup>642</sup> Lawton Robert Burns. *The U.S. Healthcare Ecosystem*. (New York: McGraw-Hill, 2021) at Chapter 12, Figures 12-4 and 12-8.

While the intuition, and the rhetoric, surrounding consolidation, has been positive, the reality is less encouraging. The evidence on the effects of consolidation is mixed, but it's safe to say that it does not show overall gains from consolidation. Merged hospitals, insurers, physician practices, or integrated systems *are not systematically less costly, higher quality, or more effective than independent firms* (see Burns and Muller, 2008; Burns et al., 2015; Goldsmith et al., 2015; Burns et al., 2013; McWilliams et al., 2013; Tsai and Jha, 2014). For example, Burns et al. (2015) find no evidence that hospital systems are lower cost, Goldsmith et al. (2015) find no evidence that integrated delivery systems perform better than independents, Koch et al. (2018) find higher Medicare expenditures for cardiology practices in consolidated markets, and McWilliams et al. (2013) find higher Medicare expenditures for large hospital-based practices. *Since consolidation in health care has been occurring for a long time, it seems unlikely that the promised gains from consolidation will now materialize if they haven't yet.*<sup>643</sup> (emphases supplied)

The Attorney General's expert agrees, in the context of the Proposed Transaction. Professor Lawton Burns, another oft-cited and notable healthcare management scholar, was enlisted to serve as an expert in system integration for this review. Professor Burns is the James Joo-Jin Kim Professor at the Wharton School at the University of Pennsylvania, where he is also professor of management and codirector of the Roy and Diana Vagelos Program in Life Sciences and Management. Professor Burns's extensive research of health care in the United States includes research into hospital mergers, formation of hospital systems, and physician-hospital alignment, among many other related topics.

Professor Burns evaluated the details and purported benefits of this proposed merger as described by the Parties and placed them in the context of the academic and economic literature on hospital consolidations. He then applied his more than thirty-five years of experience studying and working with hospitals to the matters the Parties should, and the Attorney General must, consider here.

In his report ("Burns Report"), Professor Burns explains why it is unrealistic to expect the consolidation of Lifespan and CNE to lead to the benefits the Parties claim. First, he describes the complex issues pertaining to the proposal for integration of the two systems. He then identifies the gaps between the Parties' aspirational outcomes and concrete experience and concludes that the risk these outcomes will not be achieved is much higher than the likelihood that they will be.

For example, two of the many areas addressed by Professor Burns are access to care and population health, and neither can be expected to improve by merging these hospital systems.

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<sup>643</sup> Statement of Martin Gaynor in *Examining the Impact of Health Care Consolidation; Statement before the Committee on Energy and Commerce Oversight and Investigations Subcommittee, U.S. House of Representatives*, Feb. 14, 2018.

a. Access to care

With respect to access to care, the Parties have made the following statements publicly:

The final piece [to protect and improve the health of communities] is decreasing health disparities and increasing access to health care. Hospitals, health care providers and medical schools play the critical role of supporting communities and individuals who have different levels of health literacy, and making health care accessible.<sup>644</sup>

After decades of nationwide experience, factors that impact access to healthcare are known. Professor Burns distills them in his report:

Access to care, studied by researchers for decades, has been linked to the availability of medical resources (physician and hospital supply), the ability to pay for care (family income, insurance coverage), travel distances to reach that care, and characteristics of the populations (e.g., illness level, willingness to seek care, factors enabling care-seeking).<sup>645</sup>

Clearly, achieving the important goal of improving access to care will prove to be complex. However, the available evidence demonstrates that hospital consolidation is *not* a factor that leads to improved access. In fact, the evidence is to the contrary. Research cited by Professor Burns in his report shows that “[c]ompared to hospitals that did not combine, merged hospitals were more likely to discontinue the obstetric and surgical lines and more likely to experience decreasing utilization (stays, admissions) for mental/substance abuse disorders.”<sup>646</sup>

Expected increases in cost will decrease access to health care as well. Because a key factor in access to health care is the ability to pay for care, it is critical to understand the relationship between hospital consolidation, access, and cost. There also, the evidence is concerning:

Indeed, there is empirical evidence that mergers have just the opposite impact [on access], and may increase disparities in health insurance access and thus inequities in healthcare.<sup>647</sup>

An entirely realistic outcome from consolidating these two hospital systems is that insurance coverage will become *more* costly, thereby reducing access to care.

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<sup>644</sup> *What we're all about*, HealthierRI.com, Feb. 15, 2020, HealthierRI.com/our-vision/#controlled-costs

<sup>645</sup> Burns Report at 43.

<sup>646</sup> *Id.* at 45

<sup>647</sup> *Id.* at 44, citing Robert Town, *et al.*, *Hospital Consolidation and Racial/Income Disparities in Health Insurance Coverage*, *Health Affairs* 26 (4): 1170-1180, 2007.

Overall, Dr. Burns concludes, “[r]esearch evidence indicates that hospital consolidation does not improve access to care but in fact hurts it.”<sup>648</sup>

#### **b. Population health and the healthcare system**

Promises of achieving improved “population health” for Rhode Islanders simply through a merger are also unrealistic. Research has also consistently shown an inherent challenge in trying to achieve health – broadly defined – through the tool of a healthcare system: our healthcare system contributes only ten to fifteen percent to our health status.<sup>649</sup> Given that stubborn fact, in order to deliver on this audacious promise, the Parties owe not only this regulator but the patients the new system will serve evidence that they have done the hard work and developed a rigorous, reality-based plan showing how this merged system will achieve what they promise. The Attorney General feels confident that, if the Parties had such a plan, it would appear front and center in their Application.

### **5. Conclusion**

The Attorney General must review the Parties’ transaction as proposed and measure how well the public will be served by what is being proposed. Where, as here, the Attorney General has little insight into the details of what is actually proposed, he cannot fairly and effectively evaluate what, if any, *positive* impacts the Proposed Transaction will have on Rhode Islanders. This inability is especially troubling where, the potential *negative* effects of concentrating this much market power in one system are demonstrable and significant. Under these circumstances, an HCA review can have only one outcome. And that is denial of the Parties’ Application.

#### **D. The Parties’ approach to the Proposed Transaction raises questions about whether they will be able to effectively integrate and improve healthcare delivery and outcomes across the state.**

If the Proposed Transaction were to be approved, the Parties would begin the complicated tasks of integrating their clinical care, facilities, operations, information systems, and workforces, and contracting with key counterparties like healthcare payers. When hospital systems consolidate in this manner, that consolidation is difficult to undo, even if regulatory agencies later identify additional, significant reasons for concern. Courts, academics, and antitrust enforcers all acknowledge the challenge in “unscrambling the eggs” and restoring the prior, pre-merger level of competition.<sup>650</sup>

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<sup>648</sup> Burns Report at 44.

<sup>649</sup> See J. Michael McGinnis and William Foege, *Actual Causes of Death in the United States*, *JAMA* 270(18), 1993, at 2207-2212. Paula Braveman and Laura Gottlieb, *The Social Determinants of Health: It's Time to Consider the Causes of the Causes*, *Public Health Reports*, Jan-Feb 2014, at 19-31.

<sup>650</sup> *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1217 n.23 (11th Cir. 1991) (“once an anticompetitive merger is consummated it is difficult to ‘unscramble the egg’”); Thomas L. Greaney, *Coping with Concentration*, *Health Affairs* 36, no. 9, Sept. 2017 (“challenges to consummated transactions are notoriously difficult to mount, particularly because of difficulties inherent in fashioning relief, or ‘unscrambling the egg’”); FTC Comm’r J. Thomas Rosch, *Consummated Merger Challenges – The Past*

For this reason, the Parties are asking Rhode Islanders to place considerable trust in them. As discussed above, in proposing this transaction – and a near-irreversible course for the State’s healthcare system – the Parties are promising that they will be able to effectively integrate and improve healthcare delivery and outcomes throughout Rhode Island, without describing how they plan to do it. The commitment of the systems’ leaders, doctors, nurses, and staff to pursuing these critical goals is evident and should not be questioned.

The HCA requires scrutiny of the Parties’ approach to this merger, particularly when their words in one setting have often diverged from the facts in another. For instance, the public website created by the Parties to advocate for the merger says that, “[w]ith few exceptions, Lifespan and Care New England offer [sic] do not compete on the basis of clinical services.”<sup>651</sup>

[REDACTED]

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At the core of the Parties’ proposal is the creation of a “fully-integrated academic health system”<sup>654</sup> and the benefits it will bring to Rhode Islanders. As Dr. Babineau explained in a public forum discussing the merger, “Rhode Island is the only state in New England that does not have at least one integrated academic health system . . . Massachusetts has five . . . Rhode Island has zero.”<sup>655</sup> But this marketing point for the merger is difficult to square with Lifespan’s own website, which calls Lifespan, in its current un-merged state, a “comprehensive, integrated, academic health system with the Warren Alpert Medical School of Brown University.”<sup>656</sup>

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*Is Never Dead*, (Mar. 29, 2012), [https://www.ftc.gov/sites/default/files/documents/public\\_statements/consummated-merger-challenges-past-never-dead/120329springmeetingspeech.pdf](https://www.ftc.gov/sites/default/files/documents/public_statements/consummated-merger-challenges-past-never-dead/120329springmeetingspeech.pdf), remarks delivered to ABA Section of Antitrust Law Spring Meeting (“we need to challenge and unwind anticompetitive transactions as quickly as possible to minimize consumer injury. The longer we wait, the greater the problem of ‘unscrambling the eggs’”).

<sup>651</sup> *Frequently Asked Questions*, HealthierRI.com/faq (accessed Feb. 7, 2022). Submissions by the Parties also contend that Lifespan and Care New England are not competitors. *See, e.g.*, Hospital Conversion Application, resubmitted Oct. 1, 2021 (“Application”) at R-CNE-LS-0000046 (“Further, to a significant extent, the services of the Transacting Parties complement each other and are not redundant or competitive.”); HCA Application at R-CNE-LS-0000114 (“Lifespan and CNE are primarily complementary health systems, with little overlap in services.”).

<sup>652</sup> See Section II.A.3.a.

<sup>653</sup> [REDACTED] (FTC-CNE-02483140 at - 141.)

<sup>654</sup> *See, e.g.*, Application at R-CNE-LS-0000015.

<sup>655</sup> *The Business of Healthcare* panel discussion part of “The Future of Healthcare in Rhode Island” event (Dec. 15, 2020), [TheFutureOfHealthcareInRI.splashthat.com](http://TheFutureOfHealthcareInRI.splashthat.com).

<sup>656</sup> *About Lifespan*, [Lifespan.org/about-lifespan/overview](http://Lifespan.org/about-lifespan/overview) (accessed Feb. 3, 2022). [REDACTED]

More critically, the Parties have argued that the merger “will improve the quality of medical care for patients across Rhode Island and surrounding region.”<sup>657</sup> Put another way, using the slogan chosen to market the merger, the Parties have repeatedly said they will be “Better Together” at delivering high quality care to Rhode Islanders.<sup>658</sup>

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Brown University’s involvement in the Proposed Transaction is another area where the public messaging has not always aligned with the details presented to regulators. Statements and marketing materials position Brown as a third partner in the transaction that will merge Lifespan and CNE.<sup>660</sup> But, Lifespan and CNE structured this Proposed Transaction in a manner that does not include Brown as a transacting party.<sup>661</sup> The Definitive Agreement, signed only by Lifespan and Care New England, alludes to a yet-to-be-developed affiliation agreement with Brown and suggests that three seats on the new system’s board of directors may be occupied by individuals affiliated with Brown.<sup>662</sup> Because these provisions and Brown’s role have not been formalized, and because the Proposed Transaction is not contingent on any of those additional developments

. Babineau Dec. 21, 2021 Tr. 51:3-9 (

<sup>657</sup> *Our Vision*, HealthierRI.com <https://healthierri.com/our-vision/> (accessed Feb. 7, 2022).

<sup>658</sup> *Our Pledge*, HealthierRI.com/2021/04/26/our-pledge/ (accessed Feb. 7, 2022) (committing to the “Better Together Pledge” that states “Together, Lifespan, Care New England, and Brown University are uniquely positioned to create a Rhode Island-based, integrated academic health system that will improve quality. . .of health care for all Rhode Islanders”); Timothy J. Babineau and James E. Fanale, *Opinion/Babineau and Fanale: A bright future for health care in RI*, *The Providence Journal*, Mar. 20, 2021 (calling the merger “a singular opportunity to improve the quality of medical care for all Rhode Islanders”).

<sup>659</sup> C-R-CNE-LS-0081028.

<sup>660</sup> *Home*, HealthierRI.com (accessed Feb. 7, 2022) (prominently displaying Brown’s logo alongside logos of Lifespan and Care New England and explaining that “[t]hese three organizations have complementary strengths that, when combined, hold the promise of a thriving integrated academic health system”); Brown University, *Brown, Lifespan, Care New England to create integrated academic health system* (Feb. 23, 2021), [Brown.edu/news/2021-02-23/academic-health](http://Brown.edu/news/2021-02-23/academic-health); *The Business of Healthcare* panel discussion part of *The Future of Healthcare in Rhode Island* event (Dec. 15, 2020), [TheFutureOfHealthcareInRI.splashthat.com](http://TheFutureOfHealthcareInRI.splashthat.com) (presenting President Paxson alongside Dr. Babineau and Dr. Fanale to explain the proposed academic health system).

<sup>661</sup> See Definitive Agreement by and between Care New England Health System and Lifespan Corporation (Feb. 23, 2021), R-CNE-LS16-00007.

<sup>662</sup> *Id.* at 2 (“the Parties desire to execute a comprehensive and robust affiliation agreement with Brown”); *id.* at 9 (the new system’s board will include “up to three (3) individuals who are not, and have not been, associated with either CNE or Lifespan, including, for example, individuals employed by or associated with Brown”), R-CNE-LS16-0000808.



ever transpiring, it is difficult for regulators to fully assess the impact of Brown's involvement under the HCA framework that evaluates transactions by transacting parties.

Relatedly, it was difficult for the Attorney General to get clear answers about the role of Brown's affiliated physician organization in the Proposed Transaction. The prospect that the Parties and Brown would next consolidate physician services was an area of specific concern. When questioned by the Attorney General's Office about efforts underway to merge Brown's physician group with Lifespan's and Care New England's physician organizations, the health systems' leaders paused the three-way consolidation

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Sequencing transactions and limiting a key partner's on-paper involvement are both strategies the Parties are entitled to employ, but their use here does little to allay concerns about allowing the new system to take control of a large part of Rhode Island's healthcare market, with such limited planning and view into how the integration would occur. Nor does a marketing campaign downplaying the realities of competition or promising healthcare improvements that the Parties know they may struggle to deliver allay these concerns.

Finally, the Attorney General notes the Parties' disregard for important and applicable statutory criteria that apply to a transaction involving non-profit hospitals. The HCA directs the Attorney General to determine whether each applicant hospital system, when deciding to pursue the transaction, "established appropriate criteria in deciding to pursue a conversion in relation to carrying out its mission and purposes."<sup>667</sup> It is therefore significant and concerning to the Attorney General that the Parties chose to ignore this provision of the HCA, stating in their Application: "Because of the unique nature of a CNE and Lifespan merger . . . there was no R[equest] F[or] P[roposal] process with board established criteria."<sup>668</sup> The Parties' position is similar with respect to the HCA criteria that directs the Attorney General to address whether the transaction is the only or best alternative, all in relation to the mission and purpose of each

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<sup>663</sup> Babineau Dec. 21, 2021 Tr. 171:3-187:24.

<sup>664</sup> *Id.* Tr. 173:14.

<sup>665</sup> *Id.* Tr. 184:5-7.

<sup>666</sup> *Id.* Tr. 187:15-18; *id.* Ex. 24, AM\_042851.

<sup>667</sup> R.I. Gen. Laws § 23-17.14-10(b)(3).

<sup>668</sup> HCA Application at R-CNE-LS-0000043.

system.<sup>669</sup> Without considering alternatives, the Parties do no more than assert that the Proposed Transaction is the only and best alternative.<sup>670</sup> These provisions contained within the HCA should not be treated with presumptive disregard, particularly where, as here, these HCA criteria were the subject of focused inquiry by the Attorney General. In the context of the magnitude of the Proposed Transaction, this disregard is particularly significant.

**E. The anticompetitive effects of this type of healthcare consolidation and the shortfalls in the Proposed Transaction’s integration and financial planning cannot be solved through more regulation or conditions imposed under the HCA.**

**1. The use of conditions and “Certificate of Public Advantage” laws by states to regulate otherwise anticompetitive health system mergers have not been shown to constrain price growth or promote quality improvements over the long term.**

Over the last three decades, several states – including Georgia, Maine, Montana, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia – have approved mergers of competing hospitals with large market shares.<sup>671</sup> Federal antitrust law has developed to exempt state actions authorizing otherwise anticompetitive mergers from being subject to liability for antitrust violations.<sup>672</sup> These state actions have often come in the form of “Certificate of Public Advantage” or “COPA” laws permitting state regulators, like an attorney general’s office or a health department, to confer a COPA to merging hospitals, effectively approving a transaction.<sup>673</sup> State regulators have used the COPA process to place a range of constraints on a newly merged entity in an attempt to address the anticompetitive harms posed by consolidation. Studies show, however, that COPAs tend to be ineffective at preventing healthcare prices from rising over the long term or promoting healthcare quality improvements.<sup>674</sup>

Most COPAs seek to control hospital prices and keep costs down for consumers. Regulators have employed different mechanisms in their efforts to constrain healthcare spending, including caps on hospital revenues, operating margins, cost growth, and charge growth, as well as limits on the growth of the number of physicians employed by a hospital system.<sup>675</sup> Some of

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<sup>669</sup> R.I. Gen. Laws § 23-17.14-10(b)(4).

<sup>670</sup> HCA Application at R-CNE-LS-0000044.

<sup>671</sup> See, generally, Christopher Garmon and Kishan Bhatt, *Certificates of Public Advantage and Hospital Mergers: Evidence from Maine, Montana and South Carolina*, June 24, 2020, at 2-4.

<sup>672</sup> Randall R. Bovbjerg and Robert A. Berenson, *Certificates of Public Advantage: Can They Address Provider Market Power?*, Feb 18, 2015, at 4-5.

<sup>673</sup> *Id.*

<sup>674</sup> Garmon and Bhatt at 35-40; Christopher Garmon and Laura Kmitch, *Hospital mergers and antitrust immunity: the acquisition of Palmyra Medical Center by Phoebe Putney Health*, Dec. 2017, at 15-20.

<sup>675</sup> COPA hospital price and spending control mechanisms have taken different forms:

Georgia’s Hospital Authority Laws limited Phoebe Putney Health from obtaining more than a “reasonable rate of return” above operating expenses. Garmon and Kmitch at 5.

these measures have temporarily controlled price growth in the areas they sought to constrain. But these regulatory tools are imperfect because, as healthcare economists like Dr. Cory Capps have observed, “[i]t is hard to design a system that doesn’t leave scope for evasion” and allow a health system with market power to generate more revenue.<sup>676</sup> Using the COPA imposed by North Carolina on Mission Health as an example, Dr. Capps explained that the COPA featured a cost growth cap tied to cost per case-mix adjusted discharge, which was derived from a weighted average of inpatient and outpatient services. By raising its charges or costs for outpatient services relative to inpatient services, Mission Health could change the weighted average and manipulate its overall costs as a matter of accounting. Similarly, a cost growth cap that applied specifically to Mission Hospital, the new system’s anchor hospital, could be evaded by shifting costs or investments outside that hospital to other parts of the system.

More importantly, COPA-driven price controls are impermanent. COPAs providing regulatory oversight of hospital mergers often end not because they run their intended course, but because they are repealed at the request of a health system that has amassed significant political influence. For example, in 2007, Benefis Healthcare successfully lobbied Montana’s legislature to repeal its COPA,<sup>677</sup> and in 2015, Mission Health persuaded North Carolina legislators that its COPA had “outlived its usefulness.”<sup>678</sup>

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Maine required Southern Maine Medical Center to restrict its operating margin to no more than 3% of its total operating revenue. Garmon and Bhatt at 16.

Montana capped Benefis Healthcare’s total revenue based on a cost target that deducted non-patient revenues and was adjusted for inflation using the Bureau of Labor Statistics’ Hospital Producer Price Index. Garmon and Bhatt at 8-9.

North Carolina capped Mission Health’s operating margins and costs per case to the average levels at comparable hospitals in the state. Additionally, it capped Mission Health’s physician employment and exclusive contracting with physicians at 20%, later raising this cap to 30%. Erin C. Fuse Brown, *To Oversee or not to oversee? Lessons from the Repeal of North Carolina’s Certificate of Public Advantage Law*, Milbank Memorial Fund, Jan. 2019, at 4.

South Carolina reduced gross charges for all payers, restricted Palmetto Health’s growth in gross revenue to higher patient volume alone, and prohibited the system from receiving higher case-mix adjusted net inpatient revenue. Garmon and Bhatt at 5.

Tennessee and Virginia limited price increases by Ballad Health to the latest CMS Medicare Market Basket amount plus 0.25% and applied price limitations to all payers. Erin C. Fuse Brown, *Hospital Mergers and Public Accountability: Tennessee and Virginia Employ a Certificate of Public Advantage*, Milbank Memorial Fund, Sep. 2019, at 18.

West Virginia limited Cabell Huntington Hospital and St. Mary’s Hospital rates to the benchmark rates set by the West Virginia Health Care Authority. *Assurance of Voluntary Compliance, In re: Cabell Huntington Hospital Acquisition of St. Mary’s Medical Center*, Nov. 4, 2015.

<sup>676</sup> Cory Capps et al., *Completed COPAs: Reviewing the Mission Health and Benefis Health COPAs*, Jun. 18, 2019, at 34.

<sup>677</sup> Garmon and Bhatt at 5.

<sup>678</sup> Erin C. Fuse Brown, *To Oversee or not to oversee? Lessons from the Repeal of North Carolina’s Certificate of Public Advantage Law*, Milbank Memorial Fund, Jan. 2019, at 5.

When COPA conditions are removed, hospital prices often rise. After the repeal of the Montana COPA, Benefis' prices increased 20% more than the prices of similarly sized and positioned Montana hospitals.<sup>679</sup> A COPA overseeing the Southern Maine Medical Center expired in 2015 and its prices increased by over 40% more than the prices of other large Maine hospitals.<sup>680</sup> Prices have risen significantly in some systems even as COPA controls remained in place, with, for example, South Carolina's Palmetto Health increasing prices by 27% during the COPA period, though these increases were consistent with price trends at other South Carolina hospitals.<sup>681</sup>

There is also little evidence that COPA conditions can deliver improvements in healthcare quality. A study of the Phoebe Putney Health System's acquisition of the Palmyra Medical Center, the only other hospital in Albany, Georgia, found that, in addition to a large price increase in the first year following the merger, the consolidation led to a significant reduction in the quality of care delivered at the newly combined hospital.<sup>682</sup> Most of the measured hospital performance metrics, including heart attack readmissions, heart failure readmissions, pneumonia mortality, pneumonia readmissions, as well as patient dissatisfaction, increased following the merger.<sup>683</sup> One recent study did observe promising healthcare quality improvements following the merger of NYU Langone Health, a New York City-based academic medical system, and Lutheran Medical Center, a Brooklyn-based teaching hospital, but these hospitals were not competitors and had small market shares in a hospital-dense environment.<sup>684</sup> The removal of COPA controls can also threaten quality. After the Maine COPA ended, patient outcomes at the Southern Maine Medical Center deteriorated across most mortality and readmissions measures.<sup>685</sup>

**2. The conditions proposed by the Parties insufficiently address the competition problems created by this type of consolidation and the shortfalls in the Proposed Transaction's integration and financial planning.**

The Parties have recognized that the Proposed Transaction raises a range of concerns for patients, workers, taxpayers, and regulators. In response, they have proposed a set of "pledges"

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<sup>679</sup> Garmon and Bhatt at 31.

<sup>680</sup> *Id.* at 34.

<sup>681</sup> *Id.* at 36.

<sup>682</sup> Garmon and Kmitch at 15-20.

<sup>683</sup> *Id.* Of the eight performance measures examined, only heart attack mortality and heart failure mortality improved following the merger.

<sup>684</sup> Erwin Wang *et al.*, *Quality and Safety Outcomes of a Hospital Merger Following a Full Integration at a Safety Net Hospital*, JAMA Netw. Open, Jan. 6, 2022, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787652#:~:text=We%20found%20that%20a%20full,and%2027%25%20relative%20reduction%20in.>

<sup>685</sup> Garmon and Bhatt at 38.

or “commitments,” to the public as part of their marketing campaign,<sup>686</sup> and suggested “conditions,” to regulators as part of their advocacy for the Proposed Transaction.<sup>687</sup> These commitments, whether styled as pledges or drafted as legal conditions, are largely the same and touch on areas where the Proposed Transaction has been subject to criticism: healthcare costs, quality, access, and equity. But, after careful review, it is evident the commitments are insufficient to address the competition problems created by this type of consolidation and the shortfalls in the Proposed Transaction’s integration and financial planning.

Critically, the Parties’ commitments inadequately address the extensive harms caused by the elimination of competition that have been well documented in Section II.A. Key to the Parties’ proposal on managing healthcare costs is a commitment to “operate within rate caps established by OHIC, with no appeals, for the first three years post-closing.”<sup>688</sup> Setting aside that the Parties are obligated by law to comply with this regulation, the “commitment” does little to address competition concerns because, as Section II.A.7.a demonstrates, the OHIC hospital rate cap cannot prevent the anticompetitive effects of the Proposed Transaction. Section II.A.7.a shows that the scope of OHIC’s regulation is limited – it does not apply to all healthcare services – and that the rate cap could be challenged and overridden. Indeed, Care New England’s hospitals filed suit against OHIC challenging the rate cap on January 31, 2022.<sup>689</sup> Moreover, the commitment is limited to three years, which renders it a weak constraint.<sup>690</sup>

<sup>691</sup> When this

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<sup>686</sup> *Our Pledge*, HealthierRI.com, Feb. 7, 2020, HealthierRI.com/2021/04/26/our-pledge/.

<sup>687</sup> On January 12, 2022, the Parties met with the Attorney General and submitted a set of proposed conditions that, in the Parties’ view, could be imposed under the HCA to mitigate concerns about the Proposed Transaction. These conditions were similar to the commitments detailed on HealthierRI.com, the Parties’ website marketing the Proposed Transaction. In analyzing the public commitments and the conditions submitted by the Parties, the Attorney General reviewed the record, examined the extensive academic literature on these types of conditions, as detailed in Section II.E.1, and consulted Dr. Pflum, an economist specializing in healthcare matters, and Farella Braun + Martel’s healthcare antitrust practitioners.

<sup>688</sup> *Our Pledge*, HealthierRI.com (Feb. 7, 20220), HealthierRI.com/2021/04/26/our-pledge/.

<sup>689</sup> Complaint, *Hospital Association of Rhode Island et al. v. Tigue*, R.I. Sup. Ct., PC-2022-00595 (Jan. 31, 2022). Lifespan has also challenged OHIC’s attempts to expand its regulatory authority; Office of the Health Insurance Commissioner, “*Stakeholder Comments on Advance Notice of Proposed Rulemaking 230-RICR-20-30-4 Powers and Duties of the Office of the Health Insurance Commissioner*,” (Received as of Jun. 24, 2019), <http://www.ohic.ri.gov/documents/July%202019/Stakeholder%20Comments%20on%20Advance%20Notice%20of%20Proposed%20Rulemaking%20Combined%202019%206-24.pdf> at 42.

<sup>690</sup> BCBSRI agrees that the three-year commitment opens the door for future rate increases. Bush Decl. ¶ 19 (“[I]t is unclear what rate increases the merged entity could insist upon after [three years].”).

<sup>691</sup> [REDACTED]

see also Bush Decl. ¶ 19 (“it is unclear what rate increases the merged entity could insist upon after that time”).

commitment expires, Sections II.A.4.d and II.E.1 show that hospital prices and, consequently, Rhode Islanders' healthcare costs, are likely to rise.

In another attempt to address healthcare costs, the Parties commit to achieving the “cost trend target to hold the total annual health care spending increases to 3.2% as established by the Rhode Island Cost Trends Steering Committee.”<sup>692</sup> Here, it turns out, the Parties are committing to something they had previously agreed to do in December 2018 when Dr. Babineau, on behalf of Lifespan, and Dr. Fanale, on behalf of CNE, joined the “Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island.”<sup>693</sup>

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Other “commitments” by the Parties are non-specific pledges to do things that most Rhode Islanders assume their health systems are already working towards, like “increas[ing] ease of access to primary care and behavioral health services” and “advanc[ing] quality by demonstrating improvement in readmissions and maintaining or improving national rating benchmarks.”<sup>696</sup> The Parties' public pledges are riddled with commitments to do things they are already obligated to do – and do not require a merger to do – and things that Rhode Islanders would hope they are already doing as non-profit health systems.

The Parties also have sought to resolve concerns raised by their workers, reaching an agreement with four labor unions that, if the merger occurs, commits the Parties to: reserving a seat on the new system's board for a union representative; assuming the existing collective bargaining agreements; creating protections against layoffs; and offering retraining opportunities for union members whose positions are eliminated.<sup>697</sup> The Attorney General again recognizes the impressive work of the unions and their leadership in securing these commitments from the Parties to the benefit of their members. Such negotiations are challenging and often shrouded by uncertainties about the Parties' plans and the regulatory process.

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<sup>692</sup> *Our Pledge*, HealthierRI.com.

<sup>693</sup> Rhode Island Health Care Cost Trends Steering Committee, *Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island*, Dec. 19, 2018, <http://www.ohic.ri.gov/documents/cost%20trends%20project/Compact-to-Reduce-the-Growth-in-Health-Care-Costs-and-State-Health-Care-Spending-in-RI.pdf>.

<sup>694</sup> [REDACTED].

<sup>695</sup> [REDACTED].

<sup>696</sup> *Our Pledge*, HealthierRI.com.

<sup>697</sup> *Proposal by Lifespan/CNE*, Jan. 27, 2022 (agreement between the Parties and Service Employees International Union 1199NE, United Nurses & Allied Professionals, International Brotherhood of Teamsters Local 251, and Rhode Island Federation of Teachers and Health Professionals).

As explained in Section II.A.6.d, the Attorney General has analyzed the Proposed Transaction's impacts on the labor market with a significant advantage: confidential information obtained from the Parties, sensitive healthcare market data, extensive testimony by hospital executives, and expert analyses of this information. With that perspective, the Attorney General notes that almost all of the Parties' commitments to the unions feature the same limitation: they only bind the Parties through July 1, 2025,<sup>698</sup> a three-year period similar to the duration of the Parties' pledge to abide by OHIC's rate cap. The Attorney General also observes that the Parties have not committed to forgoing or limiting the shifting of services or patient volume from hospitals with organized workforces, like Rhode Island Hospital, to those without, like Miriam, over the long term. And, while the agreement with the unions provides for the Parties' proposed new cancer center to be a union facility, this commitment expires if the center has not opened by July 2025 – and does not extend to the Parties' planned new ambulatory care facilities. Again, while it is clear that the unions were able to negotiate meaningful concessions and protections for their workers, the Attorney General is concerned that the commitments are insufficient to address the likely harms to the labor market, as discussed in Section II.A.6.d.

To understand the Parties' willingness or unwillingness to make commitments, the Attorney General looks to

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<sup>698</sup> *Id.*

<sup>699</sup> FTC-CNE-02616680; Thomas C. Tsai and Ashish K. Jha, *Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better*, JAMA, July 2, 2014.

<sup>700</sup> FTC-CNE-02616680.

<sup>701</sup> FTC-CNE-00049601 at -601, -602 ([REDACTED]).

<sup>702</sup> *Id.*

[REDACTED]

**3. Rhode Island stakeholders have suggested thoughtful and creative conditions, but any such constraints that could be imposed by the Attorney General are also insufficient to mitigate the concerns posed by the merger.**

The Attorney General commends the organizations, agencies, and individuals that have weighed in on the types of regulatory constraints that might be employed to address the concerns posed by the merger. Here, the Attorney General discusses two sets of particularly thoughtful recommendations: one submitted by the Rhode Island Foundation,<sup>703</sup> and the other submitted by OHIC's Commissioner Patrick Tighe.<sup>704</sup> Both sets of recommendations suggest approaches for containing costs, incentivizing quality care, and developing oversight of a Lifespan/CNE system. But, after review and consideration, the Attorney General is not convinced that these conditions – to the extent they could even be imposed by the Attorney General under the HCA – adequately mitigate the Proposed Transaction's anticompetitive effects.

From June 2021 through November 2021, the Rhode Island Foundation convened an Integrated Academic Health System Community Input Committee to make recommendations to regulators about the Proposed Transaction.<sup>705</sup> This work resulted in a series of helpful proposals the Attorney General considered during the review. Many of these recommendations do not cure the problems raised by the Proposed Transaction's consolidation but are commitments that Lifespan and CNE should consider making outside the context of the merger – things like expanding access for communities of color, directing institutional purchasing towards Minority Business Enterprises and Women Owned Business Enterprises, and setting benchmarks for addressing health disparities.<sup>706</sup> Other recommendations, like targeting for 80% of the new system's patient population to be in valued based payment models or recommitting to the cost containment goals of the Rhode Island Health Care Cost Trends Project, address the likelihood of rising costs and the need to incentivize quality.<sup>707</sup> However, as Section II.E.1 demonstrates, even much stronger regulations have struggled to constrain price growth over the long term and regulation has not been shown to assure quality improvements.

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<sup>703</sup> Rhode Island Foundation, *Ensuring the Integrated Academic Health System Benefits all Rhode Islanders*, Nov. 2021, [https://issuu.com/rifoundation/docs/rif\\_healthreport\\_2021\\_v6f\\_digital\\_singlepages](https://issuu.com/rifoundation/docs/rif_healthreport_2021_v6f_digital_singlepages).

<sup>704</sup> Office of the Health Insurance Commissioner, *The Care New England and Lifespan Proposed Merger: Payment Model Characteristics Necessary to Maximize Affordability and Quality Related to the State of Rhode Island Office of the Health Insurance Commissioner's Statutory Purpose*, June 2021, <http://www.ohic.ri.gov/documents/2021/June/OHIC%20CNE-Lifespan%20Proposed%20Merger%20Policy%20Considerations%20Working%20Paper%206-29-21%20Final.pdf>.

<sup>705</sup> Rhode Island Foundation at 4-6.

<sup>706</sup> *Id.* at 20-22, 24-26.

<sup>707</sup> *Id.* at 26-28.



Working papers submitted by OHIC’s Commissioner also suggest strategies for regulating a Lifespan/CNE system. As Section II.A.7.a explains, OHIC is charged with regulating Rhode Island’s health insurance industry. While OHIC does not take a position on whether the merger should be approved, OHIC advances its recommendations in the event that the Proposed Transaction proceeds and argues that “a permanent regulatory oversight structure” is needed to oversee the merged system.<sup>708</sup> If the Proposed Transaction were approved, such permanent regulatory oversight would be necessary, but the Attorney General remains concerned that the tools this regulator would have at its disposal are insufficient to address the new system’s market power. OHIC discusses implementing “comprehensive price caps” and, like the Rhode Island Foundation report, requiring the adoption of value-based payment structures.<sup>709</sup> But, as Section II.E.1 shows, states around the country have attempted to design effective price controls with little success, and similar restraints can be evaded and even repealed by a health system with considerable political influence.

**4. The Attorney General cannot impose conditions on the Transacting Parties that adequately address the Proposed Transaction’s anticompetitive effects and shortfalls in financial and integration planning.**

Under the HCA, the Attorney General may approve a proposed transaction with “conditions directly related to the proposed conversion.”<sup>710</sup> The Attorney General has used this tool to safeguard Rhode Islanders’ access to quality and affordable care in recent transactions such as the 2021 change in ownership of Roger Williams Medical Center and Our Lady of Fatima Hospital and the 2016 acquisition of Westerly Hospital by the Yale New Haven Health System.<sup>711</sup> These hospital conversions, however, differed significantly from the Proposed Transaction in that they did not seek to combine competing hospitals or health systems with large shares of Rhode Island’s healthcare market. Whether modeled by other states, proposed by the Transacting Parties, or suggested by other Rhode Island stakeholders, the types of conditions that could be imposed through the HCA are inadequate to address the Proposed Transaction’s anticompetitive effects and shortfalls in financial and integration planning. Such conditions cannot recreate the competition lost, they are not permanent—even when well-designed—and

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<sup>708</sup> Office of the Health Insurance Commissioner at 19-20.

<sup>709</sup> *Id.* at 4-19.

<sup>710</sup> R.I. Gen. Laws § 23-17.14-10(a)(4). A separate section of the HCA provides the Attorney General with similar authority to impose conditions on for-profit acquirors. R.I. Gen. Laws § 23-17.14-28(c).

<sup>711</sup> Attorney General HCA Decision, In Re: Initial Application of Chamber Inc., Ivy Holdings Inc.; Ivy Intermediate Holdings, Inc.; Prospect Medical Holdings, Inc.; Prospect East Holdings, Inc.; Prospect East Hospital Advisory Services, LLC; Prospect CharterCARE, LLC; Prospect CharterCARE SJHSRI, LLC; Prospect CharterCARE RWMC, LLC. (Jun. 1, 2021), [https://riag.ri.gov/sites/g/files/xkgbur496/files/documents/Prospect\\_Chamber\\_Ivy\\_AG\\_HCA\\_Decision.pdf](https://riag.ri.gov/sites/g/files/xkgbur496/files/documents/Prospect_Chamber_Ivy_AG_HCA_Decision.pdf); Attorney General HCA Decision, In Re: Expedited Review Hospital Conversion Initial Application of Yale-New Haven Health Services Corporation, Lawrence + Memorial Corporation and LMW Healthcare, Inc. d/b/a Westerly Hospital (Sep. 1, 2016), <https://riag.ri.gov/sites/g/files/xkgbur496/files/documents/LMYNHFinal.pdf>.

can be removed or inevitably will expire, and they cannot [REDACTED].

To the extent that competition regulators like the FTC and DOJ consider proposals from parties seeking to proceed with an otherwise anticompetitive merger, they prefer structural remedies that maintain competition in the relevant markets by requiring the merging firms to divest certain assets.<sup>712</sup> As Section II.A.3 explains, the head-to-head competition between CNE's Kent Hospital and Lifespan's Rhode Island Hospital and Miriam Hospital that would be eliminated by the Proposed Transaction is considerable. But, even if Kent Hospital were not part of the Proposed Transaction, the merger would still eliminate significant competition in the markets for behavioral health, outpatient surgical services, ACOs, and the labor market, as Section II.A.6 shows. These anticompetitive effects illustrate the challenge of identifying a structural remedy for the Proposed Transaction. [REDACTED].

Moreover, conditions like hospital price caps or quality incentives cannot cure the anticompetitive harms resulting from the Proposed Transaction. As shown in Section II.E.1, this consolidation of competing health systems with large market shares is precisely the type of merger that has proven difficult to constrain through COPA conditions targeting price or cost growth. Any conditions the Attorney General could impose on the Parties under the HCA would suffer the same limitations as those used in COPAs – they could be evaded and likely would not improve healthcare quality.

Even if such conditions were effective, the HCA limits their use to a five-year period.<sup>713</sup> While this interval may be sufficient to oversee the milestones related to a hospital integration, it does not lend itself to monitoring the consequences of the Proposed Transaction's elimination of competition. Section II.E.1 demonstrates that these harms are likely to worsen over time as the now-dominant system cements its control of Rhode Island's healthcare market. And, if the new system were subject to conditions, it would likely seek to remove or revise them using its enormous influence, as Section II.E.1 shows other dominant health systems have attempted. When the conditions end, either because they are removed or they have run their natural course, Sections II.A and II.E.1 make clear that Rhode Islanders' healthcare costs are likely to rise.

Conditions are also unable to increase the new system's debt capacity and the likelihood that the Parties will make the necessary investments to deliver on the promises of the new integrated academic health system. In the recent Prospect Medical HCA decision, the Attorney General imposed conditions that sought to ensure the long-term fiscal stability of two Rhode Island hospitals. There, Leonard Green & Partners, a well-resourced private equity firm, was selling its ownership interest after having extracted hundreds of millions of dollars from Prospect

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<sup>712</sup> Martha Samuelson, *et al.*, *Merger Remedies Guide at Economic Analysis of Merger Remedies*, Global Competition Review (4th ed 2021), <https://globalcompetitionreview.com/guide/the-guide-merger-remedies/fourth-edition>; U.S. Department of Justice Antitrust Division, *Merger Remedies Manual*, Sep. 2020, <https://www.justice.gov/atr/page/file/1312416/download>.

<sup>713</sup> R.I. Gen. Laws § 23-17.14-28(d).

Medical, the company that owns Roger Williams Medical Center and Fatima Hospital, leaving Prospect a financially unstable and highly leveraged entity. The Attorney General required Leonard Green and Prospect Medical to set aside \$80 million to shore up the hospitals' perilous finances.<sup>714</sup>

Here, unlike in Prospect, there is no exiting party with a responsibility to contribute to the solvency of the system created by the transaction. Instead, as Section II.B explains, the new system's finances – and its ability to make planned investments – depend on revenues, debt capacity, philanthropy, identifying efficiencies, and government aid.

[REDACTED]

### **III. Public comments submitted during the HCA review reveal Rhode Islanders' appreciation for the promise of a new integrated health system and concerns about its potential negative impacts on healthcare quality, access, and affordability.**

The Proposed Transaction has generated a significant amount of interest and comments from the public. Members of the public submitted around 200 written comments and, over the course of three public meetings, 55 individuals offered their views on the Proposed Transaction. Commenters wrote and spoke on behalf of businesses, community and nonprofit organizations, and labor unions, and in their capacities as patients, workers, taxpayers, community members, and elected officials. Taken together, the record of public comments reviewed and considered by the Attorney General reveals Rhode Islanders' appreciation for the promise of a new integrated academic health system and concerns about its potential negative impacts on healthcare quality, access, and affordability. In this Section, the Attorney General discusses a representative set of comments from Rhode Island's business community and healthcare organizations, labor unions and health system workers, patients and community members, community and civic organizations, and state government officials.

#### **A. Business community members and healthcare organizations**

Business community views on the Proposed Transaction were mixed, with organizations highlighting the benefits of a high-quality healthcare system for Rhode Island's economy, while also expressing concern about the potential for a merged Lifespan/CNE system to abuse its market power. In an opinion piece published in the Providence Journal, Bruce Van Saun, CEO of Citizens Financial Group, and Tom Gilbane, Chairman and CEO of Gilbane Inc., echoed the views of several prominent businesses, writing that the Proposed Transaction is an "opportunity to transform downtown Providence into a nationally leading research hub, and recreate the economy-driving success that cities such as Boston, Pittsburgh, Cleveland, and Baltimore have enjoyed in recent years," and that "[b]ringing Lifespan and Care New England together to form an integrated academic health system with Brown University should help position Rhode Island's economy for growth moving forward while at the same time ensuring that the health

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<sup>714</sup> Attorney General HCA Decision, In Re: Initial Application of Chamber Inc., *et al.* at 71-79.

care needs of Rhode Islanders are met.”<sup>715</sup> Aidan Petrie, managing partner of the New England Medical Innovation Center, said, “I think that [the Proposed Transaction] can only benefit [health care] in Rhode Island if we have a larger system that is well integrated, well informed, well managed appropriately with appropriate controls.”<sup>716</sup>

Several healthcare organizations shared significant concerns about the Proposed Transaction’s likely anticompetitive effects. Michael Souza, CEO of Landmark Medical Center, wrote in opposition to the Proposed Transaction explaining that “this will create a healthcare monopoly” and, in addition to “the numerous healthcare services that would be monopolized by the new company, it would also have an impact on the labor market [because other providers of healthcare] would have extreme difficulty recruiting staff against the new company.”<sup>717</sup> Joan Kwiatkowski, CEO of PACE Organization of Rhode Island which is a nonprofit health plan for low-income elderly Rhode Islanders, wrote that PACE is “concerned the rate we pay the hospitals will increase if the merger is allowed to go through” because, “[w]ith decreased competition, we expect that a unified hospital system would require PACE-RI to pay increased rates across all hospitals, something that would cost PACE-RI, and in turn the government, hundreds of thousands of dollars in extra fees each year.”<sup>718</sup> As discussed in Section II.A, Blue Cross Blue Shield of Rhode Island, the state’s largest health insurer, testifies about the potential anticompetitive effects of the Proposed Transaction and also submitted a comment letter expressing consistent views.<sup>719</sup>

David Katseff, a Pawtucket-based small business owner, wrote urging the Attorney General to consider “what a merger between the state’s two largest health systems will mean for small businesses . . . . Mainly, will it increase costs for my business and my workers?” As the comment explained, “[h]ealth expenses are already a large expense for the operation of my small business [ ] and when health insurance costs continue to rise, things like wage increases or additional worker benefits become unsustainable . . . . Health costs often crowd out other incentives I would like to provide for my workforce but cannot afford.”<sup>720</sup> Public testimony from Al Charbonneau, Executive Director of the Rhode Island Business Group on Health, noted that it was important to focus on the outcome of the Proposed Transaction, describing it as “a formation of what arguably will be the most highly consolidated hospital market in the country.”<sup>721</sup> Mr. Charbonneau also stated that “the data identify hospitals as a major source of

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<sup>715</sup> Bruce Van Saun and Tom Gilbane, *Opinion/Van Saun and Gilbane: Citizens, Gilbane endorse Plan to bring Lifespan and Care New England systems together*, *The Providence Journal* (Dec. 20, 2021).

<sup>716</sup> Aidan Petrie, New England Medical Innovation Center, Lifespan/CNE Public Meeting Jan. 26, 2022 Tr. 19:5-9.

<sup>717</sup> Letter from Michael Souza, Landmark Medical Center (Jan. 31, 2022).

<sup>718</sup> Letter from Joan Kwiatkowski, PACE Organization of Rhode Island (Feb. 9, 2022).

<sup>719</sup> Letter from Michelle Lederberg, Blue Cross Blue Shield of Rhode Island (Feb. 2, 2022)

<sup>720</sup> Email from David Katseff (Jan. 20 2022).

<sup>721</sup> Al Charbonneau, Rhode Island Business Group on Health, Lifespan/CNE Public Meeting Jan. 26, 2022 Tr. 30:14-18.

increasing commercial health insurance premiums, which means we should be extremely careful pulling the trigger on another merger, particularly in a fee-for-service environment.”<sup>722</sup>

## **B. Labor unions and workers**

Many labor unions and healthcare workers offered their perspectives on the Proposed Transaction. Following the agreement between the Parties and the four unions representing more than 10,000 Lifespan and CNE healthcare workers, which is discussed more fully in Section II.E.2, Service Employees International Union 1199NE (“SEIU”), United Nurses & Allied Professionals (“UNAP”), International Brotherhood of Teamsters Local 251, and the Rhode Island Federation of Teachers and Health Professionals signaled their support for the Proposed Transaction. On behalf of UNAP, union President Lynn Blais wrote that “an integrated health care system with CNE, Lifespan and Brown University will have a powerful capability to improve patient outcomes that cannot likely be achieved in a more fragmented system.”<sup>723</sup> Heather Kelley, speaking on behalf of SEIU, explained that the deal reached with the Parties “will address some of the worst fears we have expressed” by guaranteeing union representation in the new system’s governance structures and providing other protections for workers.<sup>724</sup>

A significant number of written comments and public testimony by healthcare workers at Lifespan/CNE hospitals expressed serious concerns about the Proposed Transaction. Meghan Lynch, an employee at Butler Hospital, wrote that “[t]here are many incentives for [doctors in leadership roles at Lifespan who are already affiliated with Brown] to continue to put their clinical duties on support staff and trainees so that they may pursue additional, lucrative opportunities through their affiliation with Brown,” and worries that this pattern will continue if the merger is approved.<sup>725</sup> Dana Ciolfi, a medical technologist at W&I who has worked there for 42 years, noted her experience “at Women & Infants both as a stand-alone hospital and one that is part of a system” and asked at a public meeting, in light of the pending merger:

What assurances do we have right now that corporate interests will not overshadow patient interest, as we have already experienced? What assurances do we have now that this monopoly will not abuse its extreme power over employees, union, or community? What assurances do we have now that we will be able to maintain our fair competitive wages, excellent benefits, and job security beyond our current contracts? What assurances do we have now that we will not combine our specialized services, such as the lab and diagnostic imaging and many other areas, into large departments that will have to be moved to larger central locations, diluting those specialties to the detriment of our patients?<sup>726</sup>

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<sup>722</sup> *Id.* at 33:5-11.

<sup>723</sup> Letter from Lynn Blais, United Nurses & Allied Professionals (Feb. 1, 2022).

<sup>724</sup> Heather Kelley, Lifespan/CNE Public Meeting Feb. 10, 2022 Tr. 61:20-62:11.

<sup>725</sup> Letter from Meghan Lynch (Jan. 31, 2022).

<sup>726</sup> Dana Ciolfi, Lifespan/CNE Public Meeting Feb. 10, 2022 Tr. 21:5-21.

### **C. Physicians, patients, and community members**

Rhode Islanders from across the state submitted written comments and spoke at the public hearings on the Proposed Transaction. Dan Cahill, “speak[ing] as a patient,” objected to the merger because, “I think it gives a monopoly status in the provision of health care, which won’t be good for patients.”<sup>727</sup> Niyoka Powell, who worked as a nurse at Butler Hospital until the pandemic, stated, “I do not believe the merger is going to benefit Rhode Island at all” because “we need to make sure that the bone structure of these hospitals are already fixed before you merge to something else . . . .”<sup>728</sup> In a letter, Daniel Sloat wrote, “[i]t is one thing to give the people universal health coverage, it is another thing to give them universal healthcare in the form of a monopoly. There is some real potential for progress within this new integrated entity, but far too many causes for concern clouding this merger that officials have thus far done little to explicate.”<sup>729</sup>

Several physicians and physician organizations also offered their views on the Proposed Transaction. Dr. Lynn Somerville, an internist, cited experience at Miriam Hospital during its combination with Lifespan and noted that she “watched the subsequent decline in care to patients and increasing employee dissatisfaction,” while “[c]ost to the institution and cost of medical care did not go down (which had been predicted and was one of the reasons for the merger).”<sup>730</sup> Dr. David Barrall, a surgeon, wrote to “vigorously oppose” the Proposed Transaction because it is “anti-competitive and will lead to higher costs, further limit patient choice, and further drive out independent practices thus leading to further health system monopoly.”<sup>731</sup> Dr. Keith Callahan, President of the Rhode Island Academy of Family Physicians, expressed the organization’s support for the Proposed Transaction while suggesting that regulators should impose a condition requiring the Parties to “Expand Family Medicine Graduate Medical Education (GME) Training Positions and Sites for Family Medicine” because, “at present, CNE sponsors all 48 Family Medicine GME positions in the State in two underserved areas (Pawtucket/Central Falls and West Warwick) [and] the merged entity will have over 700 GME positions.”<sup>732</sup>

### **D. Community and civic organizations**

Multiple community and nonprofit organizations provided public comments on the Proposed Transaction. Karen Malcolm, speaking at a public meeting as the coordinator of the Protect our Healthcare Coalition, stated, “[t]he proposed merger would create a monopoly [ ] with enormous influence.”<sup>733</sup> Ms. Malcolm also cited the 5-year limitation on conditions imposed under the HCA discussed in Section II.E.4, and said: “That isn’t enough. The fact that

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<sup>727</sup> Dan Cahill, Lifespan/CNE Public Meeting Jan. 26, 2022 Tr. 64:2-7.

<sup>728</sup> Niyoka Powell, Lifespan/CNE Public Meeting Jan. 26, 2022 Tr. 76:17-77:18.

<sup>729</sup> Letter from Daniel Sloat (Jan. 26, 2022).

<sup>730</sup> Email from Dr. Lynn Somerville (Feb. 2, 2022).

<sup>731</sup> Letter from Dr. David Barrall (Jan. 28, 2022).

<sup>732</sup> Letter from Dr. Keith Callahan, Rhode Island Academy of Family Physicians (undated).

<sup>733</sup> Karen Malcolm, Lifespan/CNE Public Meeting Jan. 26, 2022 Tr. 38:2-4.

we lack a permanent robust mechanism to oversee such a large system is a problem that we think should be considered when evaluating the application.”<sup>734</sup> Cortney Nicolato, President and CEO of the United Way of Rhode Island urged regulators to be vigilant in their review of the Proposed Transaction to “ensur[e] that this merger prioritizes increased and equitable access to high quality care that improves public health outcomes for our low income and Black Indigenous People of Color (BIPOC) in our communities.”<sup>735</sup> Chris Koller, President of the Milbank Memorial Fund and a Rhode Island resident, wrote to recommend the Attorney General reject the Proposed Transaction because, “by [the Parties’] own admission, they did not seek other partners,” and the Parties’ application “fails to explore or make the case for why the proposed merger is superior to the alternative of both health systems remaining independent.”<sup>736</sup> And, as examined in Section II.E.3, the Rhode Island Foundation submitted an extensive set of recommendations for regulators on the Proposed Transaction.<sup>737</sup>

#### **E. State government officials**

Several elected officials, government agencies, and other government organizations offered public comments on the Proposed Transaction. Writing jointly, House Speaker K. Joseph Shekarchi and Senate President Dominick J. Ruggerio submitted a letter detailing their “full and unequivocal support” for the merger noting that they “aspire, for the good of all Rhode Islanders, to construct a true, fully-integrated academic health system here with Brown University that will rival other well-known systems” in Massachusetts, Connecticut, and New Hampshire.<sup>738</sup> In a public meeting, Representative David Morales spoke of his concern that “the merger would essentially create a monopoly [ ] leaving Rhode Islanders with little options when pursuing care,” and noted how, across the country, “hospital mergers have been approved without the proper oversight and regulations which have resulted in severe consequences, hurting working people, communities of color, and hospital workers . . . .”<sup>739</sup> Senator Louis P. DiPalma, also speaking at a public meeting, noted “recent reductions of services at Newport Hospital,” and stated that he is “concerned this reduction of services to my constituents would accelerate any potential post-merger.”<sup>740</sup>

Other legislators and government agencies and organizations shared their views. Representative Rebecca Kislak wrote with “serious concerns regarding the proposed merger” stemming, in part, because “we do not have a sufficiently strong regulatory framework in place

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<sup>734</sup> *Id.* at 38:8-12.

<sup>735</sup> Letter from Cortney Nicolato, United Way of Rhode Island (Jan. 31, 2022).

<sup>736</sup> Letter from Chris Koller, Milbank Memorial Fund (Feb. 9, 2022).

<sup>737</sup> Rhode Island Foundation, *Ensuring the Integrated Academic Health System Benefits all Rhode Islanders*, Nov. 2021, [https://issuu.com/rifoundation/docs/rif\\_healthreport\\_2021\\_v6f\\_digital\\_singlepages](https://issuu.com/rifoundation/docs/rif_healthreport_2021_v6f_digital_singlepages). (Nov. 2021).

<sup>738</sup> Letter from Hon. K. Joseph Shekarchi and Hon. Dominick Ruggerio (Feb. 3, 2022).

<sup>739</sup> Hon. David Morales, Public Meeting Tr. Jan. 26, 2022 69:6-12; 69:18-21 (Jan. 26, 2022).

<sup>740</sup> Hon. Louis DiPalma, Lifespan/CNE Public Meeting Feb. 10, 2022 Tr. 57:25-58:5.

to appropriately manage such a large system in our state.”<sup>741</sup> Representative Liana Cassar wrote opposing the Proposed Transaction, stating that “the health of Rhode Islanders would benefit from these entities renewing their efforts to raise the bar on meeting the health care needs of the state without creating a monopoly.”<sup>742</sup> Also, as discussed more fully in Section II.E.3, OHIC Commissioner Patrick Tigie submitted multiple working papers addressing the merger<sup>743</sup> and the state Primary Care Physicians Advisory Committee noted the Parties’ “control [of] more than 700 graduate medical education (GME) positions in the state” and the need for the new system to “prioritize the well-being, support and compensation of primary care physicians and those in training.”<sup>744</sup>

**IV. The fate of Rhode Island’s healthcare market does not depend on the Proposed Transaction, and the Attorney General must promote competition and preserve the solvency of the state’s hospitals until structural reforms are embraced and pursued.**

The Attorney General’s review and this Decision have established that there are several reasons for serious concern about the Proposed Transaction, which taken alone or together require denial of this Application. In Section II.A, the Attorney General demonstrates that the merger is likely to substantially reduce competition for inpatient general acute care hospital services, violating the Rhode Island Antitrust Act and rendering it improper under the Hospital Conversions Act. The harms that are likely to result from the Proposed Transaction – higher costs, lower quality, reduced access, and less favorable conditions for workers – are also the result of competition eroding in markets for outpatient surgical services, behavioral health, and accountable care organizations, and in the labor market for nurses.

Sections II.B and II.C further show that there are significant shortfalls in the Parties’ financial and integration planning for the Proposed Transaction. As Section II.E concludes, the Attorney General cannot propose conditions that sufficiently address these anticompetitive effects and deficiencies in financial and integration planning. Together these conclusions lead to an important question: If Lifespan and Care New England do not merge, what is next for Rhode Island’s healthcare market?

The Attorney General takes that question in two parts: first, addressing whether, as some have argued, the survival of Rhode Island’s healthcare market depends on this merger and, second, discussing the importance of promoting competition and preserving the solvency of the state’s hospitals until state and federal policymakers choose to pursue more ambitious, structural healthcare reforms.

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<sup>741</sup> Letter from Hon. Rebecca Kislak (Feb. 11, 2022).

<sup>742</sup> Letter from Hon. Liana Cassar (Feb. 11, 2022).

<sup>743</sup> Email from Commissioner Patrick Tigie (Jan. 25, 2022).

<sup>744</sup> Letter from Dr. Mariah Stump and Dr. Joanna Brown (Feb. 9, 2022).



**A. Claims that this merger is necessary to limit the loss of Rhode Island patients, talent, and control to Boston- or New Haven-based healthcare systems are unsupported by the record and important realities.**

Some supporters of the merger contend that, notwithstanding the competition problems created by the Proposed Transaction, anything short of a combination of Lifespan and CNE will lead to a loss of Rhode Island patients, talent, and control to Boston- or New Haven-based healthcare systems. Serving Rhode Island patients at Rhode Island hospitals, retaining talented medical professionals trained in the state, and preserving local control over Rhode Island's healthcare systems are important health and economic policy priorities that deserve consideration. A deeper examination of Rhode Island's healthcare market and regulatory system, however, reveals that these concerns overlook key realities documented in the record.

First, Rhode Islanders exhibit strong preferences for receiving care at nearby hospitals. As Section II.A explains, Dr. Pflum's analysis [REDACTED] show that Rhode Islanders want local care and do not want to travel outside the state for services.<sup>745</sup> When Rhode Islanders do leave the state for care, they often go to hospitals in neighboring Massachusetts towns such as St. Anne's Hospital (Fall River), Charlton Memorial Hospital (Fall River), and Sturdy Memorial Hospital (Attleboro).<sup>746</sup> Rhode Islanders also leave the state for care at Boston-area hospitals. Most go to one of the world's two top-ranked hospitals: Brigham & Women's Hospital and Massachusetts General Hospital. However, the commercially insured Rhode Islanders who go to these hospitals for care are generally more severely ill. Cardiac care and cancer treatment – two forms of specialized care – are the top two reasons Rhode Islanders visit Brigham and Women's Hospital.<sup>747</sup> It is unlikely that a potential future merger with an out-of-state health system would significantly change Rhode Islanders' preference for local care or dissuade some Rhode Islanders from receiving specialized care in Boston. On the contrary, one could expect that competition would continue to apply pressure on any new entities to meet the healthcare needs and preferences of Rhode Islanders by serving them locally.

Rhode Island's current healthcare market, with Lifespan and CNE competing as distinct health systems, also manages to attract and retain talented medical professionals. As Dr. Jack Elias, the longtime Dean of Brown University's Medical School, explained in a recent column in *The Providence Journal*, doctors trained by leading research universities often stay to practice medicine where they receive their medical education.<sup>748</sup> Indeed, 50% of the physicians who complete medical school and residency at Brown end up practicing medicine in Rhode Island.<sup>749</sup>

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<sup>745</sup> See Section II.A.4.a for more discussion of Rhode Islanders' strong preference for local care.

<sup>746</sup> Pflum Report ¶ 355 and note 259.

<sup>747</sup> Pflum Report ¶ 358. Dr. Pflum's analysis of patient outmigration finds that patients who travel for a longer time usually do so for more specialized care. For example, Rhode Island residents that go to Boston hospitals for inpatient GAC services tend to have more complex conditions.

<sup>748</sup> Jack A. Elias, *Brown Doctors Stay to Serve Rhode Island*, *The Providence Journal*, Dec. 16, 2021.

<sup>749</sup> *Id.*

The qualities that already make the state an attractive place for physicians to live, practice medicine, and conduct research are unlikely to disappear if the merger is not consummated.

It is also unlikely that, absent the opportunities presented by the merger, Rhode Island's health system leaders and their control over the state's hospitals will suddenly shift to neighboring states at Rhode Island's expense. These fears seem exaggerated particularly given that several of the Parties' key executives already have significant ties to Massachusetts but nevertheless serve Rhode Island's health systems. For example, Lawrence Aubin, Sr., Lifespan's board chair, lives in Rehoboth.<sup>750</sup> Dr. Fanale, CNE's President and CEO, sees patients at Worcester's UMass Memorial Medical Center where he is an Associate Professor of Medicine.<sup>751</sup> The two systems are also able to recruit talented leaders *from* Massachusetts to Rhode Island. In 2021, Lifespan appointed Dr. Saul Weingart, who had been the Chief Medical Officer and Senior Vice President for Medical Affairs at Boston-based Tufts Medical Center and Tufts Children's Hospital, its new President of Rhode Island Hospital.<sup>752</sup>

Finally, it is important for Rhode Islanders to understand that out-of-state (or in-state) health systems are unable to acquire or merge with Rhode Island hospitals without rigorous regulatory review. Any proposed change in the control of a Rhode Island hospital whether initiated by a non-profit corporation, as is the case in this transaction, or a for-profit corporation must be reviewed by the Attorney General's Office and the Department of Health under the same Hospital Conversions Act under which this review is conducted.<sup>753</sup> For instance, when Partners HealthCare proposed to acquire Care New England in 2018, the Attorney General's Office and the Department of Health commenced a similar review under the HCA that continued until the parties withdrew their HCA application in June 2019. If, after the current regulatory process concludes, an out-of-state health system proposes to acquire one or more of the hospitals involved in the Proposed Transaction, the Attorney General will thoroughly examine the impact of that potential hospital conversion on Rhode Islanders' access to quality and affordable healthcare. And, while conditions and additional regulations under the HCA are insufficient to address the anticompetitive harms of this Proposed Transaction, the right, robust conditions could be effective to address concerns of local governance and control.

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<sup>750</sup> Citizens Commercial Banking, *Advisory Board Member & Citizens Membership Biographies*, at 3 (Lawrence A. Aubin biography).

<sup>751</sup> UMass Memorial Health, *James E. Fanale, MD*, Physicians Feb. 9, 2022), [UMassMemorial.org/details/1665/james-fanale-geriatric-medicine-worcester](https://umassmemorial.org/details/1665/james-fanale-geriatric-medicine-worcester); [REDACTED]; FTC-CNE-02614132.

<sup>752</sup> G. Wayne Miller, *New president to lead Rhode Island and Hasbro Children's hospitals*, The Providence Journal, Feb. 1, 2021.

<sup>753</sup> R.I. Gen. Laws § 23-17.14-10 establishes the review process for conversions involving not-for-profit corporations while R.I. Gen. Laws § 23-17.14-12 sets the review process for conversions where a for-profit corporation is the acquiror. A proposed change in ownership must be reviewed by the Attorney General's Office and the Department of Health under the HCA when a new acquiror gains a controlling interest in the hospital. *See* R.I. Gen. Laws Ann. § 23-17.14-4(6).

**B. The Attorney General must promote competition and preserve the solvency of Rhode Island’s hospitals until consensus emerges among state and federal policymakers to pursue more ambitious, structural healthcare reforms.**

The record has amply demonstrated that there could be more competition in the Rhode Island healthcare marketplace – and that Rhode Islanders would benefit from this competition. Lifespan, for instance, could revisit its choice to not compete with CNE for obstetrics patients. Section II.A.4.e.2 explains that, in 2016, Lifespan attempted to win over W&I patients by filing a Certificate of Need application with the Rhode Island Department of Health to expand its obstetrics services, re-filing the application in 2017. In Lifespan’s words, people “in Rhode Island have very few alternatives when it comes to where they will deliver their babies” and that “[a]lternatives to Women & Infants and the Care New England system are needed.”<sup>754</sup> Following an objection by CNE, Lifespan abandoned its application even though it was prepared to spend \$43 million to create an expanded obstetrics unit that it believed would lower costs and offer more choice to Rhode Islanders.<sup>755</sup>

Moreover, the Parties should reexamine the anticompetitive agreement RIH and W&I struck in 1983. Section II.A.7.b discusses how this ground lease agreement provides that, in return for a \$100 yearly rent to RIH, W&I may operate its hospital on the campus owned by RIH and on which RIH also operates. But the lease, which runs to December 31, 2085, prohibits W&I from offering any services that are not related to “maternity, obstetrics, gynecological and infant patients.”<sup>756</sup> Public statements, testimony, and documents show that CNE views the lease as an impediment to expanding its service offerings.

Competition in Rhode Island’s healthcare market could also be strengthened by a realignment of hospitals or health systems. The Attorney General does not take a position on the strengths and weaknesses of historical proposals but observes that there has been no shortage of them in recent years, including by non-profit health systems and organizations. In 2018, Partners Healthcare, a Massachusetts non-profit health system, attempted to acquire CNE. Also in 2018, Brown University, a Rhode Island non-profit, proposed to acquire W&I.<sup>757</sup> At a minimum, these proposals demonstrate that there are likely to be a variety of realignment paths for health system leaders and policymakers to consider.

The Attorney General has demonstrated an understanding of and willingness to act on the specific perils and concerns posed by transactions involving for-profit health systems seeking to acquire Rhode Island hospitals. In the Prospect Medical HCA decision issued in June 2021, the

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<sup>754</sup> Certificate of Need Application, Lifespan, submitted to Rhode Island Department of Health (Jan. 17, 2017) at 26.

<sup>755</sup> *Id.* at 1.

<sup>756</sup> “Ground Lease” between Rhode Island Hospital (landlord) and Women & Infants Hospital of Rhode Island (tenant) for the Land Underlying the Women & Infants Hospital of Rhode Island Building (Nov. 1, 1983) at 7.

<sup>757</sup> Ted Nesi, *Brown U., Prospect reveal they want to buy Care New England hospital group*, WPRI.com (Jan. 11, 2018), <https://www.wpri.com/news/eyewitness-news-investigates/brown-u-prospect-reveal-they-want-to-buy-care-new-england-hospital-group/>.

Attorney General imposed unprecedented conditions to safeguard two Rhode Island hospitals. Any similar proposed merger or acquisition will require robust review under the HCA, and the Attorney General will continue to scrutinize these transactions to safeguard care, access, and affordability for healthcare in Rhode Island. Again, while the Office does not have regulatory tools or conditions to prevent the competitive harms of this Proposed Transaction, the Office has the tools to guard against bad actors in the for-profit space.

Promoting competition and preserving the solvency of Rhode Island’s hospitals are key objectives for regulators like the Attorney General until state leaders decide to pursue more ambitious healthcare reform, and until those efforts are accompanied by meaningful support and reform at the federal level. One example of a more ambitious reform would be Maryland’s state-set hospital rates and caps on healthcare spending and hospital revenues. Public comments submitted by organizations including the Rhode Island Foundation and OHIC identify the Maryland approach and the Maryland Health Services Cost Review Commission as structural reforms worth reviewing.<sup>758</sup>

Maryland’s model of healthcare spending oversight is unique at the state level. Hospital rates are regulated by an independent state body and historically all payers – private, commercial, Medicare, Medicaid – were charged about the same rate for the same service at the same hospital.<sup>759</sup> To make this approach viable, the federal government agreed to pay more for Medicaid and Medicare patients, if Maryland’s hospitals agreed to accept lower rates for commercially insured patients, creating the “all-payer” rate. In 2014, Maryland modified its system to include global budgets for hospitals, setting the annual amount of funding a hospital could utilize to cover most inpatient and outpatient services.<sup>760</sup> Recent analysis of this modification by the Center for Medicare and Medicaid Services found that Maryland made notable progress in controlling hospital costs over a five-year period.<sup>761</sup>

These results are promising for policymakers, but to follow in Maryland’s path or pursue similar structural reforms, Rhode Island leaders are likely to need the federal government’s assistance and support. Maryland’s system, for instance, is made possible in part by a 45-year-old Medicare waiver that exempts Maryland from the standard Medicare payment systems for

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<sup>758</sup> Rhode Island Foundation, *Ensuring the Integrated Academic Health System Benefits all Rhode Islanders*, Nov. 2021, [https://issuu.com/rifoundation/docs/rif\\_healthreport\\_2021\\_v6f\\_digital\\_singlepagesat](https://issuu.com/rifoundation/docs/rif_healthreport_2021_v6f_digital_singlepagesat) 24; Office of the Health Insurance Commissioner, *The Care New England and Lifespan Proposed Merger: Payment Model Characteristics Necessary to Maximize Affordability and Quality Related to the State of Rhode Island Office of the Health Insurance Commissioner’s Statutory Purpose*, June 2021, <http://www.ohic.ri.gov/documents/2022/January/OHIC%20CNE-Lifespan%20Proposed%20Merger%20Payment%20Model%20Characteristics%20Necessary%20to%20Maximize%20Affordability%20and%20Quality%20Working%20Paper%201-25-22%20Final.pdf> 13, 15-18.

<sup>759</sup> See generally Susan Haber, *et al.*, *Evaluation of the Maryland All-Payer Model*, RTI Int’l, Nov. 2019 (prepared for CMS), <https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf>.

<sup>760</sup> *Id.* at 1.

<sup>761</sup> *Id.* at 247-252.

inpatient and outpatient care and allows Maryland to create the “all-payer” rate. The Attorney General also notes that Maryland ended its all-payer model in 2018 and transitioned to a “Total Cost of Care” model, which operates under a new agreement with the Centers for Medicare and Medicaid Services.<sup>762</sup>

The Attorney General also acknowledges public discussions and comments around whether the Proposed Transaction could serve as a mechanism for Rhode Island to create something akin to a single-payer healthcare system. It is undeniable that single-payer, “Medicare for All” type systems like the ones in Canada and Europe could be on the horizon in the United States, and there are significant, appreciable reasons why many Rhode Islanders advocate for them. But here, it is worth recognizing that a Lifespan and CNE merger cannot create that type of system until Congress takes national steps in that direction. As this Decision demonstrates, Rhode Island’s current healthcare market is rooted in the principles and forces of competition and the Attorney General must seek to preserve that competition and the benefits it brings to consumers and workers throughout Rhode Island.

### C. Decision

The Hospital Conversions Act and our antitrust laws are critical tools, and this Office’s regulatory and oversight role in the context of mergers and acquisitions cannot be discounted. But these laws and regulatory review processes are not appropriate vehicles to redesign Rhode Island’s healthcare market, and Rhode Islanders cannot rely on them as the only avenues for reform.

Under the HCA, the Attorney General must review the transaction that is before it – the merger proposed by Lifespan and CNE. Based on the extensive review conducted by this Office and the record developed, and as more fully set forth in this Decision, the transaction that is before this Office must be DENIED.



Peter F. Neronha  
Attorney General



Miriam Weizenbaum  
Chief, Civil Division



Stephen N. Provazza  
Special Assistant Attorney General

<sup>762</sup> *Id.* at ES-1.

**NOTICE OF APPELLATE RIGHTS**

**Under the Hospital Conversions Act, this Decision constitutes a final order of the Office of Attorney General. Pursuant to R.I. Gen. Laws Section 23-17.14-34, any transacting party aggrieved by a final order of the Attorney General under this chapter may seek judicial review in the superior court in accordance with Section 42-35-15.**

**CERTIFICATION**

I hereby certify that on this 17th day of February 2022, a true copy of this Decision was sent via electronic and first-class mail to counsel for the Transacting Parties.



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Miriam Weizenbaum