Hospital Mergers

A quick guide to the competition issues
This note is intended to facilitate a review of a proposed public hospital merger. This review should be done early in the process, and, as such, this note enables a public hospital to understand the procedures involved and the issues for consideration.

This note is designed to be used by those not familiar with competition law. It is therefore focused on practical issues and is not intended as a substitute for substantive legal advice.

“Transacting parties will need to consider the potential impact of their proposals upon patient choice and competition and take account of the potential impact upon both the provision of NHS-funded services and broader commercial activity. For example:

- Whether a referral to the NHS Cooperation and Competition Panel (CCP) may be required (e.g. proposed merger, acquisition or joint venture involving the provision of NHS-funded services); or,

- If the proposed transaction might fall under the jurisdiction of the Office of Fair Trading (OFT)

In individual cases the question of whether and how procurement and competition law (including the Enterprise Act 2002) applies may not be straightforward. This is a rapidly developing area of law and its application is expanding. The legal tests are highly technical and difficult to apply as a ‘rule of thumb’. Moreover, the provision of NHS services is changing with developments such as patient choice, NHS Foundation Trusts and contestability involving the Independent Sector. Transacting parties are therefore recommended to seek legal advice on the implications of procurement and competition law in individual cases.”

Department of Health, Monitor
Transactions Manual
For providers and commissioners of NHS services covering:
Acquisitions, Divestments, Demergers, Joint Ventures, Franchises and Statutory Mergers, page 167
Introduction

This note does not argue the case for or against public hospital transactions being subject to the usual competition regulatory regime. That topic is taken up in an article by the author that addresses the question of whether public hospital mergers should only be decided upon by a competition authority on competition principles or whether it would be better that the ultimate decision is taken by the UK Government on the basis of broader considerations – Public hospital mergers: a case for broader considerations than competition law? European Competition Law Review; E.C.L.R. 2013, 34(12); a pdf copy is attached to this note.

One of the UK Government’s policies is that it wants the NHS to become more efficient to free up funds for treating patients and keeping up with new treatments. On 2 July 2013, at the meeting of the UK Parliament’s Health Committee, the Secretary of State for Health said that “mergers between NHS providers were important to improving efficiency”.

Structure

Part 1
is a very brief description of the law and procedure in the UK for Public Hospital Mergers, providing a general framework of understanding.

Part 2
identifies the goals of a preliminary review.

Part 3
deals in detail with some of those elements of a preliminary review.

Part 4
describes what to do with the above results, what tentative conclusions can be drawn and recommended next steps.
Part 1: A brief description of UK law and procedure

Q1. What government bodies are involved and why?

Since 1 April 2013, a public hospital transaction is either:

- not subject to a decision by any government body;
- subject to a decision by the competition authority; or
- subject to a decision by Monitor.

The investigations undertaken by these bodies to reach their decisions are primarily to ensure patients (consumers) are protected by ensuring that a transaction does not reduce choice substantially for consumers.

The competition authorities are the OFT which first investigates a transaction (Phase 1), and, if necessary, a full investigation (Phase 2) is undertaken by the Competition Commission. Both of these bodies will be merged into one body, the Competition and Markets Authority, effective 1 April 2014. For ease of expression, this note refers to Phase 1 and Phase 2 of an investigation by the competition authority and makes the assumption that the new procedures, effective 1 April 2014 are applicable. In terms of substance, this note is applicable to the regime both before and after the April 2014 changes.

Q2. What transactions are investigated by the competition authority?

The competition authority can only investigate a transaction between two or more NHS Foundation Trusts or between an NHS Foundation Trust and an NHS Trust.

Transactions potentially subject to an investigation are an acquisition, merger, joint venture and the acquisition of material influence in a previously independent entity. The last could be a shareholding as low as 20%. Vertical integration (for example, transfer of a commissioner’s provider arm to an acute trust), hosting arrangements, management alliances, management contracts, shared management arrangements, franchising arrangements and other integrations involving all or part of an organization might also constitute a transaction. Such a transaction will qualify for investigation if either:

a) the UK revenues of the target in the previous financial year was at least £70 million; or

- In relation to the £70 million turnover threshold, this is a relatively low threshold for a Public Hospital. For example, the 606-bed Poole Hospital NHS Foundation Trust, which was examined by the UK competition authorities in 2013 in relation to its proposed merger with The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, had a turnover of £195 million.

b) the merging parties increase their share of supply (or purchase) of a good or service to at least 25% of the total supply (or purchase) of the good/service in at least a substantial part of the UK (the Share of Supply Test).

- The Share of Supply Test is not the same as a market share test. To take a lay person example, is a banana to be included in the market for fresh fruit, or is it in a market of its own? The competition authority does not need to answer this question to determine if it has jurisdiction. It need only determine whether or not two entities that are merging in, say, the Bournemouth area each supply bananas and that together they supply at least one-quarter of bananas in the area. By the way, the response to this question, when considered in 1975 by the EU commission, is that bananas are in their own market and so not included in the market for fresh fruit.
Q3. What transactions are investigated by Monitor?

Mergers between two or more NHS Trusts only will be subject to investigation by Monitor. Monitor will provide advice to the NHS Trust Development Authority (NHS TDA) on the effect of the merger, on choice and on competition. This assessment will be undertaken for mergers involving all types of NHS Trusts, including acute, mental health, ambulance and community services trusts. The NHS TDA will take account of Monitor’s view. However, the NHS TDA may decide that there are material factors that override the adverse impact on choice and competition identified by Monitor, and so allow the merger to proceed because it is in the wider public interest. Where this is the case, the NHS TDA will publish its decision explaining what these reasons are and why the merger is in the interest of patients.

An investigation by Monitor of public hospital transactions is not new, and the development since April 2013 is that Monitor will deal with fewer.

However, Monitor also has a role in relation to transactions investigated by the competition authority. Upon notification of a transaction to the competition authority, Monitor will be informed, and it must respond by providing its advice to the competition authority on whether customer benefits arise and any other appropriate matters.

This note does not deal further with investigations by Monitor.

Q4. What does it mean if a transaction is investigated by the competition authority?

The competition authority has the power to prohibit the transaction. Less harshly, it can impose conditions to a consent decision. The parties are at liberty to enter into and complete the transaction without first obtaining consent from the competition authority. However, if there were then to be a prohibition decision, the transaction would have to be unwound, which would be a costly and complex exercise. Consequently, the possibility of a prohibition means that, for public hospital transactions, it is likely to be rarely, if ever, appropriate to complete a transaction absent consent from the competition authority.

In terms of contractual issues, this means the transaction documentation must contain a condition precedent to completion that consent is obtained from the competition authority.

Q5. Why would the competition authority prohibit a transaction?

The competition authority will commence a Phase 2 investigation if, at the end of its Phase 1 investigation, the competition authority has a reasonable belief that the transaction may be expected to result in a substantial lessening of competition in a UK market. At the end of the Phase 2 investigation, the competition authority will prohibit a transaction if it concludes the transaction may be expected to result in a substantial lessening of competition in a UK market and that a prohibition is the appropriate action to take to prevent this anti-competitive outcome.

Q6. When is a transaction investigated?

Assuming the parties intend to make the transaction conditional on obtaining the consent of the competition authority, the transaction is investigated when notified to the competition authority. This will occur when the transaction is agreed, subject to conditions, and therefore announced to the public.
Q7. How long does the competition authority procedure take?

As previously mentioned, there is a Phase 1, and, potentially, a Phase 2 investigation. A contentious transaction will be subject to both. A non-contentious transaction or one where the concerns held by the competition authority can be clearly remedied by changes to the transaction that the parties agree to implement will only be subject to a Phase 1 investigation.

It is best practice to pre-notify the transaction in draft, thereby ensuring the competition authority has all the information it deems necessary for the investigation. The more contentious the transaction, the longer the pre-notification period is likely to be. For even non-contentious transactions, a pre-notification period of two weeks is appropriate. For contentious transactions, the period may be several months.

Upon notification, the Phase 1 period is 40 working days (about two months). For a non-contentious transaction, the competition authority will decide not to open a Phase 2 investigation, thereby clearing the transaction. The parties are then at liberty to complete the transaction, assuming they have no other outstanding conditions precedent.

For transactions where the concerns may be clearly addressed by remedies, the competition authority will decide to open a Phase 2 investigation unless such remedies are offered by the parties and accepted by the competition authority. The parties have five working days, from the date of the decision to proceed with a Phase 2 investigation, to offer remedies. The remedies offered will be published, allowing the competition authority to seek and receive the views of third parties. The period of consultation is up to 50 working days, with the possibility of an extension of up to 40 working days. If, following the consultation, the competition authority agrees to the remedies, then the transaction is consented to, subject to the remedies being implemented.

If a Phase 2 investigation is opened, the competition authority has a period of 24 weeks (about six months) to reach a decision on whether or not to prohibit the transaction, consent to it or consent to it subject to remedies. Remedies can be offered and accepted within a further 12 weeks, with a single extension of up to six weeks.

In conclusion, excluding the pre-notification period, a non-contentious transaction would receive consent within about two months. A contentious transaction would face a total investigation period of about eight months, at the end of which it will either be cleared or prohibited. A contentious transaction that could be remedied could take in total as much as about 10 months.

Q8. Who are the people involved in a competition investigation?

Obviously there are the parties to the transaction and their respective advisors.

The competition authority is composed of civil servants and independent professionals appointed to investigate the transaction. For a Phase 1 investigation, the transaction will be investigated by, and a decision taken by, civil servants, experienced in this area, including lawyers and economists. For a Phase 2 investigation, the competition authority will be led by a group of independent professionals drawn from a panel of experts from a variety of backgrounds, including economics, law, accountancy and business. There will typically be at least three and no more than five such professional experts. Those professionals will be supported by technical experts, such as economists, lawyers, business/financial advisors and statisticians.

The views of third parties are actively sought by the competition authority to comment on transactions, and third parties may also volunteer comments. Third parties will range from individual members of the public, typically from the community potentially affected by a transaction, to consumer groups, health professionals and other hospitals, both public and private, in the region potentially affected by the transaction.
Part 2: A preliminary review

Q9. What is the ultimate objective of a preliminary review?

Assuming the transaction could be examined by the competition authority, it is important to determine as early as possible whether the proposed transaction will be dealt with within a Phase 1 investigation. This will identify:

a) the achievability of the transaction; and
b) whether it can be achieved within a reasonable period of time, which has important implications for the resources to be devoted to the transaction.

Many transactions do not reach a definitive agreement (that is, beyond a memorandum of understanding between the parties), because one or both parties recognise that the time, energy and resources required for a Phase 2 procedure, as well as the inherent uncertainty that a transaction might be prohibited in the end. Alternatively, a definitive agreement is entered into but the parties remain concerned about the real prospect of a Phase 2 investigation and so agree that the parties should ‘pull the plug’ if the transaction goes to a Phase 2 investigation. If this view is adopted by the parties, then the main transaction agreement should contain a condition that completion is conditional on a Phase 2 investigation not being commenced.

A preliminary review may also result in the suggestion that consent would only be forthcoming if remedies are implemented in relation to concerns identified following the preliminary review. Those remedies might neutralise the reasons for entering into the transaction for one or both parties.

Q10. What are the key indicators to know whether or not this is a Phase 2 transaction?

Following-on from the response to question 5, the transaction will be believed to create a substantial lessening of competition if the result of the transaction is materially to limit consumers’ choices. There are many ways to measure such a reduction in choice. The easiest and often the leading indicator is that the market share of the parties post-transaction is too high. ‘Too high’ is already somewhat a term of art, but, in simple terms, the larger the market share compared to other choices (that is, competitors), the more likely it is that the conclusion will be there is insufficient choice.

Q11. So how do we measure choice and market share?

The response is two-fold in that there are two generally recognised methods of seeking to answer the question. First, identify the market definition. The market definition is a function of the services demanded by customers in the geographic area served by the parties. This is referred to technically as the product market (even though in this instance we are referring to services, not products) and the geographic market. In relation to a typical acquisition, where X merges with Y, the higher the aggregate of the merging parties’ market share post-merger within the overlap of product market and geographic market, the more likely it is the transaction will be subject to a Phase 2 investigation.

Second, instead of seeking to identify the market definitions, identify the choices that consumers have now compared to their choices post-transaction. The fewer choices and/or the lower qualitative choice for the consumer, the more likely it is the transaction will be subject to a Phase 2 investigation.
Q. 12 How do I define the market share?

There is a significant amount of theory, facts and complexity. Whilst the following is a conservative approach, it is at first useful to make the assumption that you are competing with every health care supplier in the region of your hospital for every consumer of health care services, whether they reside in that region or just outside it. On that assumption, the questions to address are:

a) what is the geographic coverage of this competitive area?; and

b) what services are included in this competitive environment?

In relation to the geographic market, for most hospitals most of the time, the answer is the immediate locality. In this sense, like politics, all health care services are local. Therefore, ignoring national centres of excellence, the question is what is the locality of a public hospital?

In relation to the services, there are many different ways of classifying these technically, whether using OPCS (fourth level codes), or others. No single codification system is definitive one way or the other. A basic determination to make is whether the market share at the relevant code(s) levels post-transaction indicates that the parties would materially increase their market share to at least 40%, as a result of the transaction. For example, if X holds 25% and Y holds 20%, then an issue might arise. However, if X holds 35% and Y holds 2%, then the increment is perhaps small enough so that no issues arise. More strongly, if X holds 45% but Y holds 0%, then this likely means there are no issues (although beware there can be!). Addressed in terms of choices, if there is a choice of only two hospitals other than the parties to the transaction post-transaction (assuming there were at least four choices pre-transaction), then a potential issue may well arise.
Part 3: Details for a preliminary review

Q.13 How do I measure market share?

Geographic market. To determine the geographic market, the simplest starting point, though rough and ready, is to use a 20 minute car journey isochrone. An isochrone is a line of equal time, in this case a 20 minute journey time by car. (Off-the-shelf software is available to create isochrones). Two isochrones should be drawn, the centre of each isochrone being the two hospitals that are the subject of the transaction. These are the primary isochrones. Isochrones should also be placed in relation to adjacent hospitals. At this first stage, a quick look can usually identify whether the transaction is likely to be a ‘no brainer’ Phase 1 investigation transaction, because there is clearly no overlap. Diagram 1 shows an example of the exercise at this stage. If the proposed transaction is the merger of Bournemouth hospital (red) and Dorset hospital (pink), at this first stage, it can be seen that this transaction is unlikely to raise competition concerns, as the catchment areas do not overlap. Moreover, both of those hospitals, but mostly Bournemouth hospital have a material overlapping catchment area with Poole hospital (blue). In addition, Salisbury hospital (yellow) and Southampton hospital (turquoise) are adjacent to Bournemouth hospital, so they may have overlaps with, and act as a competitive constraint to Bournemouth hospital.

Diagram 1: 20 minute car journey time isochrones centred on adjacent hospitals
Next, the GP practices within each of the isochrones should be plotted. These can be used as proxies for where patients are located. Counting the number of GP practices served uniquely and those shared by two or more hospitals further gives insight at this second stage, even though the assumption is being made that all GP practices are the same. Diagram 2 shows an example of the exercise at this stage. As can be seen, there is a high concentration of GP practices in the isochrones of Poole hospital and Bournemouth hospital, particularly in the overlap of the two isochrones for those hospitals.

**Diagram 2: Placement of GP practices within the isochrones**

This further advances the views from the first stag, namely, that a Bournemouth/Dorset merger likely doesn’t raise issues and could be dealt with in Phase 1 but that a Bournemouth/Poole merger likely does raise issues.
Finally, for a third stage preliminary assessment, data can be used for each patient episode of the two hospitals concerned, allocated to each GP practice. This allows greater accuracy in analysing the volume of activity that is undertaken by each hospital and the share held by each hospital of each GP practice within the isochrones. Diagram 3 shows an example of the exercise at this stage with each GP practice showing both the share held by each hospital of the episodes generated by each GP practice and the number of episodes generated represented by the size of the ‘pie’. This third stage of the preliminary analysis underlines the view from the second stage that a Bournemouth hospital (red) and Pool hospital (blue) merger is not likely to be dealt with within the Phase 1 investigation period.

**Diagram 3: Inputting patient episode data**

(Product) Service market. To determine the service markets, it is suggested that the first stage is to analyse those services at OCPS level 4 that are the subject of the geographic overlap, if any, from the isochrone exercise. It is within this overlap area that arguably GPs, and thus patients, in that area currently have a choice between the two merging hospitals and possible other hospitals. Post-transaction the choice will be reduced in the sense that the merging hospitals that formerly ‘competed’ will now have a common purpose and will not ‘compete’ with each other. This first stage exercise will identify areas where particular issues might arise and a deeper analysis is required.
Table 1 shows an example of the result. In this theoretical example, there is overlap for upper gastrointestinal surgery, but the combined total is small (7%) compared to other hospitals also serving the catchment area of the isochrones overlap. It is unlikely, therefore, to raise a competition concern. For general surgery, the combined total of the parties is material (23%), although the merging hospital Y only represents 4%, so the increment is low. This suggests the impact of the transaction would not be substantial. Finally, the combined total for breast surgery (39%) with both merging hospitals is high in this area, suggesting further analysis is required as a concern might exist.

**Table 1: Analysis of count of overlap at OPCS4 level by specialty – elective inpatient services**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Merging hospital X</th>
<th>Merging hospital Y</th>
<th>Other hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>40</td>
<td>8</td>
<td>160</td>
</tr>
<tr>
<td>Urology</td>
<td>25</td>
<td>20</td>
<td>300</td>
</tr>
<tr>
<td>Breast surgery</td>
<td>48</td>
<td>50</td>
<td>152</td>
</tr>
<tr>
<td>Upper gastrointestinal surgery</td>
<td>1</td>
<td>7</td>
<td>101</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>200</td>
<td>105</td>
<td>590</td>
</tr>
<tr>
<td>Etc.</td>
<td>…</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>852</strong></td>
<td><strong>398</strong></td>
<td><strong>4,670</strong></td>
</tr>
</tbody>
</table>
Part 4: Conclusions & recommendations

Q.14 What does it really mean if there are overlaps?

The preliminary review allows you to determine the extent, if any, of overlaps in activities relevant to patients of the to-be-merged hospitals. If there are no overlaps, this suggests the transaction will only be subject to a Phase I investigation.

If there are few overlaps, whilst more analysis is required, the working hypothesis can be that the transaction would not appear to face significant competition concerns or that any that arise might be able to be dealt with through remedies. This suggests a transaction that could be dealt with in Phase I.

If there are many overlaps, a much deeper analysis is required. In particular, it would be necessary to consider not just the nature and volume of overlaps, but also the value in revenue terms of the overlapping activities compared to the overall revenue of the merging hospitals.

Q.15 What about the benefits of the proposed transaction - is that not relevant?

Yes. Two elements are relevant here. First, what would happen in the absence of the transaction is relevant to determining whether or not there is a substantial lessening of competition, because ‘substantial’ is to an extent relative to the alternative scenario. This is referred to as the ‘counterfactual’. Second, the patient (customer) benefits that the transaction would create might counter balance any deemed anti-competitive effects.

Counterfactual. The transaction will be investigated by the competition authority and compared with the situation that would exist absent the transaction proceeding. The reason to do this is related to the point that the test the competition authority uses is whether or not the transaction can be expected to create a “substantial lessening of competition”. The point that arises is, substantial compared to what? Normally, the two hospitals will not merge and will carry on ‘business as usual’.

The parties need to be realistic in relation to any counterfactual they propose. For example, the parties might wish to argue that, given the financial and operational pressures, absent the merger, each of them independently would need to work closely with their commissioners to establish how they can best achieve balanced budgets whilst causing the least detrimental impact to the delivery of patient services. Further they might submit that this would be likely to lead to a reconfiguration of certain services that they expect would result in a decline in the quality and the ‘breadth and depth’ of services available to patients. These arguments are likely to be highly relevant to the parties’ rationale for pursuing the transaction. However, the competition authority has been conservative to date, and, as a result, arguments such as those just mentioned would not likely be considered sufficient to establish that a counterfactual situation is relevant. In other words, the competition authority would likely conclude that the counterfactual is the status quo (that is, the current situation compared to the planned merger). If no counterfactual situation is accepted by the competition authority, then there is no ability for the parties to discount or negate the negative effects of the transaction that the competition authority determines exist.

As another example, it might be the case that the submitted counterfactual is the closure of a hospital. There is no case to date on this point that has been dealt with by the competition authority. However, by analogy to the classic business world, the following can be stated: Unless there are exceptional issues, a business’ claimed future closure (and subsequent exit from the market) due to actual or impending insolvency is not a blanket reason for the competition authority to consent to a transaction that raises substantial concerns. Rather, the natural view of the competition authority would be that patients of hospital proposed for closure will go to other hospitals. Therefore, the market share held by the exiting entity will be shared between the existing market players.
Customer benefits. These are referred to within the competition regime as efficiencies, and the existence and weight of efficiencies can be used to counter the deemed anti-competitive effects. Indeed, efficiencies, whilst ultimately for the benefit of patients, can also arise in other ways. For example, a simple cost saving would not directly benefit patients, because patients do not pay for the services, but it would be a societal benefit, such a reduction would benefit the Government’s finances and, in theory, thereby lower the charges imposed by the Government on the population.

To be relevant, efficiencies need to be material, reasonably foreseeable (not hypothetical or speculative), realisable in the short to medium term and, most importantly, a result of the proposed transaction. In the classical business world, it has proven extremely rare that efficiencies have been accepted to counter balance any significant anti-competitive effect. It seems more likely than not that the same will be true in the case of public hospital mergers.

Final comment

Engaging in a potential transaction is a significant exercise, and there is much to consider, as identified in the 223 pages “Transactions Manual” produced by Monitor and the Department of Health, which can be found at the following web site address: http://www.monitor.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/transactions-man

An early consideration is to determine the extent, if any, that the competition authority would seek remedies or prohibit a proposed merger. This can be done by a preliminary assessment. This assessment also avoids a common transaction process issue that the stakeholders become committed to the end goal and do not see or discount issues that arise. This is why the preliminary analysis is preferably undertaken by an objective advisor.

Whilst such preliminary analysis might yield the unwelcome result that an issue arises, it is far better that this is known and potentially addressed than for the parties to expend the significant time, energy, resources and money on a possible transaction that might not be permitted for competition reasons.
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Our competition lawyers have strong experience in dealing with local market mergers, such as hospital mergers.

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