Antitrust Implications in Nonprofit Hospital Mergers

Courts are faced with a difficult task when addressing antitrust issues in the area of nonprofit hospital mergers. Complex economic relationships, difficult factual determinations, and amorphous speculation as to probable effects of a merger, in the midst of a convoluted and constantly changing healthcare industry, all present daunting challenges. One author has likened the required analysis to night landings on an aircraft carrier: courts aim at "a target that is small, shifting, and poorly illuminated."[1]

Traditional antitrust legislation, enforcement, and analysis are not adequate in tackling these important concerns. In the most recent district court rulings on challenged hospital mergers, courts have broadened their analysis and are beginning to give more credit to the proposed merger's potential efficiencies and are undertaking broad appraisals of relevant markets in favor of the merging entities. As a result, the government finds itself on an unprecedented losing streak in antitrust actions challenging hospital mergers.[2] Adjustments to the typical approach in merger evaluation may be necessary for the government enforcers to ensure the general economic goals of the antitrust laws and to meet the social policy needs of the healthcare field in particular. In short, in order to be successful in their challenges to hospital mergers, the Federal Trade Commission ("FTC") and the Antitrust Division in the Department of Justice ("DOJ") must keep pace with the trends of the district courts adjudicating these actions.

But how? A number of authors have recently noted many of the shortcomings to traditional antitrust enforcement, as laid out in the government's Merger Guidelines, [3] in light of present market realities in the hospital and healthcare industry. Also presented are various ways the agencies might bring their analysis in line with these realities, within the analysis mandated by the Guidelines. This note will summarize many of the criticisms presented. Whether or not the agencies charged with enforcement will alter their approach remains to be seen, but given their recent string of losses in these cases, a change seems inevitable.

One option is for the government to bring even fewer challenges than it has been

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1. Thomas L. Greaney, Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law, 23 AM. J.L. & MED. 191, 192 (1997).

2. District courts have allowed proposed mergers to proceed in the last eight decisions over the past six years. Those decisions and the analysis by the courts will all be discussed in detail.

3. U.S DEPT. OF JUSTICE & FEDERAL TRADE COMMISSION, HORIZONTAL MERGER GUIDELINES, 4 Trade Reg. Rep. (CCH) 13,104 (containing 1997 revisions) [hereinafter Guidelines], reprinted in MILTON HANDLER, ET AL., TRADE REGULATION: CASES AND MATERIALS, 942-65 (4th ed. 1997).

bringing, including perhaps some mergers that at least may initially appear to be anticompetitive. However, the agencies are already exercising their discretion to prosecute in remarkably few instances. In 1996 alone, 768 hospitals were involved in 235 merger and acquisition deals, and the agencies only challenged a handful of these as anticompetitive.[4] Given their mandate to be the enforcers of the antitrust laws in the merger field, any more leniency and the agencies would not be doing their patrolling job at all. Two possibilities remain: either the courts themselves must revert back to a more traditional approach that is more amenable to the agencies, or the government should incorporate the ideas summarized in this essay into the analysis required by its Merger Guidelines. I will argue that a little bit of both would be helpful in achieving the general economic goals of the antitrust laws and in securing the social policy needs of today's healthcare field.

Part I of the following Note will present a brief review of the applicable antitrust laws and their underlying theories and goals. In Part II, the key issues in the analysis of nonprofit hospital mergers by enforcement agencies and courts will be laid out, and the shortcomings of traditional antitrust enforcement in each element of the analysis will be noted. This Note centers on the trends in the analysis recently undertaken by courts in this area; thus, decisions that demonstrate these trends in the various stages of the analysis will be included in this section where appropriate. Two hospital merger decisions will then be discussed in Part III as illustrations of the way courts have been handling all of these issues collectively. Finally, Part IV of the Note will conclude with a few proposals that attempt to address the concerns raised.

I. BRIEF HISTORY OF ANTITRUST LAWS

A. Sherman Act

In 1890, Congress passed the Sherman Act in an effort to address concerns about the monopolies and trusts prevalent in the conglomerate tobacco and oil industries. The substantive language of the statute was intentionally broad, allowing the courts to create a common law of antitrust. Section 1 prohibits any "contract, combination . . . or conspiracy in restraint of trade," thus addressing concerted action among parties either on a horizontal (between competitors) or a vertical (between buyers and sellers) level.[5] Examples of activities subject to criminal and civil penalties by the Department of Justice include price fixing, market division, group boycotts, and coerced tying arrangements.[6]

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4. *See* John B. Saville & James Vincequerra, Note, Antitrust Issues of Non-Profit Hospital Mergers, 13 ST. JOHN'S J. LEGAL COMMENT. 427, 428 (1998). See also Greaney, *supra* note 1, at 199, pointing out that between 1987 and 1991, the agencies investigated only 27 out of 229 hospital mergers, and challenged only five.

5. 15 U.S.C. § 1 (1994).

6. *See* Standard Oil Co. v. United States, 221 U.S. 1 (1911) (price fixing); United States v. Topco Assoc., Inc., 405 U.S. 596 (1972) and United States v. Sealy, Inc. 388 U.S. 350 (1967) (market division); Fashion Originator's Guild of America v. Federal Trade Comm'n., 312 U.S. 457 (1941) (concerted refusals to deal);

The goals of the Sherman Act are to control the concentration of economic power in a few hands, to prohibit predatory practices that harm competitors, and generally to promote competition among firms and thus preserve consumer welfare.[7]

B. Clayton Act / Cellar-Kefauver Act

Section 7 of the Clayton Act, passed in 1914 and amended in 1950 by the Cellar-Kefauver Act, is probably the most significant antitrust statute for hospital merger analysis. Concerns over the limitations placed on the Sherman Act by the Supreme Court prompted the legislation, allowing the Department of Justice and the Federal Trade Commission to bring civil enforcement actions under Section 7, which deals with mergers that might "substantially . . . lessen competition or tend to create a monopoly."[8] The Clayton Act is premised on an incipiency doctrine, whereby the DOJ or the FTC may seek injunctions against proposed mergers that seemingly threaten competition.[9] As will be demonstrated in more detail later in this paper, the analysis by the agency depends largely on an examination of the potential effects of the proposed merger.

C. Federal Trade Commission Act

Section 5 of the Federal Trade Commission Act provides the FTC with exclusive jurisdiction to enforce the proscription of acts constituting "unfair methods of competition."[10] The FTC is also empowered to address Sherman Act violations.

D. Merger Guidelines

The Antitrust Merger Guidelines, produced jointly by the FTC and the DOJ in 1992, are central to merger situations because they explicitly outline the analysis used by the agencies in deciding whether or not to challenge a proposed merger as violative of Sherman Section 1 or Clayton Section 7.[11] They are not statutory law, but the provisions serve as a guide to prospective merging firms in terms of the standard of review under which their merger will be scrutinized. The stated goals of the agencies in the Guidelines are to prevent anticompetitive mergers without interfering with procompetitive mergers; that is, to promote free-market competition and to reduce barriers to efficiency-enhancing activities designed to promote competition and consumer welfare.[12]

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deal); International Salt Co. v. United States, 332 U.S. 392 (1947) (tying arrangement). See generally Richard C. Wade, Comment, Hospital Horizontal Mergers and Antitrust, 1997 DET. C.L. REV. 1281 (1997) (reviewing relevant statutory authority and caselaw).

7. *See* Saville & Vincequerra, *supra* note 4, at 430-31.

8. 15 U.S.C. §§ 12–27 (1994). States are also empowered to bring actions for injunctive relief under this section through a parens patriae rationale. *See* California v. Sutter Health Sys., 84 F. Supp. 2d 1057, 1066 (N.D. Cal. 2000) (citing Hawaii v. Standard Oil Co., 405 U.S. 251, 261 (1972)).

9. *See* Greaney, *supra* note 1, at 192–93 (highlighting three essential doctrines in the Clayton Act: (1) a prospective exam of competitive effect, (2) a focus on probabilities, not certainties, and (3) the incipiency doctrine, whereby anticompetitive behavior is prevented before it can even take place).

10. 15 U.S.C. § 45 (1994).

11. *See* Guidelines, *supra* note 3.

12. *See* Guidelines § 0; Wade, *supra* note 6, at 1287.

The Guidelines contain a five-step methodology for addressing potential mergers.[13] First, a relevant market (product and geographic) must be delineated.[14] This judgment is central to the rest of the analysis and will be addressed in great detail in Section II B of this Note. Second, the market concentration in the proposed merger field will be studied (see Section II C).[15] Generally speaking, the more concentrated a market or the more likely that the merger will increase concentration in an already concentrated market, the higher the concern that the merger is likely to be anticompetitive. Third, the market power of each firm must be determined. The Guidelines describe a positive relationship between market concentration and market power, defining the latter as the ability to impose a "small but significant and nontransitory" price increase without causing consumers to shift to competitors or the business to lose profits.[16] Again, the more market power held by one or both of the firms, the more suspect the merger will be. Fourth, the agency will attempt to note any barriers to entry into the market for potential competitors.[17] Even if a merger appears anticompetitive in terms of the present market structure, the absence of barriers to entry for potential competitors will mitigate the anticompetitive concerns that resulted from high market concentration or market. Finally, the Guidelines provide that a merger that would otherwise be problematic might not be challenged if the parties can demonstrate significant efficiencies resulting from the merger.[18] Some examples of efficiencies the Guidelines list as acceptable include economies of scale, reduction in expenses, and integration of facilities.[19] Included in those considerations is whether one of the merging firms will exit the market absent a merger.[20] The "failing company defense" is discussed in Section II D of this Note. In all of these assessments, the merger must be the best option and alternative means of achieving the goals presented in the merger must not be practicable. In general, as stated earlier, the ultimate goals of antitrust enforcement are to ensure benefits to consumers; if increased efficiencies result from the merger and are passed on to the consumer, the agencies are less likely to be concerned.

A number of slight alterations and adjustments, taken from various articles and recent court decisions, will be suggested throughout this Note in an effort to bring the agencies' traditional analysis more appropriately in line with what is happening in the healthcare market.

E. Theoretical Approaches / Goals

The general economic and public policy goals of antitrust enforcement should be

13. *See* Guidelines § 1.0.
14. *See id.*
15. *See id.* § 1.5.
16. *Id.* § 0.2, 1.0.
17. *See id.* § 3.0.
18. *See id.* § 4.0.
19. *See* Guidelines § 4.0.
20. *See id.* § 5.0.

noted here.[21] First, the concern for a free market, with no restraints on trade, is central. The American economic system is premised on an open and free market of goods and services. Interference with such a market, such as in situations of isolated market power in a concentrated area or predatory practices by competitors, is harmful to competition and thus to the consumers who benefit from a free market. Second, the antitrust laws have economic efficiency as an end to be achieved. Enhanced competition theoretically leads to better services, higher quality goods, and more efficient production. Overall, then, the antitrust laws can be said to address the promotion of competition, in an effort to enhance consumer welfare.

II. KEY ISSUES IN HOSPITAL MERGER ANALYSIS

There are a number of issues that arise in the specific area of hospital merger analysis, any one of which might be dispositive in a particular challenge. Given the uniqueness of the healthcare field and the precise difficulties highlighted in the introduction, these issues must be analyzed in detail, both in terms of traditional antitrust enforcement and the shortcomings of such an approach. Illustrations of the recent interaction with these issues by district courts, whether appropriate or misguided, will be included where relevant. But before going step by step through the methodology of merger analysis, however, a brief history of the healthcare industry may prove helpful.

A. The Changing Face of Healthcare

Joe Sims, in his piece *A New Approach to the Analysis of Hospital Mergers*,[22] provides a helpful history of the stages of development in the healthcare field. According to Sims, the healthcare field in America after World War II consisted primarily of cost-reimbursement programs.[23] With cost-reimbursement programs as the primary payment mechanism, the system provided little competition as well as increased costs and prices.[24] As government programs such as Medicare arose, they often resulted in a price increase for private patients. This gave rise to managed care programs, with less cost shifting. As improved techniques and technology have come into the market, less inpatient care is necessary because of less invasive procedures. Managed care plans now dominate the market, and excess capacity in hospitals and higher costs have resulted, with corresponding pressures to reduce prices.[25] With outpatient care, specialized clinics, and other non-hospital services providers with low barriers to entry, major hospitals often find themselves in difficult positions.

The district court in *California v. Sutter Health System*[26] gave a brief summary of the three primary types of managed care organizations ("MCOs") that now dominate

21. *See* Wade, *supra* note 6, at 1285–86.
22. 64 ANTITRUST L.J. 633 (1996).
23. *See id.* at 638.
24. *See id.*
25. *See id.* at 638–39.
26. 84 F. Supp. 2d 1057 (N.D. Cal. 2000).

healthcare in this country.[27] The court explained that health maintenance organizations ("HMOs") "integrate the financing and delivery of a comprehensive set of health care services to an enrolled population which must obtain medical care from within the HMO network of health providers . . . [t]here is generally no coverage, however, for services from providers outside of the HMO network."[28] Preferred provider organization insurance plans, or "PPOs," are "fee-for-service health care benefit plans built on indemnity insurance platforms which offer financial incentives to enrollees to acquire medical care from a predetermined ("preferred") network of physicians."[29] Finally, point-of-service ("POS") plans, administered by HMOs, allow members to go outside of the network for health care services, but with the consequence that the plan levies significant out-of-pocket costs such as deductibles and co-payments.[30]

B. Market Definition

Defining the relevant market is the first and maybe single most important task undertaken by a court when resolving a merger challenge, for the market definition controls the rest of the analysis.[31] In most instances, the broader and more inclusive the market, the more likely a merger will be allowable because of the increased possibility of competition. Unfortunately for courts, while market definition plays a significant role and demands considerable time and effort, often whether a particular merger in that market will have anticompetitive effect is derived primarily from "guesswork."[32]

1. Relevant Product Market

The Merger Guidelines define the relevant product market in a merger scenario as the products or services produced or sold by competitor firms, or reasonably interchangeable substitutes.[33] It is defined in the Guidelines as the smallest group of products for which a seller or potential monopolist can impose a "small but significant nontransitory

27. *See* also Federal Trade Comm'n v. Tenet Health Care Corp., 186 F.3d 1045, 1048–49 (8th Cir. 1999) (noting same three primary types of MCOs).

28. Sutter Health, 84 F. Supp. 2d at 1062.

29. *Id.*

30. *See id.*

31. *See* Tenet Health, 186 F.3d at 1051 (explaining that "[t]he determination of a relevant market is a necessary predicate to the finding of an antitrust violation.... Without a well-defined relevant market, a merger's effect on competition cannot be evaluated.").

32. A label applied by the court in United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1282 (7th Cir. 1990). See also Saville & Vincequerra, *supra* note 4, at 435-36 (asserting that, "in the end, the court simply speculates as to the probable effects of a merger," even after an exhaustive study of the proposed market).

33. *See* United States v. E.I. duPont de Nemours & Co., 351 U.S. 377 (1956), the definitive case concerning product market definition. In determining the relevant product market in the case over monopolization in the flexible wrapping industry, the Court looked at the uses or characteristics of the product and the responsiveness of consumers to a change in price (described by economists as elasticity, the responsiveness of demand for one product to changes in price; and cross-elasticity, the measure of the responsiveness of sales of one product to price changes in another product).

increase in price" ("SSNIP") over a period of time and maintain the supercompetitive price without losing profits from customers taking their business elsewhere.[34]

In traditional antitrust enforcement in the area of hospital mergers, on the recommendation of the prosecuting agency, courts most often define the relevant product as the cluster of services comprising acute inpatient care.[35]

An array of troubling issues can be highlighted. First, an argument can be made that a "broad" perspective, which would include items such as general outpatient services, routine surgical services, and tertiary services, is more appropriate.[36] Some writers have proposed that the product market could be broad enough to include rehabilitation, occupational, physical, and speech therapies, and even substance abuse treatment.[37] Major hospitals are thus in competition with walk-in centers, satellite locations, and urgent care centers when the product market is defined more expansively.[38] Moreover, there is the problem of differentiated products – if firms are not close substitutes in terms of reputation, diversity of staffs, or scope of services or amenities, then the proposed merger is seemingly less problematic because "these dimensions affect the degree to which hospitals in a given geographic market compete."[39] Critics of traditional antitrust enforcement analysis contend that when the product is unrealistically defined so narrowly, these subtleties are missed and refinement is necessary.

In addition, one writer has noted the difficulty of what he labels "cluster market confusion."[40] The recent developments in the healthcare industry have changed the manner in which hospital services are sought, chosen, and paid for. With large group purchasers buying bundles of services, instead of one patient choosing or desiring specific services like a shopper at a grocery store, the analysis is complicated. Not all services included in the cluster purchased by a managed care organization are commonly sold by all sellers; often, managed care organizations buy less than the full complement of inpatient services and do not demand the total package.[41] For example, a plan may buy tertiary services from only one hospital and only certain general services offered by another. Therefore, as well as being under-inclusive, the "acute inpatient care" definition for the rele-

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34. Guidelines § 1.11. An increase of at least five percent is generally accepted as meeting this test.

35. *See* Rockford, 898 F.2d at 1284; *see also* Sutter Health, 84 F. Supp. 2d at 1067; Tenet Health, 186 F.3d at 1052–53; Federal Trade Comm'n v. Freeman Hosp., 69 F.3d 260, 268 (8th Cir. 1995); United States v. Mercy Health Servs., 902 F. Supp. 968, 976 (N.D. Iowa 1995), vacated, 107 F.3d 632 (8th Cir. 1997); Federal Trade Comm'n v. University Health, Inc., 938 F.2d 1206, 1210 (11th Cir. 1991) (defining the relevant product market as acute inpatient care). Compare Saville & Vincequerra, *supra* note 4 at 437 (labeling this the "narrow" approach because it is the lowest common denominator of services offered by the hospitals). See generally Monica Noether, Overview: Economic Issues in Hospital Merger Policy, 13 ANTITRUST 6 (Spring 1999).

36. There are understood to be 3 different levels of services for product market definition purposes: acute inpatient care, comprised of medical, surgical, and other resident patient needs; general primary care services, including specialized fields such as gynecology, childbirth, and pediatrics; and tertiary or highly specialized services such as cardiology or oncology. See Federal Trade Comm'n v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996), and Sutter Health, 84 F. Supp. 2d at 1060 n.13.

37. *See* Saville & Vincequerra, *supra* note 4, at 438.

38. *See*, e.g., United States v. Carilion Health Servs., 707 F.Supp. 840, 847 (W.D. Va. 1989) (recognizing that the relevant service market included various outpatient clinics).

39. Noether, *supra* note 35, at 7.

40. Greaney, *supra* note 1, at 201–02.

41. *See id.*

vant product is also over-inclusive, as it may include particular services not necessarily relevant to a particular merger, depending on the managed care organizations involved.

The noted changing relationship among providers, patients, and payers wreaks havoc in traditional hospital merger analysis. Today, government subsidized health plans and employers, via MCOs, are the primary purchasers and contracts with hospitals are the product.[42] Employees/patients are just participants in these plans and often do not exert much choice in hospital selection or the cluster of services included.[43] Finally, the question can be asked whether in purchasing certain products the choice is made by the doctor or the patient. So often the presumed "buyer," the patient, does not have the means of selecting a certain hospital. His or her particular health plan may contain restrictions on hospital choice or costs of certain services; or, a medical emergency may preclude a choice of hospital or services because the ambulance or other carrier may take the patient to the nearest facility. Moreover, the patient/buyer may not be able to select particular services offered by a hospital once they are there. Noether notes that the benefit of the "acute inpatient services care" definition is that its general, broad sweep absorbs such variables.[44] Greaney disagrees, however, arguing that a more sophisticated market analysis is necessary in each particular situation.[45]

The district court in *Federal Trade Commission v. Butterworth Health Corp.*[46] took a novel approach to product market definition. This merger case will be discussed in greater detail later in this Note, but the way the district court dealt with the relevant product market issue is notable here. Agreeing with the FTC in its analysis, the court identified two product markets. First, it noted the traditional product definition of acute inpatient care hospital services, which includes "distinct services and capabilities that are necessary to meet the medical, surgical, and other needs of patients," such as operating rooms, anesthesia, intensive care units, nursing staff, and lodging.[47] The court then delineated a second market for discussion, primary care inpatient services, which contains offerings such as gynecology, childbirth, and pediatrics.[48] The court rejected the defendant's argument that outpatient services offered a reasonable substitute and thus that competition from those service clinics should be factored into the analysis.[49]

The benefit of this second prong for product competition analysis, according to Sims, is a disaggregation of the cluster of products at issue in hospital mergers.[50] Moreover, the assessment of two products in the market instead of only one did not create any complexities for the *Butterworth* court because it merely went about the competition and

42. *See* Sutter Health, 84 F. Supp. 2d at 1078 (stating that MCOs are "to a large extent, the true consumer of acute inpatient services," citing University Health, Inc., 938 F.2d at 1213).

43. *See* Tenet Health, 186 F.3d at 1055 (noting that "the evidence shows that patients will choose whatever doctors or hospitals are covered by their health plan").

44. Noether, *supra* note 35, at 7.

45. *See* Greaney, *supra* note 1, at 201.

46. 946 F. Supp. 1285 (W.D. Mich. 1996).

47. *Id.* at 1290.

48. *See id.* at 1291.

49. *See id.*

50. *See* Sims, *supra* note 22, at 639.

concentration analysis along both lines. One drawback to this method might be the problem of encountering a merged hospital that has high market power in one product but faces enough competition in the other to not be able to exercise market power in that field. Presumably, the court would solve this problem by assessing the results of the merger in the market and possibly fashioning a remedy in the ruling, assuming a violation is found, to limit the exercise of the market power in the one product market, but still allow certain aspects of the merger given the competition in the other product market. Regardless, this unique approach is one way to take the complexities of the healthcare market under consideration and remain within the requisite structure of analysis.

2. Relevant Geographic Market

Standard relevant geographic market definition involves as many complexities as the product market and, again, is often the dispositive issue in a given merger scenario. According to Gregory Vistnes, "there is no single, simple methodology for defining geographic markets."[51] The Merger Guidelines define it as the region where a hypothetical monopolist can profit from a price increase.[52] That is, it is the location of effective competition and reasonably interchangeable substitutes. The SSNIP test is again used, asking whether a monopolist controlling all the firms in a given region could profit from the price increase or whether a firm outside the region could exert enough influence to prevent the monopolist from realizing a profit from the increase. Basically, the court must determine "the market in which the seller operates and to which the purchaser can practicably turn for supplies."[53]

Often, the starting point of geographic market definition is the Elzinga-Hogarty test. It is employed by assessing data to determine both the area from which the hospitals draw their patients and where the residents in that area go for healthcare.[54] By analyzing the number of patients coming into and leaving a proposed market, a market analyst can test whether the proposed market constitutes a geographic market for antitrust purposes.[55]

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51. Gregory Vistnes, Defining Geographic Markets for Hospital Mergers, 13 ANTITRUST 28 (Spring 1999).

52. *See* Guidelines § 1.21.

53. Mercy Health, 902 F. Supp. at 978 (citing Tampa Electric Co. v. Nashville Coal Co., 365 U.S. 320, 327 (1960)).

54. The court in Sutter Health, 84 F.Supp. at 1069, provides a detailed explanation:

"The first prong of the Elzinga-Hogarty test requires the determination of the merging hospitals' 'service area,' that area from which they attract their patients." In the second step, two measurements are taken of the flow of patients into and out of the test market. The Little In From Outside ("LIFO") measurement calculates the percentage of patients who reside inside the test market that are admitted to those hospitals located within the test market. A LIFO of 100% would indicate that all hospital admittees in the test market are residents of the test market. The Little Out From Inside ("LOFI") measurement calculates the percentage of patients who reside in the test market who obtain inpatient services from the hospitals in the test market. A LOFI of 100% would indicate that all hospital patients who are residents of the test market are admitted to hospitals in the test market. A LIFO and LOFI of 75% is considered a weak indication of the existence of a market and a LIFO and LOFI of 90% is considered a strong indication of a market.

84 F. Supp. 2d at 1069 (citations omitted).

55. For another application and explanation of the Elzinga-Hogarty test, *see* Tenet Health, 186 F.3d at 1050–52 (8th Cir. 1999).

One final method for judging the appropriateness of a proposed geographic market is a "critical loss test."[56] The critical loss test, in conformity with the Guidelines' SSNIP test, identifies the number of patients who could defeat a price increase (make it unprofitable) by obtaining services at other hospitals. It involves two steps: (1) finding the threshold number of patients who would have to leave the proposed market to defeat the SSNIP by the hypothetical monopolist and (2) determining whether that many patients (enough to constitute a critical loss) would actually leave the market when faced with the price increase.[57]

A list of troublesome issues must be given. First, each of these approaches employed by courts and the agencies fails to account for travel-pattern analysis: patients tend to travel farther for exotic, complex, or sophisticated services.[58] For example, a patient in South Bend, Indiana, requiring special oncology care may choose to forego a local hospital and travel to the Cleveland Clinic, whereas a student who sprains his ankle while playing basketball in the gym is taken to a local hospital for care. Second, as noted earlier, the managed care organization is often the direct purchaser, and according to one writer, the relevant geographic market depends on health plans steering enough enrollees to hospitals outside of region to make price increase unprofitable.[59] The Guidelines' analysis of the geographic market does not account for the effect of a managed care organization as purchaser.

The district court in *Sutter Health* spent considerable time thoroughly investigating and discussing the proposed geographic markets of the parties. It is one example of the broadening of the analysis beyond the traditional scope. The proposed merger was between hospitals in Oakland and Alameda, California, in the east side of the San Francisco Bay Area. After the court scrutinized the experts' opinions as to the service areas and the Elzinga-Hogarty test results, it undertook a "dynamic analysis" of the market. The court examined three additional factors that it considered vital to determining which hospitals would serve as practical alternatives to patients in the event of a price increase.[60] First, the court looked to the degree of overlap between the service area of the merging hospitals and those of other hospitals. According to the court, "[w]here a hospital outside of the proposed geographic market draws patients from the same region from which the merging hospitals draw their patients, the hospital located outside of the test

56. Tenet Health, 186 F.3d at 1050; Sutter Health, 84 F. Supp. 2d at 1076–77.

57. *See* Sutter Health, 84 F. Supp. 2d at 1077.

58. *See* Noether, *supra* note 35, at 8. Thus, "appropriate geographic market definition varies across services according to the complexity." Id.

59. *See* Vistnes, *supra* note 51, at 28. He suggests a number of possibilities for steering patients to other hospitals: (1) drop the price-increasing hospital from the provider network; (2) impose an additional deductible if the patient goes to a particular hospital, and require the doctor to pay some of the bill if they admit the patient to the targeted hospital; (3) divert patients for certain services because of a price increase in other services. In assessing the geographic market, the court or the agency must ask how cost-effective such a strategy might be, the likely savings to result, and the magnitude of patient diversion. The central element in market definition for Vistnes, given the importance of the managed care organization as the buyer, is the health plan's response to the price increase. The ability to divert patients is central.

60. *See* Sutter Health, 84 F. Supp. 2d at 1073–74.

market is considered a practical alternative," to which patients in the service area overlap could turn for services.[61] Next, the court discussed the argument of the plaintiff's expert that certain hospitals do not serve as practical alternatives because of time and distance constraints on patients. Travel-time surveys of trips to hospitals outside of the proposed market, patient-flow data, and the proximity of those hospitals to residents that live at the ends of the proposed market were all elements that factored into the court's examination.[62] Finally, the court considered the perceptions of market participants regarding the competition offered by outside hospitals.[63]

Typical market definition relies heavily on patient-flow data for its determinations. A number of criticisms of patient-flow data have been raised: (1) it inappropriately focuses on patients, not the immediate purchaser (health plans); (2) it focuses on ex-post hospitalization choices and thus fails to account for ex-ante information regarding choice of hospital or the relevance of diversionary tactics; (3) it focuses on where patients live in terms of preferences and ignores other factors such as doctor preference, reputation, employment location, type of care needed, recommendations and referrals; and (4) it is disrupted by emergency services for out-of-town patients.[64]

Vistnes identifies three key aspects of geographic market definition.[65] First, it does not matter where the patients live or go. The presence or absence of other hospitals as alternatives is all that matters, and these alternatives are based on the diversion capacity of the plan discussed in the preceding paragraph. Second, markets must be defined with a view towards potential entrants that would prevent the price increase. Entry must take place in the relevant market, such that if hospitals elsewhere can affect the price increase's profitability, the definition must include that in the relevant market. Third, a potential monopolist need not increase price at each firm or location but could increase price at just one firm and drive patients to a different hospital within the market also controlled by the monopolist. For example, if a monopolist controls two hospitals in a given market and raises prices at both, patients might be driven to a third firm not controlled by the monopolist, which would demand that the third firm then be included in the relevant market.[66] If the monopolist raised prices at only one firm and simply drove patients to the other hospital in the market that it also controlled, the third hospital would not be a factor and would not be included in the relevant market.[67]

Merger challenges are often won or lost on this issue, and the importance of geographic market definition was demonstrated to the government in three of its recent enforcement actions. Each of the decisions on the geographic market ended the case for the government, and each demonstrates the deference given to merging hospitals in the widening analysis of the courts. In *Mercy Health Services*,[68] the Antitrust Division of the

61. *Id.* at 1073.
62. *See id.*
63. *See id.* at 1075-76.
64. *See* Vistnes, *supra* note 51, at 31–33.
65. *See id.* at 29–30.
66. *See id.*
67. *See id.*
68. 902 F. Supp. 968 (N.D. Iowa 1995).

DOJ sought to enjoin the merger of the only two acute care hospitals in Dubuque, Iowa. In the proposed merger between Mercy Hospital and Finley Hospital, the district court ruled that the government failed to establish a prima facie case for illegality because the court did not agree with the government's geographic market definition.[69] Both parties had stipulated to the relevant product as acute inpatient care services and thus limited the product market to those services for which only Mercy and Finley competed for patients.[70] The government contended that the geographic market was either the city of Dubuque itself, or at most included a 15-mile radius around the city, reaching into parts of Illinois and Wisconsin. Of this market, 86% of residential patients used one of the merging hospitals, and almost three-fourths of the patients at the hospitals came from within that market.[71]

The defendants maintained that the market was broader, encompassing seven rural hospitals up to 60 minutes away from Dubuque and several regional hospitals in a 70-to-100-mile stretch out of the city, extending out to Cedar Rapids, Iowa City, and Madison, Wisconsin.[72] Mercy and Finley's share of this market was only ten percent. The court ruled that those regional hospitals did constitute an alternative that would prevent the merged entity from exercising market power and protected against the capability of the merged hospital of imposing a small but not insignificant increase in price and maintaining a profit.[73] In its decision, the court placed heavy emphasis on a "dynamic" assessment of the region and the importance of considering current and potential patient responses.[74] It criticized the government's case for relying too heavily upon past health care conditions and merely looking at the current situation in the present market. The court noted the importance of outreach clinics, the potential competition presented by expansion of services of other regional hospitals, and the role of MCOs in changing plans based on financial motivations.[75]

The government responded to this proposal with skepticism. It argued that people would not travel that far for hospital services, basing its claim on the fact that medical emergencies are more likely to occur in the city where people live and that patients prefer to stay close to their homes and families when hospitalized.[76] The government also contended that patient loyalty to doctors and the importance of physician privileges at their own hospitals would keep people from going to other hospitals outside of Dubuque.[77] Because Mercy and Finley shared most of their physicians, the market excluded rural hospitals. Finally, the prosecution presented evidence that HMOs and other carriers believed that the merged hospital would be indispensable from any health plan

69. *See id.* at 987.
70. *See id.* at 976.
71. *See id.*
72. *See id.*
73. *See id.* at 982.
74. *See* Mercy Health, 902 F. Supp. at 978.
75. *See id.* at 979–80.
76. *See id.* at 977–78.
77. *See id.*

they could offer.[78]

The court rejected the government's arguments and its ruling on the relevant geographic market secured victory for the merging hospitals. In doing so, the court made three points. First, evidence showed that a number of residents already drove 90 miles to the University of Iowa seeking higher quality services.[79] As to the MCOs, the court weighed evidence suggesting that they might be able to successfully shift patients away from the merged hospital if it attempted a price increase.[80] Finally, the court found that financial incentives overcame patient loyalty to physicians, such that patients would demonstrate a willingness to travel.[81]

In dicta, the court noted that if the government had made the prima facie case, the proposed merger would have been defeated because there were no efficiencies that could not be achieved by other means and the proposed benefits of the merger were speculative.[82] Thus, by winning the geographic market debate with a broader, more inclusive definition, the hospitals did not have to rebut a presumption of illegality by proving their affirmative defenses. The government failed to establish the relevant geographic market, and therefore failed to demonstrate the likely anticompetitive effects of the merger.[83]

Greaney presents some biting criticisms of the *Mercy Health* decision by the district court, labeling the result "startling" and its findings "highly improbable."[84] First, Greaney writes that the court required too high a degree of certainty from the government in its definition of the geographic market.[85] Second, Greaney addresses the evidence weighed by the judge: he contends that some evidence presented was ignored or dismissed, either for lack of corroboration or in response to questionable rebuttal evidence. Greaney criticizes the judge for discounting witnesses he believes to be "knowledgeable market participants" and experts and instead relying on dubious (he uses this word many times in his assessment) hard evidence from the defense.[86] For example, he notes that the patients who traveled greater distances to other regional hospitals received services not available in Dubuque, such as elective plastic surgery. That this evidences a future likelihood of switching by patients away from the Dubuque hospital is a "gener-

78. *See id.* at 981–82.

79. *See id.* at 982. The government responded to this evidence by asserting that those patients were going to the University of Iowa to receive care not available in Dubuque. The court drew a questionable conclusion from the percentage of non-doctor referrals and the varied use of the University across zip codes. The first conclusion is questionable because it is possible for patients to choose a hospital without formal referral, and the second because the zip codes only evidence that people from all over, not just Dubuque, seek out the University services.

80. *See id.* The government contended that the shifting was irrelevant because the plans were successful in redirecting patients only in services outside of the relevant product market. The court, however, defended its reliance, assuming that if people will travel for long-term, specialized care, they would travel for other services in the market.

81. *See id.*

82. *See id.* at 987-89.

83. *See* United States v. Mercy Health, 107 F.3d 632 (8th Cir. 1997) (failing to address any of the substantive findings by the lower court and vacating the case as moot when Finley withdrew from the merger).

84. *Greaney*, *supra* note 1, at 209.

85. *See id.* at 210.

86. *Id.* at 211.

aliz[ation] from experiences involving obviously dissimilar circumstances and disparate, highly differentiated service markets."[87] In addition, Greaney stresses that even if MCOs could use financial incentives to induce some patients to switch, this does not negate the fact that any managed care plan would have to include local options, especially a dominant local hospital.[88]

Market definition doomed the government challenge in *Federal Trade Commission v. Freeman Hospital*[89] as well. This controversy centered on a proposed merger in Joplin, Missouri, where three hospitals competed at the time: St. John's, the largest, with 331 beds; Freeman, with 158 beds; and Oak Hill, an osteopathic hospital, with only 96 beds.[90] Due to financial difficulties, Oak Hill sought bidders for its facilities and services and eventually planned a merger with Freeman. The FTC sought a preliminary injunction, and once again the market definition was determinative.

The district court stated that a two-step analysis was required. It first had to determine where the patients of Joplin hospitals came from; this was labeled the "service area."[91] The court then was to identify other hospitals to which patients residing in the service area could turn if they were dissatisfied with the price or service of the hospitals in Joplin.[92]

The expert testifying for the FTC argued that the market included only the area within a 27-mile radius around Joplin; he concluded that the market was highly concentrated, with only three hospitals dominating the area, and that this raised a presumption of illegality. The district court ruled, however, with the defendants, finding that the geographic market consisted of a 13-county area, included 17 hospitals, and was up to 54 miles from Joplin. Therefore, the market was not concentrated, and a merged entity would still face competition.[93]

In its analysis, the court looked to where residents of Joplin could practically go for alternative acute care and not where patients actually were going at the time.[94] The method used by the prosecution was "limited to evaluating pre-merger usage patterns" and "is incapable of identifying competitors who will become relevant if the prices . . . rise."[95] The Commission had ignored proximate hospitals to which patients could turn, and thus failed to meet its burden.

The Eighth Circuit affirmed the lower court's ruling.[96] The court rejected the argu-

87. *Id.* at 210 n.154.

88. *See id.*

89. 911 F. Supp. 1213 (W.D. Mo. 1995).

90. *See id.* at 1217.

91. *See id.* at 1218; *see also* Tenet Health, 186 F.3d at 1048 n.4 (defining service area as "the area from which a hospital derives ninety percent of its inpatients").

92. *See* Freeman, 911 F. Supp. at 1220.

93. *See id.* at 1221.

94. *See id.* Thus, the court accepted the testimony of the defendant's expert, Dr. Lynk, utilizing patient migration patterns and geographic proximity data of the other hospitals, rather than that of the plaintiff's expert, Professor Leffler, relying on patient flow data.

95. *Id.* at 1220.

96. Federal Trade Comm'n v. Freeman Hosp., 69 F.3d 260 (8th Cir. 1995).

ment that the FTC had too high a burden or faced too stringent a task in delineating the relevant market.[97]

Greaney levels many of the same criticism at the *Freeman* decision as he does against the *Mercy Health* ruling. Dismissal of patient-flow data, Greaney contends, is unnecessarily restrictive, for it can support other evidence and it demonstrates consumer preferences over long periods of time.[98] Moreover, as in the *Mercy Health* scenario, market participants viewed the merged hospital as indispensable to any health care plan.[99] He notes a potential Catch-22 for the government in cases like *Freeman*: the court rejects some hard evidence of historical data such as patient-origin data as unacceptable because it fails to address future contingencies, while also rejecting managed care testimony concerning future possibilities because of a lack of specificity and hard evidence. Finally, too high a standard of precision was required of the Commission, and their injunction was denied even though the evidence offered and rejected "seemed to speak as directly and persuasively to [the issue of geographic market] as any testimonial evidence could."[100]

Tenet Health[101] is another recent case in which the failure of the government to establish a relevant geographic market ended its challenge of a hospital merger. Lucy Lee, with 201 licensed beds, and Doctor's Regional Medical Center, with 230 licensed beds, were the two general acute care hospitals located in Poplar Bluff, Missouri. Both hospitals were described by the court as "profitable" but "underutilized."[102] Tenet Healthcare Corporation, owner of Lucy Lee, entered into an agreement to buy Doctor's Regional, planning to operate it as a long-term care facility and to consolidate all other services at Lucy Lee.[103] The goal was to draw more specialists to the facility, to offer higher quality care, and to expand into comprehensive, tertiary care services.[104] After the filing of the requisite premerger notification pursuant to the Hart-Scott-Rodino Act,[105] the FTC sought to enjoin the merger. The district court, after a five-day hearing, concluded that the merger would be anticompetitive and enjoined the merger.[106] The Court of Appeals reversed, based on the government's failure to establish a geographic market.[107]

The circuit court began its analysis by describing the service area of the two hospitals.[108] Poplar Bluff, with a population of 17,000, is the largest city in several counties in southeastern Missouri.[109] The hospitals drew patients from eight counties over a 50-mile

97. *See id.* at 268. The FTC had argued that the standard for obtaining a preliminary injunction, raising substantial or serious questions of the merits of a case, applied to its burden for proving relevant geographic market.

98. *See* Greaney, *supra* note 1, at 207.

99. *See id.* at 208.

100. *Id.*

101. 186 F.3d 1045 (8th Cir. 1999).

102. *Id.* at 1047-48.

103. *See id.* at 1048.

104. *See id.*

105. 15 U.S.C. § 18a.

106. *See* Tenet Health, 186 F.3d at 1051.

107. *See id.* at 1047.

108. *See id.* at 1048.

109. *See id.* at 1047.

radius, including general acute care hospitals in Sikeston (40 miles away) and Cape Girardeau (60 miles away), St. Louis, and Jonesboro, Arkansas.[110] The court noted that, in examining patient admission data, between 22% and 70% of admissions of residents within the service area were to hospitals in cities other than Poplar Bluff.[111] The court acknowledged that many residents travel to major metropolitan centers such as St. Louis or Memphis for tertiary care; however, "significant numbers of patients in the Poplar Bluff service area travel to other towns for primary and secondary treatment that is also available in Poplar Bluff."[112]

The plaintiff's expert economist gave testimony regarding the Elzinga-Hogarty test.[113] He eliminated certain patients traveling greater distances from his analysis because he believed those patients were most likely seeking services not available in Poplar Bluff and were not significant in the analysis. The defendant's expert testified concerning critical loss analysis.[114] He concluded that if the merged hospital were to raise prices, enough patients would go to other hospitals for care, thus rendering the price increase unprofitable. The district court found that the evidence failed to establish the relevant geographic market because of the conflicting testimony regarding where patients were seeking hospital services and what kind of services they required.[115] However, the court enjoined the merger based on "anecdotal evidence 'confirmed by common sense'" that the merger would be anticompetitive.[116]

The Court of Appeals stated the well-settled understanding that "[a] geographic market is the area in which consumers can practically turn for alternative sources of the product and in which the antitrust defendants face competition."[117] The FTC was required to show where consumers of hospital services could practically turn for alternative sources in the event prices became anticompetitive after the merger. Once again, the court emphasized that the evidence "must address where consumers could practically go, not on where they actually go."[118]

The FTC proposed a geographic market that matched the service area of the hospitals in Poplar Bluff, one that contained four other hospitals: a regional hospital in Kennett, and three rural hospitals. [119] The merged entity would enjoy a post-merger market share of 84%, from which monopoly power could be inferred.[120] The defendants offered evidence that the geographic market stretched all the way to include hospitals in St. Louis, over 65 miles away, and Cape Girardeau, where the population in this area was the most

110. *See id.* at 1048.
111. *See id.* at 1050.
112. *Id.*
113. *See id.*
114. *See id.*
115. *See id.* at 1051, citing Freeman, 69 F.3d at 268.
116. Tenet Health, 186 F.3d at 1051.
117. *Id.* at 1052.
118. *Id.*; citing Freeman, 69 F.3d at 269.
119. *See id.*
120. *See id.*

concentrated.[121] Within this wider market region, marginal consumers would cause a critical loss, such that a SSNIP would be unprofitable.

The court found the FTC's proposed market to be too narrow.[122] The court noted the importance of the fact that 22% of patients "in the most important zip codes" in the service area already travel to other hospitals outside of the area.[123] It then reasoned that, "[i]f patients use hospitals outside the service area, those hospitals can act as a check on the exercise of market power by the hospitals within the service area."[124] The FTC's argument that those patients traveling outside of the service area were seeking tertiary care was not supported by the record; the defendant's analysis of those patients specifically excluded those seeking services not available in Poplar Bluff.[125]

The court also discounted the testimony of managed care providers, who resisted the merger because of fear of price increases in the exercise of market power.[126] The court determined that non-price competitive factors such as quality of care, actual or perceived, and the ability of MCOs to steer patients to other hospitals would make such a price increase resistible.[127] According to the Court of Appeals, the district court placed too high an emphasis on price competition alone, and relied too heavily on the testimony of market participants.[128]

Because the FTC failed to establish its proposed geographic market, the circuit court reversed the ruling by the district court to enjoin the merger. To complement its findings regarding the geographic market, the court made some concluding points as to the merits of the merger. The proposed benefits of the merger, such as a larger and more efficient entity which is better able to provide high quality care, were overlooked by the district court.[129] Moreover, managed care was invading nearby markets such as Cape Girardeau. Doctor-patient loyalty was a less important factor; the ability of a healthcare plan to govern where patients receive care demanded more attention.[130] Finally, according to the court, it just may be the case that Poplar Bluff could no longer support two general care hospitals.[131]

A few brief remarks can be made. First, this case, like *Mercy Health* and *Freeman*, demonstrates the importance of geographic market definition in an antitrust challenge to a merger. It also portrays the broader approach courts are taking in analyzing these mergers, such as emphasizing quality of care over price competition, giving substantial weight to the ability of MCOs to steer patients, and accounting for the impact of outpatient clinics in broadening the market.

The court's reasoning can be questioned in two respects. One, there is a certain incon-

121. *See id.*
122. *See id.* at 1054.
123. *Id.*
124. *Id.* at 1053.
125. *See id.*
126. *See id.* at 1054.
127. *See id.*
128. *See id.*
129. *See id.*
130. *See id.*
131. *See id.*at 1055.

sistency in the court's opinion. In its ruling it emphasized the ability of MCOs to offer financial incentives to combat a price increase by a merged entity attempting to exercise market power.[132] However, it then turned and discounted the testimony of those same managed care providers who expressed fear that they would be forced to accept a price increase rather than steer their subscribers to other hospitals.[133] Like in *Mercy Health* above, and Greaney's criticisms there, it seems that a managed care plan would also have to include a dominant local hospital such as the merged entity in Poplar Bluff, and the payers themselves would know best. Two, it seems that the court did not heed its own words when it stressed that the market is defined by where patients could go, not where patients actually go for services. The court's ruling was based in large part on evidence demonstrating that Poplar Bluff residents were currently traveling greater distances than the FTC would admit for services available close to home.[134] The FTC did offer evidence that those traveling greater distances were seeking more sophisticated services not available in Poplar Bluff, but the court discounted it in favor of the defendant's proposals.[135]

C. Anticompetitive Effects of Merger

When the relevant product and geographic markets are defined, the analysis turns to the potential anticompetitive effects of the proposed merger. Once the agency demonstrates the problems the merger might cause and meets the burden of proof, the merger is deemed presumptively illegal and the burden shifts to the defending hospitals to try to argue the benign or pro-competitive nature of the merger.

1. Market Concentration and Market Power Analysis

The Guidelines call for an application of the Hirfindahl-Hirschman Index, where the before and after status of the market share is assessed.[136] Basically, the HHI test takes the percentage of market share owned by each firm, computes the sum of the squares of those percentages, and then compares that number to the sum of the square of the market share of the merged firm.[137] Depending on where the sum of the separate firms' total falls on a scale, certain numeral raises in the market share demonstrate the high concentration and therefore problematic nature of the merger. For example, assume a market

132. *See id.* at 1054.

133. *Id.* at 1049–1054. The court questioned the payers' testimony as "disingenuous or self-serving" because their testimony indicated they had been "playing the two hospitals off each other" and achieving discounted rates for their subscribers at both hospitals. However, the testimony of these market participants was a crucial factor in the district court's decision to enjoin the merger despite the absence of a conclusive geographic market. In general, third-party payers may be able to steer patients, but it was doubtful in this situation.

134. *See id.* at 1053.

135. *See Greaney, supra* note 1, at 210 (criticizing courts for requiring too high a degree of certainty in defining the geographic market).

136. *See* Guidelines § 1.50.

137. *See id.*

with four firms, two of which hold market shares of 30% each and two with 20% each.[138] The HHI for that market would be 2600, the sum of the squares of each percentage. In calculating the market shares after the merger, the shares of the two merging firms are added and then squared as a single unit.[139] The Guidelines divide the HHIs into three levels: below 1,000 is unconcentrated; between 1,000 and 1,800 is considered moderately concentrated and an increase after a merger of over 100 raises concerns; and a market with an HHI of over 1,800 is highly concentrated, such that a merger increasing the HHI over 100 leads to a presumption of creation of market power.[140]

The difficulty in terms of HHI analysis of hospital mergers is deciding on what to base the statistics for market share. Is it discharge percentage? Number of beds? Other services? Market definition is central in this process. If the relevant product market is inpatient acute care, then the discharge percentage of the hospital probably goes a long way in deciding how much of that market the particular hospital controls. If the product market is defined more broadly, as proposed in this paper, then the type and number of services provided becomes a relevant variable in the equation. For example, a hospital with a high number of beds that has a poor reputation or that fails to offer certain crucial services has, from one point of view, a large percentage of the market and has a high HHI rating. In another sense, however, it does not have a high degree of market control and its presence in a merger would be less problematic in terms of market concentration than the HHI test reveals.

2. Presumptive Illegality

Once the business of market definition and the prediction of the impact on the market is complete, the court will make its ruling. If the HHI numbers are problematic and if the two-prong test reveals a significant increase in the concentration of firms and a merger entity with an undue percentage share of the market, the merger is deemed presumptively violative of the antitrust laws.[141] The burden then shifts to the defendants to demonstrate otherwise.

D. Defendant's Rebuttal

Proposed participants in a challenged merger can attempt to rebut the presumption of illegality using three arguments. First, the hospitals could argue that their non-profit status awards them special treatment under the antitrust laws because they do not function economically as other for-profit firms. Second, the merger might provide certain efficiencies which are not available absent the merger. This appeals to one of the economic goals of antitrust, to encourage efficient economic behavior. The key here is to

138. *See* Handler, *supra* note 3, at 952, n. 87.

139. A review of high school algebra will reveal that the increase in HHI after a merger is the difference between squaring individual shares and squaring the sum of the shares of the merging firms, which can be calculated by multiplying the two shares together and doubling that total.

140. *See* Guidelines § 1.51.

141. *See United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 363 (1963) (setting out the paradigm for the first time).

show that the benefits of the merger would be passed on to consumers because the ultimate goal of the antitrust laws is consumer welfare. Finally, the merger might be the only way to save a failing company and thus may be permitted despite being anticompetitive. A failing company's ability to exist as a party to a merger might be more attractive than allowing it to exit the market and thus lessen competition in the community in which it operated.

1. Non-profit status

In *National Collegiate Athletic Association v. Board of Regents of the University of Oklahoma*, [142] the Supreme Court ruled that the antitrust laws apply to nonprofit entities because they may still act to increase profits by raising prices or reducing services if they have market power.[143] This is the major hurdle for the non-profit defense to overcome. Most courts follow the *NCAA* ruling and its progeny in its application to hospital mergers, and many defendants do not even bother to raise the argument.[144]

Proponents of the significance of non-profit status in defense of hospital mergers respond with a few observations. Hospitals are not profit maximizers, in that their primary mission is to provide quality health care at affordable prices. Often the governing boards of the hospitals are benevolent, composed of religious and other community leaders focused less on making a profit and more on serving the very community of which they are an integral part.[145] In some cases, evidence has been presented that suggests that price concentration data refute traditional assumptions; high market concentration and share do not necessarily lead to high prices.[146] Saville and Vincequerra write, "data illustrates that high market shares for non-profit hospitals do not result in anticompetitive effects, rather they result in better services and lower prices."[147] For the *Butterworth* court, per se illegality based on increased market share was counterintuitive, because if the merger was not allowed, the hospitals would have had to raise prices to deal with

142. 468 U.S. 85 (1984).

143. *See Northwest Wholesale Stationers, Inc. v. Pacific Stationary & Printing Co.*, 472 U.S. 284 (1985) (declining to apply per se analysis to a cooperative buying agency). See also United States v. Brown Univ. 5 F.3d 658 (3rd Cir. 1993) (applying antitrust laws to financial aid program of educational institution).

144. *See Hospital Corp. of America v. Federal Trade Comm'n*, 807 F.2d 1381 (7th Cir. 1986) and *United States v. Rockford Mem'l*, 898 F.2d 1278 (7th Cir. 1990) (rejecting hospital mergers for lack of proof that nonprofit firms compete differently and because of the implications of NCAA). *But see* Jeffrey W. Brennan and Paul C. Cuomo, The "Nonprofit Defense" in Hospital Merger Antitrust Litigation, 13 ANTITRUST 13,14 (Spring 1999), (noting that the opinions rested more heavily on the lack of evidence, and did not reject the defense as a matter of law).

145. *See Carilion Health*, 707 F. Supp. at 849 (stating that, "[d]efendants' boards of directors both include business leaders who can be expected to demand that the institutions use the savings achieved through the merger to reduce hospital charges. . . "). See also Freeman, 911 F. Supp. at 1222 (reasoning that "if a nonprofit organization is controlled by the very people who depend on it for service, there is no rational economic incentive for such an organization to raise its prices to the monopoly level even if it has the power to do so."). *See also Butterworth*, 946 F. Supp. at 1296 (expressing similar faith in benevolent boards).

146. *See Butterworth*, 946 F. Supp. at 1295 (citing the defendant's expert Dr. Lynk with statistics that demonstrate that high concentration in a nonprofit area is correlated to low prices in that area).

147. *Saville & Vincequerra*, *supra* note 4, at 446.

increased costs.[148]

The skeptics present a few objections to the non-profit defense. First, nonprofit entities behave similarly to for-profit firms. Wade notes that most courts realize that merely because a firm is not-for-profit does not mean that it will not be concerned about raising cash revenues or that it will not affect competition in the market.[149] The concern of antitrust law remains the impact on the consumer. Second, human and economic incentives to maximize profits are unavoidable.[150] Almost every court has rejected the "pure motives" argument put forth in the non-profit defense.[151]

Brennan and Cuomo reach two conclusions in the area of non-profit defense for hospitals.[152] First, the defense complements other evidence. It cannot defeat a merger challenge on its own, but is best used in conjunction with broad market definition, ease of entry, bargaining strength of managed care organizations, and other traditional arguments. Second, pure theory in this area will fail; factual evidence is crucial to a successful defense. [153] The authors list a number of items that courts have favorably considered, including prices studies indicating an absence of correlation between higher market concentration and higher prices, and hospital boards' mission statements about keeping costs affordable and proof of implementation of that mission through new programs and other services to the community.[154]

2. Efficiencies

After the agency shows the presumptive anticompetitiveness of the merger, the other major argument available to the defense is to demonstrate the benign or procompetitive aspects of the hospitals' merger. Examples of potential efficiencies in a merger are economies of scale, reduction in operational expenses, and integration of facilities.[155] More specifically, hospital mergers are often an attempt to save a struggling hospital or to allow growing hospitals to expand, thus promoting higher quality care and invigorating competition via revitalization.[156]

The 1997 Revisions to the Horizontal Merger Guidelines reveal the increased recognition by enforcers of the importance of evaluating potential efficiencies. Under the

148. *See Butterworth*, 946 F. Supp. at 1295.

149. *See Wade*, *supra* note 6, at 1305.

150. *See HCA v. FTC*, 807 F. Supp. at 1390, Judge Posner noting "The adoption of the nonprofit form does not change human nature."

151. *See Mercy Health*, 902 F. Supp. at 989 (stating that even if the current board has pro-competitive motives, board members change over time and there is no possibility of predicting future behavior). See also Brennan, *supra* note 144, at 16 (second-guessing the likelihood of responsible board oversight concerning day-to-day operations). Compare Greaney, *supra* note 1, at 217 (noting that community members on boards may face conflicts with the fiduciary obligations they owe to their corporations).

152. *See Brennan*, *supra* note 144, at 18.

153. *See id.*

154. *See id.*

155. *See* Guidelines § 4.0.

156. *See Saville & Vincequerra*, *supra* note 4, at 450–52. The authors cite Carilion as a prime example, in which Roanoke Memorial needed more space for various services and Community Hospital's occupancy was declining.

Guidelines specific to hospitals, two tests must be passed.[157] First, the efficiencies must be merger-specific, such that the merger is the best means of accomplishing the goals and the efficiencies are unlikely to be achieved without a merger. Second, the efficiencies must be verifiable; that is, conjecture as to the possibility of efficiency is not allowed. The central concept under the guidelines is that the efficiencies must be "cognizable," meaning that they meet the stated tests and do not result from anticompetitive behavior.[158] Generally, the more closely the efficiencies are tied to variable costs, the more likely they are to be found cognizable. Less weight is given to those factors affecting fixed costs in balancing against anticompetitive effects of merger; those efficiencies that are not merger specific are given no consideration at all.[159]

The extensive categories of potential savings include the following: (1) consolidation of laboratory services; (2) consolidation of medical units and reduction in staff; (3) central food production or combination of dietary departments; (4) volume discounts through purchasing and materials management; (5) one laundry service for all hospitals; (6) information services; and (7) joint administration.[160] Also, capital cost savings (fixed costs) can be achieved through the integration of facilities.

The efficiencies defense will be addressed in more detail by summarizing two illustrative district court decisions in Part III.

3. The "Failing Company" Defense

The district court in *Sutter Health* addressed a third defense in challenges to a merger, that of the "failing company."[161] The court initially permitted the merger based on the failure of the State of California to sufficiently establish a relevant geographic market. However, it went on to discuss the defendant's proposed failing company defense.

In order to prevail under the failing company defense, a defendant "must show that the resources of the acquired company are 'so depleted and the prospect of rehabilitation so remote' that it faces 'the grave probability of business failure' and that 'the company that acquires the failing company . . . is the only available purchaser.'"[162]

The first and most important factor considered by the court is the firm's insolvency. This could mean either that the firm has no net worth (the bankruptcy sense) or that it is unable to meet its debts as they come due (the equity sense).[163] In examining the state of Summit Hospital, a party to the proposed merger, the court highlighted several fiscal problems: drastically increased operating losses over the past 2 years, reduction in Medicare payments to hospitals, the loss of financial reserves, overdue bills, extensive

157. *See* Guidelines § 4.1; *see generally* Richard D. Raskin and Bruce M. Zessar, Telling the Efficiencies Story: Practical Lessons from the Hospital Merger Field, 13 ANTITRUST 21 (Spring 1999).

158. *See Raskin & Zessar*, *supra* note 157, at 21.

159. *See id.* at 21–22.

160. *See id.* at 22.

161. 84 F. Supp.2d at 1081–86.

162. *Id.* at 1081, quoting *Citizen Publ'g Co. v. United States*, 394 U.S. 131, 138 (1969).

163. *See* Summit Health, 84 F.Supp.2d. at 1081–82.

long-term debt, and the prospect of future debt due to required seismic upgrades to its facilities.[164] The court concluded that the hospital could not meet its current debt and could not assume more debt to meet its obligations.[165]

The court further ruled that the fair market value of its assets was less than the value of its liabilities.[166] It dismissed the fact that another firm, Tenet Health Corp., had submitted a bid that would have allowed the hospital to meet its obligations. The court explained that the bid was made 18 months before, and there was no evidence to suggest that the same offer would be made again given Summit's decreased financial status. Therefore, the defendant hospital satisfied the "grave risk of business failure" test, the first prong of the failing company defense.[167]

The court next admitted that there was a disagreement among courts as to whether the defendant must show that the prospects of reorganization in bankruptcy are slim.[168] The hospital made such a showing because the outcome of bankruptcy proceedings would likely lead to liquidation rather than a successful reorganization, the hospital made such a showing.

As quoted above, the second prong of the defense requires that the defendant prove that the acquiring firm was the only available purchaser.[169] Under the Merger Guidelines, a good faith effort to seek offers from other potential purchasers is necessary.[170] The court again dismissed the offer from Tenet because it was made over 18 months before when Summit was in better financial shape. Tenet made no effort to pursue the deal as the merger with Alta Bates was impending. The court ruled that Summit satisfied the second prong of the test and thus successfully established the failing company defense.[171]

III. TWO ILLUSTRATIVE DECISIONS

Two recent decisions by district courts over hospital mergers illustrate many of the important considerations in the required analysis, as well as the trends toward the more inclusive analysis that have been noted.

In *Federal Trade Commission v. Butterworth Health Corp*,[172] the district court considered the proposed merger of the two largest hospitals in the Grand Rapids, Michigan area. There were four general acute care hospitals in the city of just over 190,000 people, the largest two being Butterworth Health Corp. and Blodgett Memorial Medical

164. *See id.* at 1064–65.

165. *See id.* at 1082. The plaintiffs argued that the hospital had understated its available funds, pointing to the Summit Medical Center Foundation, an associated charitable foundation, as a source for capital. The court arguably took form over substance by not considering the assets of the Foundation because the two were separate legal entities. *See id.*

166. *See id* at 1083.

167. *Id.*

168. *See id.* at 1084.

169. *See id.*

170. *See* Guidelines § 5.1.

171. *See Summit Health*, 84 F. Supp. 2d at 1085.

172. 946 F. Supp. 1285 (W.D. Mich. 1996).

Center.[173] Both hospitals were operating well above the minimum efficiency, but in 1993 Blodgett became interested in building a new multimillion dollar replacement facility, in order to expand and update its facilities in a more desirable location that could accommodate an expansion to meet outpatient diagnostic services and inpatient care.[174] A local commission opposed the new facility because of its cost and the inconvenience of moving the hospital to a new location. The commission, made up of various community leaders and officials, instead began investigating a possible merger between the two hospitals.[175] A merger would allow a combination and integration of inpatient services and also would enable Blodgett to reorganize its facilities at its present site.[176] They announced the merger decision in May, 1995.[177] Because the proposed merger would create a surviving entity with near-monopoly status in the area, the FTC objected and sought a preliminary injunction.[178]

As noted earlier, the court agreed with the FTC on the relevant product and geographic market definitions. The court outlined two product markets, that of general acute inpatient care services and primary care inpatient services such as gynecology and pediatrics.[179] The geographic market was the greater Kent County, including Grand Rapids and a 30-mile radius around the city. This market included the four major hospitals in the city and five rural hospitals for the general acute inpatient care product market, but only the four central hospitals for the primary care field.[180]

The court then proceeded with the analysis by applying the HHI test.[181] It determined that a merger would result in a significant increase in market power for the merged entity, consisting of between 47-65% of the first product market and 65-70% of the second product.[182] The post-merger HHI in the first product market would be between 2767 and 4521, a point increase of 1064-1889; the post-merger HHI in the second market would be between 4506 and 5079, a point increase of 1675-2001.[183] The result would be a dominant firm with large market power, with high barriers to entry and ineffective competition. Managed care organizations and employers would have to include the hospital on any health plan and would not be able to effectively deter patients away from the new entity. In short, for the court there was "no question . . . that the merged entity would have substantial market power in two relevant markets."[184] The FTC had established its prima facie case, and the burden shifted to the defendants to rebut the presumption of

173. *See id.* at 1288. Butterworth contained 529 general acute care beds; Blodgett held 328 beds; St. Mary's Hospital operated 150 beds; and Metropolitan Hospital had 101 beds. *See id.*

174. *See id.*

175. *See id.* at 1289.

176. *See id.*

177. *See id.* at 1288.

178. *See id.*

179. *See id.* at 1290-91.

180. *See id.* at 1291.

181. *See* discussion *infra* Section II C1.

182. *See id.* at 1294. The defendants did not challenged the government's calculations.

183. *See id.*

184. *Id.* at 1302.

illegality.

Three major factors contributed to the success of the merging hospitals in demonstrating that the merger would not have anticompetitive effects. First, the non-profit status of the hospitals, while not determinative, was material to the court's decision.[185] The court found that evidence indicated that contrary to historical understanding of the correlation between prices and concentrated markets, market concentration is not correlated with higher prices but in fact with lower prices when nonprofit firms are involved.[186] Moreover, given the governance structure of the hospital, the court presumed the new hospital would operate benignly because of community leaders on the board with an interest in maintaining low cost services.[187]

Second, the court examined the proposed efficiencies created by the merger which discounted its anticompetitive nature. Most significant here was the cost-savings of Blodgett not constructing a new facility in a new location. This avoidance of capital expenditures, as well as the combination of duplicative services between the hospitals, was crucial.[188]

Finally, the defendants took a unique approach by proposing a community commitment which would bind the hospitals to hold prices down and pass on efficiencies to the consumer.[189] The commitment became part of a consent decree issued by the court, and it contained four elements: a freeze of list prices, a freeze of prices to managed care plans at pre-merger levels, a limit on profit margins, and an insurance of consumer representation on the board.[190]

Given the efficiencies provided by the merger and the benefits passed on to the consumer, the expenditures and likely increased cost in the absence of a merger, the commitment to not raise prices or exercise market power, and the non-profit status of the hospitals, the court was persuaded that the defendants had overcome the presumption of illegality. The Sixth Circuit affirmed in an unpublished opinion.[191]

United States v. Long Island Jewish Medical Center[192] may be as remarkable a decision as *Butterworth*, given the two hospitals seeking to merge and their place in the New York City healthcare field. Long Island Jewish Medical Center ("LIJ") sits in Queens County and is comprised of a 450-bed acute care facility, a children's hospital, and a psychiatric ward.[193] LIJ does face competition in each area of practice.[194] Its patients are comprised of over 50% Medicaid and Medicare payers, and 30% participants in various MCOs.[195] North Shore Manhasset Hospital, part of North Shore Health Systems, sits about two miles away from LIJ and is primarily a teaching facility with New York Uni-

185. *See id.* at 1297.
186. *See id.* at 1297.
187. *See id.*
188. *See id.* at 1301 (noting an excess of $100 million in cost savings due to efficiencies).
189. *See id.* at 1298.
190. *See id.*
191. Aff'd per curiam, No. 96-2440 (6th Cir. July 8, 1997).
192. 983 F. Supp. 121 (E.D. NY 1997).
193. *See id.* at 126.
194. *See id.*
195. *See id.*

versity, with patients comprised of 40% government payers and 30% managed care.[196] Both hospitals offer general primary and secondary care services, and both hold highly prestigious reputations in the New York area; according to one CEO, both hospitals are "must haves" on any health care plan.[197] Given the size and reputations of the two hospitals, the FTC sought preliminary and permanent injunctions against their proposed merger.

The outcome of the case turned on the relevant product market definition. According to the government, the relevant product was "anchor hospitals," those with prestigious reputations and sophisticated services, which provide high-quality primary and secondary services.[198] The FTC argued that the reputations of the hospitals distinguished them from all others, and their product was a unique one worthy of special delineation. Only one other hospital on Long Island, Winthrop Hospital, compared in quality and reputation and could offer competition. The court, however, ruled with the defendants, taking a traditional general acute inpatient care line for demarcation.[199] Anchor hospitals such as the government described was too restrictive a definition, and the hospitals faced effective competition from an array of other general acute care hospitals. According to the court, reputation was a reflection of where patients went, not where they might practically go for alternatives after the merger.[200]

Given the broader, more inclusive definition of the relevant product market, the FTC failed to establish a presumption of illegality. The market was not concentrated and the merged entity faced significant competition such that the result of the merger would not be anticompetitive. The court did complete the analysis for the record, even though the product definition was determinative.[201]

The geographic market was split into the market for primary and secondary care, and the market for tertiary care. The first, constituting 85% of the services, included only Queens and Nassau; the second included Manhattan and Western Suffolk County as well.[202]

The court then went through the two-step process for assessing the anticompetitive effects of the merger. First, the issue was whether the merged entity might have "enough market power to profitably increase prices above competitive levels for a substantial period of time."[203] The defendants won on this point as well, for a variety of reasons: not holding a large enough share of the market, entering into an agreement with the state not to raise prices for two years, and the impact of MCO purchasers and government payers. Second, the court judged whether the merged entity might reduce the quality of care or

196. *See id.*
197. *See id.* at 130.
198. *See id.* at 137 (citing Plaintiff's Pre-Trial Memo at 7).
199. *See id.* at 140.
200. *See id.*
201. *See id.*
202. *See id.* at 141.
203. *Id.* at 142.

treatment given.[204] The court again ruled for the defendants, based on the proposed motivations for the merger, such as high quality patient treatment, physician education and training, and research.[205]

Regarding efficiencies, the court ruled that the potential cost savings in the merger further supported its decision. The efficiencies were found to be merger specific, per the requirements of the 1997 Guidelines Revisions, and included reduction in personnel, reduction in cost of lab services and medical supplies, claims recovery costs, utilities savings, laundry cost reduction, and cheaper computer and information services capabilities.[206] One claimed area of savings, the downsizing of faculty, was ruled not to be merger specific, since both hospitals could accomplish this individually. The court determined that the hospitals' estimates of operating savings and capital avoidance were too high, but also that the government's numbers were too low, finding a middle ground of $25-30 million in savings per year.[207] Given the nonprofit status of the hospitals and the concern for community service and aid, the court determined there was a "reasonable certainty" of the savings being passed on to consumers.[208]

IV. CONCLUSION

As may be obvious from his many noted criticisms throughout this paper, Thomas Greaney does not agree with many of the recent district court decisions. He concludes his article on hospital mergers by alerting the reader to the danger of "standardless inquiries" in merger cases, and by issuing a call back to "a reasoned parsing of the economic facts."[209]

Joe Sims, however, believes that "it is not clear that merely doing a more careful job of implementing the traditional analysis will solve the entire problem."[210] In advocating an analysis that steps outside of the traditional economic evaluations and predictions, Sims asks that certain principles be incorporated: deemphasis of assumptions based on market structure (given the unique and ever-changing healthcare field), weighing of both community support and objectives as well as opposition, consideration of future distress as well as likely failure of a merging hospital, recognition of community control or influence over the operation of the merged firm, and giving of great weight to significant potential efficiencies and other benefits.[211]

A middle ground between these two positions on the future of hospital merger analysis seems the most appropriate. Greaney is correct in asserting that the primary concern of antitrust law is economics, and that the appropriate evaluation involves an economic

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204. *See id.*

205. *See id.* at 145.

206. *See id.* at 148.

207. *See id.*

208. *See id.* at 149. The defendants also entered into an agreement with the state attorney general to pass on $100 million in savings over the first five years. Id.

209. Greaney, *supra* note 1, at 220.

210. Sims, *supra* note 22, at 642.

211. *See id.* at 647.

take on the current market, the effects of the merger on market concentration and market share, and the potential economic efficiencies that may alleviate concerns over anticompetitiveness. The agencies are thus accurate in the framework laid out in the Guidelines.

But Sims' insight that there is something special and different about hospitals is proper as well. The uniqueness of the healthcare market has been noted throughout this paper. A few illustrations can be mentioned again: the presence of managed care organizations as the purchaser and not the patient, the influence of patient loyalty and the fact that patients do not always choose hospitals or the care they receive, and the nonprofit status of many hospitals and the commitment to the communities they serve. Hospitals and healthcare are different and a merger in this field cannot be reduced to pure economics.

However, even Sims acknowledges that a richer inquiry that accounts for all of the above factors, while desirable, may be impractical or even impossible. The factors are not readily definable nor quantifiable, and the prediction of the future market would be even more uncertain than guesswork.

Where does that leave us? We want the agencies and the courts to be honest about the potential anticompetitive nature of a merger resulting in high market concentration or market power. But we also want them to consider nonprofit status, to recognize boards that are mindful of and accountable to community needs, to heed the recommendations and opinions of managed care groups. This target is not so much like an aircraft carrier at night but more like an astronaut mission to Mars – the goal is large and clearly defined, and probably obtainable with the resources and knowledge at hand, but also very distant, costly, and time consuming such that it may not be worth pursuing.

Maybe a better option for now is to build a permanent space station, utilizing our current technology, equipment, and procedures. The agencies will work within their established framework set out in the Guidelines, but with an aim to acknowledge the intricacies not captured by economic indexes both in deciding whether to challenge the merger initially and in presenting the reasons for opposing the merger given those considerations. Courts will continue to go through the steps of the analysis, but within that analysis is discretion for judges to factor in special circumstances relevant to particular mergers in the healthcare field. With these mutual compromising adjustments, the general economic goals of the antitrust laws and the social policy needs of the healthcare field will be met.

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