Hospital mergers and antitrust policy: arguments against a modification of current antitrust law

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I. Introduction

America's hospital industry and antitrust enforcement agencies face a complicated dilemma. Many factors,[1] including the nation's economy, health care policy and technological advances have created an unprecedented health care crisis. As millions of Americans lose their health insurance and health care costs continue to

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[1] For the argument that the health care crisis is at least partially the result of lax enforcement of antitrust policies in the area of health care, *see* John J. Flynn, *Antitrust Policy and Health Care Reform*, 39 ANTITRUST BULL. 59, 72 (1994), arguing that a "30-year period of ignoring the antitrust laws and growing anticompetitive practices [has] ensued until a gradual and then a galloping increase in the cost for all forms of health care [has] began its seemingly inexorable rise" (citation omitted).

climb, the federal government has attempted to institute reforms, many of which are still being hotly debated. In the midst of this chaos, hospitals once encouraged to grow now face massive excess capacity. As a result of this pressure, competitors are merging at an unprecedented rate. Commentators, along with the hospital industry, now call for a suspension of merger enforcement, or at least a substantial change in policy. At the same instant, the enforcement agencies must review an increasing number of hospital mergers. This article will analyze the sources of this dilemma, the arguments for a change in enforcement policies, and whether these arguments are sound.

II. The development of the American hospital industry

A. *Excess capacity in the hospital industry*

Begining in the late 1940s and early 1950s, the federal government actively promoted health care. The government encouraged hospital expansion to meet the needs of the postwar baby boom.[2] The Hill-Burton Hospital Survey and Construction Act[3] offered a package of loans and grants for hospital construction, followed by Medicare[4] and Medicaid[5] that stimulated nonprofit hospital growth.[6] The rate of hospital growth eventually outstripped demand, resulting in excess capacity.[7] A second important factor in the growth of the hospital industry is the third-party payor system. Because the hospital is reimbursed by an insurance

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2 William G. Kopit, *Managed Competition, Antitrust, and the Clinton Health Reform Plan: Too Modest a Proposal*, HEALTHSPAN (No. 10, 1993, at 21).

3 42 U.S.C. §§ 291–291O (1982 & Supp. 1987).

4 42 U.S.C. §§ 1395–1395XX (1982 & Supp. 1987).

5 42 U.S.C. §§ 1396–1396p (1982 & Supp. 1987).

6 Katherine Kravitz, *Nonprofit Hospital Mergers and Federal Antitrust Law: The Quest for Compatibility*, 15 DEL. J. CORP. L. 539, 543 (1990).

7 For example, "in 1988 there was a daily surplus of 350,000 hospital beds for every 1 million Americans." *Id.* (citation omitted).

company rather than the consumer patient, there is little pressure to reduce costs.[8] In fact, nine-tenths of all hospital bills and three-quarters of all doctors' fees are paid by third-party providers.[9]

In the last decade, however, a shift in policy and a change in the nature of the predominant payment system have reversed incentives, resulting in a massive amount of excess capacity. First, there has been a shift in federal and state policy with regard to payment for services, away from a cost-based reimbursement approach. In 1983, a Prospective Payment System for Medicare reimbursement was instituted,[10] fixing reimbursement amounts at a set price based upon a given diagnosis, regardless of the actual cost to the hospital. Both states and private insurers followed suit, establishing similar payment plans.[11] The result was pressure to reduce the length and cost of an inpatient stay, which has led to a corresponding increase in excess hospital in-patient capacity.[12]

Second, "[h]ospital care that would have required an inpatient stay 10 years ago is now routinely delivered in the out-

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[8] For example, the American Hospital Association has noted that "[i]n 1990, there were about 248.6 million non-institutionalized persons in the United States. Approximately 14 percent of those persons had no insurance, 11 percent had Medicare, 7 percent had Medicaid, and the remaining 68 percent had insurance coverage from other sources." OFFICE OF THE GENERAL COUNSEL, AMERICAN HOSPITAL ASSOCIATION, HOSPITAL COLLABORATION: THE NEED FOR AN APPROPRIATE ANTITRUST POLICY 27 (1992) [hereinafter AHA White Paper] (citing CRS (Congressional Search Service) analysis of March 1991 Current Population Survey, *cited in* COMMITTEE ON WAYS & MEANS, UNITED STATES HOUSE OF REPRESENTATIVES, OVERVIEW OF ENTITLEMENT PROGRAMS: 1992 GREEN BOOK 312 (1992)).

[9] Kopit, *supra* note 2, at 22 (citing Lee & Lamm, *Europe's Medical Model*, N.Y. TIMES, Mar. 1, 1993).

[10] 42 U.S.C. § 1395ww (1982 & Supp. 1987).

[11] David L. Glazer, *Clayton Act Scrutiny of Nonprofit Hospital Mergers: The Wrong Rx for Ailing Institutions*, 66 WASH. L. REV. 1041, 1044 n.25 (1991) (citing AMERICAN HOSPITAL ASS'N (AHA), HOSPITAL STATISTICS: A COMPREHENSIVE SUMMARY OF U.S. HOSPITALS, xxxi (1990)).

[12] Kopit, *supra* note 2, at 21.

patient setting,"[13] broadening the field of competition for the provision of these services.[14] The increase in utilization of outpatient services, and the corresponding drop in the utilization of inpatient services, is the result of changing federal policies[15] and the development of medical technology.[16]

B. The failure of the American health care system

The American health care system cannot meet its citizens' needs. Rising health care costs[17] have produced less health care

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13 AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 1993–1994, at xi (1994) [hereinafter AHA, HOSPITAL STATISTICS 1993–1994]. At first glance, this fact appears to undermine the arguments for defining the relevant product market as inpatient hospital services. *See infra* notes 87–105 and accompanying text. However, the apparent contradiction can be reconciled if one accepts the contention that the market area of overlap between inpatient and outpatient services has been captured by the cheaper outpatient services. The remaining inpatient market is in demand by only those patients for which outpatient services are not adequate.

14 For example, whereas 86% of surgeries were done on an inpatient basis in 1979, only 50% were done on an inpatient basis 10 years later. Glazer, *supra* note 11, at 1044 n.25 (citing AHA, HOSPITAL STATISTICS 1993–1994, *supra* note 13, at xxxi, xli). This trend has been continuing for some time. Inpatient admissions fell steadily from 1983 through 1987, leading to 4 million fewer admissions in 1987 than in 1982, and those who were admitted stayed for a shorter period of time. William G. Kopit & Robert W. McCann, *Toward a Definitive Antitrust Standard for Nonprofit Hospital Mergers*, 13 J. HEALTH POL., POL'Y & L. 635, 636 (1988).

15 "The largest drops [in the number of inpatient days] occurred in 1984 and 1985 after implementation of Medicare prospective payment, when admissions and lengths of stay fell sharply. Between 1982 and 1992, total inpatient days declined by 20.5 percent, as a result of declining admissions and shorter hospital stays." AHA, HOSPITAL STATISTICS 1993–1994, *supra* note 13, at xii.

16 "Less invasive procedures made possible by advances in radiology and surgery have made diagnosis and treatment of disease less traumatic for patients and have allowed more care to be provided on an outpatient basis." *Id.* at xiv.

17 In 1991, health care expenditures were $751.8 billion, an increase of 11.4% over 1990. The government projection for 1992 is $819

for Americans.[18] An alarming number of Americans are losing their health insurance.[19] Each month, 2 million Americans become uninsured.[20] In California, the state with the highest rate of insurance loss, 306,000 Americans lose their health care each month.[21] In 1993, 35 million Americans were without health insurance.[22] Currently all uninsureds are estimated at 39 million, or a shocking 14.7 percent of the population.[23]

III. The increase in hospital mergers

In short, since "American hospitals are currently supporting a costly and underutilized infrastructure that was largely created by previous build and spend incentives,"[24] the hospital industry faces extensive excess capacity.[25] The hospital industry's

billion. "By the year 2000, national health spending is projected to increase to over $1.7 trillion, accounting for over 18 percent of Gross Domestic Product." AHA, HOSPITAL STATISTICS 1993–1994, *supra* note 13, at xxxiii–xxxiv. In 1994, Americans will spend $982 billion on health care services, nearly 14% of the gross domestic product. "If prices keep rising as they have, [Americans will] spend $2.1 trillion on health care in 2003, or 20 percent of [gross domestic product]." Donna Shalala, Secretary of Health and Human Services, *Health Care Reform Isn't Dead Here Are the Top 10 Reasons Why. . . .* , WASH. POST, Oct. 10, 1994, at A23.

18 Kopit, *supra* note 2, at 21.

19 This number is ever changing, as one person may gain health insurance as another loses it. The overall result, however, is a steady increase in the numbers of uninsured Americans.

20 *New Rules Clear Obstacles to Health Care Mergers*, BOSTON GLOBE, Sept. 16, 1993, at 21.

21 *Id.*

22 *Clinton Plan Seen as 'Scary' for Hospitals*, L.A. TIMES, April 11, 1993, § A, at 1.

23 Donna Shalala, *supra* note 17, at A23. If current trends continue, the number of Americans without health care in 2003 will be 43 million, or 15.7% of the total population. *Id.*

24 AHA White Paper, *supra* note 8, at 1.

25 Estimates as to the actual excess capacity vary. One congressman has complained of "the current state of 40 percent excess hospital capac-

solution[26] has been to seek mergers with competitors, rather than fight to the death.[27]

Various proposals exist for health care reform, which will probably involve some system of managed competition.[28] These proposals involve the creation of a government purchaser of health care similar to large Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) that will purchase health care for large segments of the populace. Because of the large amount of services to be purchased, large providers will be able to make the most competitive bids. Mergers are an obvious component of this positioning. "The hospital community is searching for ways to position itself for an enormous amount of change [and recent mergers are] a clear indicator that the industry

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ity." AHA White Paper, *supra* note 8, at 4 (citing Rep. Fortney H. Stark (D-Calif.), *Opening Statement at Hearings on The Structure of the Hospital Industry in the 21st Century Before the Subcommittee on Investment, Jobs and Prices of the Joint Economic Committee*, 102d Cong., 2d Sess. (June 24, 1992), transcript available from the Joint Economic Committee)).

26 The current administration has a similar goal, and "[e]limination of excess capacity is one of the most important goals for the administration's new [guidelines]." Antitrust Division, *New Rules Offer Hospitals Meager Relief*, DOJ ALERT, Oct. 4, 1993 [hereinafter DOJ ALERT].

27 "The intended results of mergers between hospitals are to reduce the excess capacity and minimize the duplication of services." Stephen Paul Paschall, *Antitrust and Hospital Mergers: A Law and Economics Rationale for Exemption*, 30 DUQ. L. REV. 61, 62 (1991); "Exempting nonprofit hospitals from . . . the Clayton Act can help . . . eliminate . . . excess capacity." Glazer, *supra* note 11, at 1056; "[M]ergers between nonprofit hospitals can . . . reduce excess hospital capacity and costs. . . ." Brian J. McCarthy & Toni Weinstein, *Special Strategies Sidestep Legal, Regulatory Obstacles to Health Care*, HEALTHSPAN (No. 4, 1994), at 7.

28 "Most of the proposals for health care reform that are currently being debated in Congress fall under the broad principles of 'managed competition.' Managed competition generally describes a regulated marketplace wherein health plans compete for clients on the basis of price and quality." Dennis A. Yao, et al., *Antitrust and Managed Competition for Health Care*, 39 ANTITRUST BULL. 301, 301–02 (1994).

believes that the arrival of national health care reform is going to require corporate entities of large size and scale."[29]

As a result, there has been an increase in the number of hospital mergers across the country. In 1991, twenty-three mergers involving fifty-three hospitals took place.[30] In 1992, forty-two acute care hospitals filed merger notifications pursuant to the Hart-Scott-Rodino Act.[31] In 1993, forty-eight acute care hospitals filed these merger notifications.[32] The enforcement agencies reported in September of 1993 that there have been "more than 200 hospital mergers in the United States since 1987."[33]

IV. Uncertainty among hospitals prevents mergers

As hospitals across the nation rush to restructure in response to the changing health care market, they face the prospect of investigation by, or litigation with, the antitrust enforcement agencies. In response, the hospital industry and some commentators argue that the prospect of litigation and the current state of the law give rise to a level of uncertainty that prevents procompetitive and efficient mergers that are necessary to the survival of the hospital industry.

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29 McCarthy & Weinstein, *supra* note 27, at 7.

30 *Hospitals Seek Ties to Compete in New Health Care System*, BOSTON GLOBE, June 27, 1993, at 16.

31 HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, UNITED STATES GENERAL ACCOUNTING OFFICE, REPORT TO THE HONORABLE FORTNEY H. (PETE) STARK, HOUSE OF REPRESENTATIVES, FEDERAL AND STATE ANTITRUST ACTIONS CONCERNING THE HEALTH CARE INDUSTRY, table 1, at 8 (1994) [hereinafter GAO REPORT]. For an explanation regarding the requirements for filing under Hart-Scott-Rodino, *see infra* notes 253–254 and accompanying text.

32 *Id.*

33 Department of Justice and F.T.C., *Antitrust Enforcement Policy Statements in the Health Care Area*, 4 Trade Reg. Rep. (CCH) ¶ 13,150, at 20,758 [hereinafter New Guidelines].

The American Hospital Association[34] and other health care providers[35] argue that neither written nor actual enforcement policies offer adequate predictive guidance to hospitals contemplating merger. The proposed "safety zones" offer only limited protection and a vague efficiencies defense. The position of the courts is equally confusing.[36]

The hospital industry argues that uncertainty prevents beneficial hospital mergers. "Hospital executives . . . [say] [m]any deals are scuttled before they get started . . . because hospitals and their lawyers are worried about running afoul of the law."[37] An investigation alone may be enough to deter hospitals contemplating mergers to cancel their plans. For example, in both Pennsylvania and Indiana, two hospitals in a three-hospital market canceled plans for consolidation in the face of investigations by the enforcement agencies.[38] Forty-four percent of hospital CEOs

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34 AHA White Paper, *supra* note 8, at 1, 21–25. "In March 1993, [the] AHA further claimed that the uncertainty of antitrust policy and the threat of enforcement has had a 'chilling effect' on attempts by hospitals to merge providers or to engage in joint ventures." GAO REPORT, *supra* note 31, at 1–2. "[S]ome have questioned whether the optimal reconfiguration of the health care industry can occur within the present legal framework established by the antitrust laws. One of the most prominent proponents of this view is the American Hospital Association." Richard E. Feinstein & Scott B. Whittier, *Health Care Antitrust Update* (PLI Comm. Law & Practice Course Handbook Series No. A-700, at 17 1994).

35 "[American Medical Association] General Counsel Kirk Johnson called the policy statements 'a step backward,' suggesting they had increased uncertainty." DOJ ALERT, *supra* note 26.

36 Thomas Campbell & James Teevans, *Mixed Signals: Recent Cases Make the Legality of Future Hospital Mergers Less Predictable*, 59 ANTITRUST L. J. 1005 (1991) (noting that the 7th and 4th Circuits "reached opposite results on *every* legal issue" in the *Rockford* and *Roanoke* merger cases, *infra* notes 41 and 42, even though the Department of Justice had treated the two mergers as twins) (emphasis added).

37 *Hospital Merger Plans Raise the Question: Is Bigger Better?*, L.A. TIMES, Mar. 6, 1994, Business at 1.

38 In Reading, Pennsylvania, the investigation was by the FTC. Dave Burda, *FTC, 2 Not-For-Profits Sign Antitrust Pact*, MODERN HEALTHCARE,

who responded to a survey by *Hospital* magazine acknowledged that antitrust concerns have slowed collaborative efforts among hospitals.[39] Hospital mergers decreased to pre-1987 levels after the Justice Department challenged[40] the mergers reported in *United States v. Carilion Health System*[41] (hereinafter "*Roanoke*"), and *United States v. Rockford Memorial*[42] (hereinafter "*Rockford*").[43]

Even if the merging hospitals had a reasonable probability of resisting a challenge, the prohibitive costs of litigation may be enough to act as a deterrent.[44] These costs include "significant

January 29, 1990, at 4. In Fort Wayne, Indiana, the investigation was by the DOJ. Dave Burda, *Indiana Hospitals Call Off Merger Following Probe*, MODERN HEALTHCARE, July 1, 1991, at 2 (cited in AHA White Paper, *supra* note 8, at 19).

39 J. Johnson, *Collaboration Grows Despite Antitrust Rules*, HOSPITALS, April 20, 1992, at 60 (cited in AHA White Paper, *supra* note 8, at 21).

40 AHA White Paper, *supra* note 8, at 22. Although the AHA argues that this statistic supports the conclusion that antitrust laws have slowed the pace of hospital mergers, there are other explanations. One argument is that the wave of mergers has reduced the worst of the excess capacity and further consolidation of the market will proceed at a slower pace.

41 707 F. Supp. 840 (W.D.Va. 1989), *aff'd*, 892 F.2d 1042 (Table, Text in WESTLAW, Unpublished Disposition, 1989 WL 157282, 1989-2 Trade Cas. (CCH) ¶ 68,859 (4th Cir. (Va.), Nov. 29, 1989) (No. 89-2625)).

42 717 F.Supp. 1251 (N.D.Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990), *cert. den.*, 498 U.S. 920 (1990).

43 Unless noted otherwise, all references to these decisions refer to the opinion written by the district court.

44 The cost of the *Ukiah* litigation, involving two small hospitals in northern California, was approximately $2.5 million in fees. David Olmos, *Mega-Medicine Hospital Merger Plans Raise the Question: Is Bigger Better?*, L.A. TIMES, Mar. 6, 1994, at D1. Frederic J. Entin, general counsel to the AHA, has said "[t]here's an unwillingness by hospitals to expose themselves to the expense and delay that an antitrust challenge might mean." *Id. See In re* Adventist Health System/West, Docket No. 9234, April 1, 1994, 5 Trade Reg. Rep. (CCH) ¶ 23,591 at 23,255 [hereinafter, *Ukiah*].

legal fees and fees for other attendant planning, development, and consultant services, lost staff time and effort, and, in some cases, the actual loss of funds invested in joint projects and/or the costs of dismantling the consolidated services or facilities."[45]

V. Sources of uncertainty—the FTC merger guidelines

In support of their arguments, commentators claim that government policy statements are contradictory and offer little guidance. The New Guidelines create "safety zones" wherein the enforcement agencies will not seek to enforce the antitrust laws, unless the circumstances are "extraordinary."[46] Hillary Clinton has said that these guidelines "allow mergers that are competitive and save consumers money."[47] However, at the Department of Justice (DOJ), "the Antitrust Division is moving dramatically toward more aggressive enforcement that seemingly discourages consolidation [between hospitals]."[48] Often, the result of such inconsistent statements is confusion.[49] Even though very few hospital mergers are challenged,[50] a review of the enforcement actions

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45 AHA White Paper, *supra* note 8, at 21 n.60.

46 NEW GUIDELINES, *supra* note 33, at 20,758. *Feds Offer Antitrust 'Safety Zone' to Hospitals*, ATLANTA JOURNAL, Sept. 15, 1993, at C3.

47 281 Trade Reg. Rep. (CCH) 7 (1993).

48 DOJ ALERT, *supra* note 26. In fact, "on the same day president Clinton was talking to delegates of the AMA about the government providing some relaxation of antitrust . . . enforcement relating to doctors, the FTC Assistant Litigation Director responsible for the health care area was in Washington speaking in favor of vigorous enforcement of antitrust laws pertaining to doctors." Robert J. Enders, *Antitrust Issues Under Health Care Reform*, 16 WHITTIER L. REV. 117, 136 (1995).

49 "Some argue that Clinton's plan—intended to encourage cooperative ventures among health care providers and thus help control costs—doesn't always jibe with the Administration's push for tough enforcement of antitrust laws." Olmos, *supra* note 44, at D1.

50 Of 397 acute care hospital mergers reviewed by DOJ or FTC during the 13-year period from fiscal year 1981 through fiscal year 1993, less than 4% were challenged. For an additional 13% of these mergers,

taken by the DOJ and the FTC shows a marked increase in recent years. Between 1981 and 1986 the average number of preliminary investigations of acute care hospital mergers per year was 3.33, whereas the number of investigations from 1987 through 1993 was a little over twice that, with an average of 6.86 investigations per year.[51]

The enforcement agencies have issued policy statements in the form of antitrust merger guidelines. Both enforcement agencies will use the 1992 Guidelines in conducting merger analysis.[52] However, a new set of guidelines was issued on September 15, 1993,[53] tailored to respond to health care concerns[54] and directed specifically to hospital mergers.[55]

DOJ or FTC conducted a preliminary investigation and then allowed the mergers to go forward. The remaining 83% of cases involved no more than the required initial filing of notice of proposed merger; that is DOJ or FTC did not seek any further data about the mergers and allowed them to go into effect. GAO REPORT, *supra* note 31, at 2.

51 Figures calculated from information reported in GAO REPORT, *supra* note 31, at table 1, p. 8. It should also be noted that while the average number of investigations doubled, the average number of Hart-Scott-Rodino filings also increased, almost doubling. *Id.*

52 The 1992 Guidelines "mark[ed] the first time that the two Federal agencies that share antitrust enforcement jurisdiction have issued joint guidelines." Department of Justice and F.T.C., 1992 Horizontal Merger Guidelines, 57 Fed. Reg. 41,552 (1992) [hereinafter 1992 Guidelines]. Despite the fact that both agencies have adopted the same guidelines, each agency still has discretion as to how to interpret and enforce them.

53 New Guidelines, *supra* note 33, at 20,755.

54 On September 27, 1994, the DOJ and the FTC released a revised version of these guidelines. Department of Justice & F.T.C., *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust*, 4 Trade Reg. Rep. (CCH) ¶ 13,152 at 20,769 (Sept. 27, 1994). However, the section addressing hospital mergers changed only three words, and these changes were not substantive. From this it can be determined that the enforcement agencies are satisfied with the approach outlined in the earlier version. Accordingly, the phrase "New Guidelines" covers the same rules in either instance, but refers specifically to the citation at *supra* note 33.

55 New Guidelines, *supra* note 33, at 20,755.

The New Guidelines recognize the problems of applying current antitrust law to health care.[56] However, the hospital industry argues that the New Guidelines do not solve the problem of uncertainty[57] for hospitals contemplating merger.

A. The New Guidelines

The New Guidelines create a "safety zone" wherein hospital mergers won't be challenged, absent "extraordinary circumstances."[58] The agencies will not challenge mergers between two acute care hospitals where, in the three previous years, one hospital has: (1) less than 100 licensed beds; and (2) less than forty inpatients per day.[59] However, the safety zone does not apply if the hospital is under 5 years old.[60] Should merging hospitals find themselves within the safety zone, any anticompetitive effects are

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56 "Policy statements like those concerning health care regulation provide insights into how the Antitrust Division views a complex and emerging new area of litigation." JOHN J. FLYNN & HARRY FIRST, ANTITRUST: STATUTES, TREATIES, REGULATIONS, GUIDELINES, AND POLICIES iii (1994). The DOJ has also published draft antitrust guidelines for international operations and for the licensing and acquisition of intellectual property.

57 The problem of uncertainty is not unique to hospitals. In 1984, the DOJ noted that by a public statement of enforcement policy "the Department hopes to reduce the uncertainty associated with enforcement of the antitrust laws in [the] area [of mergers]." Department of Justice, 1984 Merger Guidelines, 49 Fed. Reg. 26,283, 26,827 (1984).

58 New Guidelines, *supra* note 33, at 20,758.

59 *Id.*

60 *Id.* The rationale is twofold, first that a hospital of such a small size that has less than 100 licensed beds is likely to be the only hospital in the relevant market and therefore will not compete with other hospitals. Therefore, there is no danger to competition in the event of a merger with another hospital. Second, the agencies also believe that small hospitals, especially those in rural areas, would be more likely to achieve cost-saving efficiencies through a merger with a larger hospital. *Id.*

ignored.[61] However, this is the end of the much hailed hospital safety zone.[62]

Perhaps as consolation, the New Guidelines identify three considerations that could defeat the conclusion that a merger "would otherwise raise an inference of anticompetitive effects."[63] These considerations apply where the merger does not increase the likelihood of excessive market power due to remaining competition or because of sufficient differentiation between hospitals,[64] the hospitals would realize significant cost savings,[65] or the merger would eliminate a hospital that would fail anyway.[66] Finally, the New Guidelines offer the option of a business review or an advisory opinion.[67]

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61 Except, of course, in the event of "extraordinary circumstances," which are never specifically defined. The vague nature of the term "extraordinary circumstances" may offer little security to a hospital in a limited geographic market, whose merger with another may significantly raise market concentration or involve other indicia of anticompetitive behavior. Since almost any merger will do both of these, hospitals will want to examine whether they are creating "extraordinary circumstances." The enforcement agencies offer little by way of definition for this phrase, noting only that "the Agencies anticipate that extraordinary circumstances warranting a challenge to such conduct will be rare." New Guidelines, *supra* note 33, at 20,757 n.2.

62 And, it has been noted, in some cases the New Guidelines "actually shrink the safe harbors that applied during the Reagan Administration." David L. Meyer & Charles F. (Rick) Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169, 173 (1994).

63 New Guidelines, *supra* note 33, at 20,758.

64 *Id.*

65 *Id.*

66 *Id.*

67 *Id.* Review is sought under either the DOJ's business review procedure (28 C.F.R. § 50.6 (1992)), or the FTC's advisory opinion procedure (16 C.F.R. §§ 1.1–1.4 (1993)). The agencies promise to conduct this review within 90 days of receipt of "all necessary information." According to Anne K. Bingaman, head of the DOJ's Antitrust Division, the agencies have completed every review sought within the 90-day

Despite the New Guidelines assertion that hospital merger analysis is now simple,[68] gaps leave hospitals in the dark on many important issues. First, although safety zones provide refuge, they are so limited that very few hospitals fall comfortably within them,[69] and it has been argued that the limited exemption will lead to inconsistent enforcement,[70] which may send mixed signals to the hospital industry. Once merging hospitals are excluded from a safety zone and fall within the control of the 1992 Guidelines, a fact-intensive merger analysis mandates that each situation will be analyzed separately.[71] As a result, virtually no hospital contemplating merger can be certain of its protection.

B. The 1992 Guidelines

In the New Guidelines, the enforcement agencies offer the consolation that "hospital mergers that fall outside the antitrust

period. Anne K. Bingaman, *Address at the Utah Law Review Antitrust Policy and Health Care Reform Symposium*, University of Utah College of Law (Oct. 5, 1994).

68 The New Guidelines proclaim that "the competitive effect of many hospital mergers is relatively easy to assess." New Guidelines, *supra* note 33, at 20,757.

69 For example, 60% of hospitals in this country have more than 100 beds, and hospitals with 100 or fewer beds represent only 15% of hospital beds in the country. *See* Kopit, *supra* note 2, at 22–23. Also, the trend of hospital mergers presumably means larger hospitals with more beds. "[B]ecause the safety zone is limited to small hospitals . . . it is unlikely to apply to many transactions other than those involving small rural hospitals." David Marx, Jr. & Roxane C. Busey, *Insights for Hospitals: The 1994 Health Care Antitrust Enforcement Policy Statements*, 28 J. HEALTH & HOSP. L. 143 (1995).

70 This argument has even been advanced by Deborah K. Owen, a Commissioner of the FTC, leading her to dissent from the policy statements themselves. For a discussion of her argument, *see* Steven Zoric, *Antitrust Enforcement Guidelines for Providers in the Wake of Health Care Reform*, J. HEALTH & HOSP. L. 359, 363 (1993).

71 The 1992 Guidelines note that "the specific standards [the 1992 Guidelines] set out must be applied in widely varied factual circumstances, mechanical application of those standards could produce misleading results." 1992 Guidelines, *supra* note 52, at 41,552.

safety zone are not necessarily anti-competitive and may be pro-competitive."[72] The agencies refer potential violators to the 1992 antitrust guidelines.[73] This reference offers little solace to the hospital industry, it is argued, because "neither the 1992 Guidelines nor any other policy pronouncements by the enforcement agencies enable hospitals to clearly distinguish the circumstances in which their specific collaborative arrangement would, in fact, be challenged from those in which it would not."[74]

Any policy statement is somewhat vague in some aspects, leaving those who fall into the gray areas with little guidance for their behavior.[75] One problem faced by the hospital industry is the emphasis on market concentration by the 1992 Guidelines[76] as a key factor in determining the legality of a proposed merger.[77]

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72 New Guidelines *supra* note 33, at 20,758.

73 *Id.*

74 AHA White Paper, *supra* note 8, at 24.

75 For a thoughtful summary of the evolution of the guidelines, and discussion regarding ambiguities in the guidelines that make them difficult tools for predicting enforcement agency reactions to a given transaction, *see* William Blumenthal, *Ambiguity and Discretion in the New Guidelines: Some Implications for Practitioners*, 61 ANTITRUST L. J. 469 (1993).

76 For an in-depth statistical analysis of the HHI as applied to hospital mergers, *see* Gloria J. Bazzoli et al., *Federal Antitrust Merger Enforcement Standards: A Good Fit for the Hospital Industry?*, 20 J. HEALTH POL. POL'Y & L. 137 (1995), and the response by Gregory Vistnes, *Hospital Mergers and Antitrust Enforcement*, 20 J. HEALTH POL. POL'Y & L. 175 (1995).

77 This approach is a direct result of the analysis done by the Supreme Court in *Philadelphia Bank*, where the Court found that "a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market, is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects." United States v. Philadelphia National Bank, 374 U.S. 321, 363 (1963).

The enforcement agencies currently[78] measure market concentration using the Herfindahl-Hirschman index (HHI).[79] The HHI attempts to remove the difficulties of determining the anticompetitive effects of different market concentration levels by assigning a numerical figure to the process. The HHI puts a numerical value on a market's concentration by summing the squares of the individual market participants' percentage shares of the market. The 1992 Guidelines dictate that a postmerger HHI above 1800 indicates a "highly concentrated" market,[80] and any such merger that has increased the HHI by more than 100 points is "presumed . . . to create or enhance market power or facilitate its exercise."[81]

The HHI may be ill suited to application to the hospital industry. As early as 1984 some scholars noted that "[t]he application . . . of an index developed in and for other industrial and retail settings may not prove sound in analyzing hospital mergers."[82] Of particular difficulty is the fact that almost all hospital geographic markets start out with an HHI index of over 1800.[83] Therefore,

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78 Prior to 1982, the year that the DOJ adopted the HHI, the agency used a four-firm concentration ratio to calculate the level of concentration in a market. The method sums the market shares of the four largest firms. The HHI is more accurate because it "reflects a higher market concentration as the disparity in the size of firms increases and as the number of firms outside the largest four . . . decreases." F.T.C. v. University Health Inc., 938 F.2d 1206, 1211 n.12 (11th Cir. 1991).

79 The Herfindahl-Hirschman index was introduced into the guidelines in 1982. Department of Justice, Merger Guidelines, 47 Fed. Reg. 28,493, 28,497 (1982).

80 A market with an HHI below 1000 is labelled as "unconcentrated" and a market with an HHI between 1000 and 1800 is labelled "moderately concentrated." *See* 1992 Guidelines, *supra* note 52, at 41,558. These distinctions are of little use to hospitals, however, because most hospital markets begin with a HHI of over 1800. *See infra* note 83.

81 1992 Guidelines, *supra* note 52, at 41,558.

82 Carl J. Schramm & Steven C. Renn, *Hospital Mergers, Market Concentration and the Herfindahl-Hirschman Index*, 33 EMORY L.J. 869, 870 (1984).

83 *Id.* at 874. *See also* Kopit & McCann, *supra* note 14, at 640 noting that "[g]enerally, a market would have to have more than six hospitals in

"[m]ost hospital markets are considered to be highly concentrated because most communities have only a few hospitals, and patients generally do not consider hospitals outside their communities to be acceptable alternatives for most procedures."[84] Because of this, "in more than 80 percent of the United States communities that have more than one hospital, any reduction in the number of hospitals, through merger or acquisition, is presumptively illegal under the 1992 Guidelines."[85] Accordingly, it is practically impossible for merging hospitals to stay below the presumptively illegal concentration threshold of the guidelines.

Therefore, refererence to the 1992 Guidelines offers little or no guidance to hospitals contemplating mergers because the nature of the market is such that hospitals already appear to be presumptively violating the laws. Furthermore, if a merger would not reach the threshold of the HHI as interpreted by the enforcement agencies, it will still be illegal under the Clayton Act if the effect of the merger "may be substantially to lessen competition,"[86] regardless of the concentration ratio. Therefore, threat from civil litigants or a change in policy by the enforcement agencies remains a potential, albeit perhaps distant, deterrent to hospitals contemplating merger.

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order for a merger of any two to produce an HHI of less then [sic] 1,800." In fact, all communities with five or fewer hospitals will have a HHI of more than 1800. The AHA explained that "[t]he lowest possible HHI value in a given market will occur when all firms have an identical market share, a highly unusual circumstance. For a market with six firms, the lowest HHI value is 1,668; for a market with five firms, it is 2,000." AHA White Paper, *supra* note 8, at 13.

84 AHA White Paper, *supra* note 8, at 3 n.6.

85 *Id.* at 13 (citing Robert W. McCann & William K. Kopit, *The Government's Hospital Merger Policy* (1990) (unpublished manuscript, on file with Epstein Becker & Green, P.C.), *cited in* ADVISORY COUNCIL ON SOCIAL SECURITY COMMITMENT TO CHANGE: FOUNDATION OF REFORM 126 (1991)).

86 Clayton Act, 15 U.S.C. § 18 (1988).

VI. Sources of uncertainty—current antitrust law as applied to hospital mergers

Unfortunately, the developed case law offers only slightly more guidance than the enforcement agency's guidelines. In all four steps of the traditional antitrust merger analysis, uncertainty persists because different outcomes have resulted from arguably similar fact situations. The effect, argue commentators and the hospital industry, is that there is little predictive value from the developed case law, and even more reason for uncertainty by hospitals contemplating merger.

A. Defining the relevant market

1. PRODUCT MARKET Defining the product market for hospital health care is difficult because it is essentially unique to each consumer, as each patient needs treatment specifically tailored to his or her illness or injury. Similarly, each physician has different treatment preferences. Generalizations regarding the product market definition are therefore necessary, but because of the fact-intensive nature of the analysis, confusion is often the result. Unfortunately, judicial decisions have the strange effect of complicating, rather than clarifying the product market for hospitals contemplating merger. This incongruity in the case law also applies to the areas of jurisdiction, geographic market, and determination of the likelihood of a reduction of competition.

Both the DOJ[87] and the FTC[88] have consistently argued that the product market should be defined as acute inpatient

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87 "[T]he [Justice Department] proposes that inpatient care is the relevant product market to be examined, while the defendants proffer a broader product market that includes both inpatient and outpatient care provided by all health care providers." *Rockford, supra* note 42, at 1259. "The [Justice Department] . . . contends that the district court was in error in failing to find that the product market is acute inpatient services." *Roanoke, supra* note 41, at 1042.

88 For example, in summarizing the analytical framework of the 1992 Guidelines, the FTC noted that "[g]enerally, the product market in which hospital mergers are analyzed is general acute care hospital

care.[89] This argument has prevailed in part, and failed in part. In challenging this characterization, defendants attempt to broaden the product market by including outpatient care services.

One argument is that outpatient care should be included because many of the same services that are provided by inpatient care can be provided by outpatient clinics.[90] Therefore, the argument goes, any increase in price as a result of a merger between two hospitals will simply encourage patients to shift to outpatient services.[91] However, this argument was rejected in both *Hospital Corporation of America v. F.T.C.*[92] *[HCA]* and *Rockford. HCA* involved the merger of two hospitals in Chattanooga, Tennessee. In affirming the FTC ruling, Judge Posner noted that "most hospital services cannot be provided by non-hospital providers."[93] Another argument raised by the defense in *HCA* was that hospital services are customized to a particular patient.[94] The court summarily rejected this idea, noting that customized services in the hospital industry were "no greater than in other markets"[95] and

services. The Commission has explored, however, a number of unspecified 'alternate product market definitions.' " Toby G. Singer, *Recent Developments in Antitrust Enforcement: Hospital Mergers* (PLI Comm. Law & Practice Course Handbook Series No. A4-4455 1994) (citing Letter from Donald S. Clark, Secretary, Federal Trade Commission to Senator Orrin G. Hatch (June 8, 1993).

89 In *Ukiah*, even the defendant's expert "agreed that most economists who study the hospital industry consider [the provision of inpatient acute care hospital services] to be the appropriate market in which to analyze hospital competition." *Ukiah, supra* note 44, at 23,257.

90 *Rockford, supra* note 42, at 1259; *Roanoke, supra* note 41, at 843.

91 *Rockford, supra* note 42, at 1259; *Roanoke, supra* note 41, at 844–45.

92 807 F.2d 1381 (7th Cir. 1986), *cert. denied,* 41 U.S. 1038 (1987) (*aff'g* In re HCA, 106 F.T.C. 436 (1985)).

93 *Id.* at 1388.

94 *Id.* at 1390.

95 *Id.* This raises the implication, perhaps unintended, that the court might consider the product market differently if the defendant had proven

that "the fact that hospitals provide different mixtures of service seems irrelevant to the feasibility of collusion."[96]

The *Rockford* court went into greater detail. In *Rockford* the two largest hospitals in Rockford, Illinois, attempted to merge. The district court began by citing language from *Brown Shoe*, and then held that "the service market in which the impact of a merger is measured should include services with sufficiently peculiar characteristics and uses to constitute them [sic] products sufficiently distinct from all others."[97] The court made a number of observations in rejecting the inclusion of outpatient services in the product market.

First, the court recognized that the structure of the industry is such that third-party payors are responsible for most payments to a hospital. Because third-party payors are attempting to contain costs, "only patients who are too 'sick' to receive out-patient care [or where no comparable outpatient treatment is available] receive in-patient care."[98] In other words, inpatients don't have a choice about accepting or purchasing services, and therefore there is no elasticity of demand because a price increase will not lead these sick patients to shift to outpatient services. The *Rockford* court found that although certain services may be provided both on an inpatient and outpatient basis, it is the nature of the in-patient's illness and the requirement that he or she receives multiple types of services that defines the relevant product market for hospital services.[99] The *Rockford* court concluded its analysis by adopting the definition used by the court in *HCA*, finding "that the relevant product market consists of that cluster of services offered only by acute care hospitals."[100]

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that the provision of services was so customized that these services did not compete with one another.

96 *Id.*

97 *Rockford, supra* note 42, at 1259.

98 *Id.*

99 *Id.*

100 *Id.* at 1261.

By contrast, in *Roanoke*[101] the district court included outpatient services in the product market. This was appropropriate because the court found sufficient choice between inpatient and outpatient care in "a significant number of cases"[102] and that "certain clinics and other providers of outpatient services compete with the defendants' hospitals to treat various medical needs."[103] One problem with the court's rationale, however, is that the court never defines what constitutes a "significant number" of cases, or even presents any statistics or details of specific testimony.[104]

Because of the split between the Seventh and Fourth Circuits, the value of these decisions for hospital decisionmakers contemplating mergers is uncertain. Perhaps in recognition of the uncertain outcome of litigation in this area, or a concensus that the position of the enforcement agencies will prevail, recent litigants have stipulated to acute care inpatient services as the relevant market.[105] Regardless, it is almost certain that enforcement agencies will continue to argue for product markets limited to acute inpatient care, while defendants will want outpatient services included.

2. GEOGRAPHIC MARKET A geographic market constitutes the area within which merging hospitals draw their patients. Thus, the product market becomes a factor in determining the geographic market for an inpatient hospital because certain patients will travel farther (expanding the geographic market) for certain types of specialized care that may not be offered in a nearby area.[106]

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101 *Roanoke, supra* note 41, at 844–45.

102 *Id.*

103 *Id.* at 845.

104 In fact, although this finding was upheld on appeal, the Fourth Circuit thought "the district court may not have stated its findings with the precision that would facilitate appellate review." United States v. Carilion Health System, 892 F.2d 1042, 1989 WL 157282 at **3 (4th Cir. 1989).

105 U.S. v. Mercy Health Services, 902 F. Supp. 968, 976 (N.D. Iowa 1995); F.T.C. v. Freeman Hospital, 69 F.3d 260, 268 (8th Cir. 1995).

106 *Rockford, supra* note 42, at 1276.

A broader market will have more providers, thereby reducing the cross elasticity of demand, because patients will be able to travel to another provider within the geographic market in the event of a raise in price.

The *Rockford* and *Roanoke* decisions again invite comparison. In *Rockford*, the court did not include outlying areas in the relevant product market,[107] found a violation of the Clayton Act,[108] and enjoined the merger. In *Roanoke*, by contrast, the court included outlying areas in its analysis,[109] and allowed the merger,[110] although it applied the rule of reason analysis of the Sherman Act rather than the incipiency test of the Clayton Act.[111]

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107 *Id.* at 1285. In fact, the *Rockford* court termed the defendant's contention that outlying areas should be included in the geographic market "ridiculous." *Id.* However, the *Rockford* approach has since been explicitly rejected. *Mercy, supra* note 105, at 986; *Freeman, supra* note 105, at 271 n.16.

108 *Rockford, supra* note 42, at 1287.

109 *Roanoke, supra* note 41, at 848–49.

110 *Id.* at 844, 847.

111 *Id.* at 846. The language of the two acts is clearly different, and a challenge under the Sherman Act appears to be more difficult because it involves the need to prove either anticompetitive intent or effect. Times-Picayune Publishing Co. v. United States, 345 U.S. 594, 614 (1953). The language of the Clayton Act appears to require less certainty because the act prohibits actions where "the effect . . . *may* be substantially to lessen competition." 15 U.S.C. § 18 (1988) (emphasis added). As to the practical effect of the two acts, there is a difference of opinion, with some arguing that the Clayton Act and Sherman Act apply different standards. *See* PHILLIP AREEDA & DONALD E. TURNER, ANTITRUST LAW ¶ 304 (1978). *See also* American Bar Ass'n, *Seventh Circuit Says No to Rockford Merger*, 4 HEALTH LAWYER 1 (1990). There have been suggestions that the differences between the two acts are not so dramatic, despite the different language. *See Philadelphia Bank*, 374 U.S. at 355 ("[T]he tests of illegality under the Sherman and Clayton Acts are complementary"); Brown Shoe v. United States, 370 U.S. 294, 317 n.30 (1962); U.S. v. Penn-Olin Co., 378 U.S. 158, 170–71 (1964) ("Overall, the same considerations apply to joint ventures as to mergers, for in each instance we are but expounding a national policy enunciated by the Congress to preserve and promote a free competitive economy"). In *Roanoke*, the

The impact of the choices of geographic markets on the final decision is, of course, debatable,[112] but the differences in the decisions highlight the importance of defining geographic markets. One author has written that different "boundaries played a significant, if not definitive, role in producing the different outcomes in the two cases,"[113] and this conclusion appears to remain correct.[114]

Fourth Circuit noted that "[t]he government believes that the Supreme Court eliminated any [analytical] distinction [between the Sherman Act and Clayton Act] in United States v. First National Bank of Lexington, 376 U.S. 665 (1964)." *Roanoke, supra* note 41, at **4 n.1. The *Mercy* court also explicitly adopted this view, noting that "Section 1 of the Sherman Act requires the same analysis" as section 7 of the Clayton Act. *Mercy, supra* note 105, at 975 (citations omitted).

112 The difficulty is that the *Roanoke* court did three things differently than the *Rockford* court. First, the Sherman Act rule of reason test was applied instead of the incipiency standard of the Clayton Act. Second, the product market was found to include outpatient services. Finally, the geographic market was defined to include outlying areas. It is impossible to tell if any single factor was responsible for the different results in the two cases, or if it was a combination of these factors. *See supra* note 36, noting that the two courts reached different results on almost every issue.

113 Jack Zwanziger et al., *Hospital and Antitrust: Defining Markets, Settting Standards*, 19 J. HEALTH POL. POL'Y & L. 423, 425 (1994). In the *Ukiah* case, the Commissioner noted the importance of the geographic market, noting that "[t]he *dispositive issue* is whether the town of Ukiah, California and its immediate environs is a relevant geographic market." *Ukiah, supra* note 44 at 23,256 (emphasis added).

114 *See Mercy, supra* note 105, at 987 (holding that because "[t]he government has failed to establish the relevant geographical area" it has "failed to establish that the merger . . . will likely result in anticompetitive effects"); *Freeman, supra* note 105, at 272 (refusing to enjoin a hospital merger where the FTC "failed to meet its burden of establishing the relevant geographic market" because "identification of a relevant market is a 'necessary predicate' to a successful challenge under the Clayton Act").

B. Substantial lessening of competition

Once the product and geographic markets have been determined, the next step in the analysis is to determine whether the effect of the proposed merger "may be to substantially lessen competition" or tend to create a monopoly. This is the "incipiency standard."[115] The enforcement agencies and private plaintiffs only need show a probability that competition will be lessened. The courts and the enforcement agencies have different methods for determining whether a merger creates the likelihood of substantially lessening competition. Within each of these approaches, there are a number of factors that play a role in evaluating the anticompetitive effects of a hospital merger.

1. THE 1992 GUIDELINES TEST The 1992 Guidelines[116] initial focus is on concentration in the market. The enforcement agencies note that "[o]ther things being equal, market concentration affects the likelihood that one firm, or a small group of firms, could successfully exercise market power."[117] The result of an increase in market concentration is an increased likelihood of a lessening of competition through either coordinated action[118] or the effect of concentration such that a unilateral restriction on output will yield

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115 *See Brown Shoe*, 370 U.S. at 317–18, n.32 and United States v. E.I. Du Pont de Nemours & Co., 353 U.S. 586, 589 (1957) ("Section 7 is designed to arrest in its incipiency . . ."); *Mercy, supra* note 105, at 975 (citing *Du Pont*). However, in *HCA*, Judge Posner seemed to lean more toward requiring certainty than incipiency, when he argued that "the ultimate issue is whether the challenged acquisition is *likely* to facilitate collusion." *HCA, supra* note 92, at 1386 (emphasis added). Judge Posner seemed to correct himself later in the opinion, however, when he noted that "[a]ll that is necessary is that the merger create an appreciable danger of [higher prices] in the future" and that this judgment is "probabilistic" rather than "demonstrable." *Id.* at 1389.

116 The approach of the 1992 Guidelines is analyzed because these are the guidelines that will be used by the enforcement agencies in the event a hospital merger does not fall within the safety zones defined under the New Guidelines. *See supra* note 73 and accompanying text.

117 1992 Guidelines, *supra* note 52, at 41,558.

118 *Id.*

an increase in price.[119] After this analysis, the 1992 Guidelines take into consideration the difficulty of entry,[120] efficiencies,[121] and failing firm analysis.[122]

2. THE JUDICIAL TEST The courts apply an approach similar to that of the enforcement agencies in determining whether a merger will substantially lessen competition. For example, in determining the anticompetitive effect of a hospital merger, the *Rockford* court noted that the incipiency standard applies to hospital mergers:

> proof of actual anti-competitive practice is not required; rather evidence that these practices are likely to occur in the future is all that is necessary. This standard allows anti-competitive tendencies to be arrested in their "incipiency."[123]

In deciding whether a hospital merger will violate the incipiency standard, different courts rely upon different factors.[124] In *Rockford*, the district court listed four factors for evaluating the competitive effect of the merger. These were market concentration, barriers to entry, the nature of the competition, and the market participants.[125] The *HCA* court, by contrast, considered the elasticity of the demand for hospital services, the tradition of cooperation among hospitals in the relevant geographic market, and the pressure that hospitals were feeling from third-party payors as providing a motivation for collusion.[126]

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119 *Id.* at 41,560.

120 *Id.* at 41,561.

121 *Id.* at 41,562.

122 *Id.*

123 *Philadelphia Bank*, 374 U.S. at 362 (citing *Brown Shoe*, 370 U.S. at 317, 322).

124 The *Roanoke* court addressed market concentration, but found that the market proposed by the government was inaccurate, that competing hospitals existed in the market, the merger was designed to strengthen competition, and the nonprofit status of the merging hospitals weighed in favor of the merger. *Roanoke, supra* note 41, at 848–49.

125 *Rockford, supra* note 42, at 1278.

126 *HCA, supra* note 92, at 1388–89.

3. FACTORS IN DETERMINING THE LIKELIHOOD OF SUBSTANTIALLY LESSENING COMPETITION[127]

(a) Market shares and concentration The primary method for determining whether a merger results in a percentage of the market high enough to create the likelihood of a decrease in competition, is an analysis of concentration and market shares that results from the merger,[128] although once the government has made its prima facie case, "the defendants can overcome the presumption of illegality by showing that the market-share analysis gives an inaccurate reflection of the acquisition's probable effect on competition within the relevant market."[129]

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127 One argument that should be mentioned, but which deserves no more than a footnote, is the defense argument in *HCA* that the cancellation of a management contract after the acquisition could have been an attempt at improving the hospital's litigation position. This argument was quickly dismissed by the *HCA* court, which held that "[p]ost acquisition evidence that is subject to manipulation by the party seeking to use it is entitled to little or no weight." *HCA, supra* note 92, at 1384.

128 The Supreme Court in *Philadelphia Bank* noted that "competition is likely to be greatest when there are many sellers, none of which has any significant market share." *Philadelphia Bank,* 374 U.S. at 363. Similarly, the DOJ has noted that the converse is true, and that "[w]here only a few firms account for most of the sales of a product, those firms can in some circumstances either explicitly or implicitly coordinate their actions in order to approximate the performance of a monopolist." 1984 Merger Guidelines, *supra* note 57, at 26,827.

129 *Mercy, supra* note 105, at 976. The defendant hospitals were successful in making such a showing with regard to the geographic market in *Mercy*, where the court noted that "[t]he analysis must focus not merely on where patients have gone for acute inpatient services, but where they practicably could go." *Id.* at 978 (citations omitted). The court then found that such alternatives existed, and that the merger was therefore not anticompetitive. *Id.* at 982–83, 985–86. It is impossible to predict whether this approach will be successful in other markets, or if it was a result of the specific dynamics of the demographics of Dubuque, Iowa. Regardless of the answer, the outcome of future litigation remains uncertain, and it is this uncertainty that has led to the cry for a modification of antitrust law as applied to hospital mergers.

The simplest method is to review the number of competitors and their percentage of the market share, the percentage of the market eliminated by the merger, and the percentage of the market that remains in the hands of the merged entity. This approach is simple and understandable. In *Philadelphia Bank*, for example, the Supreme Court compared the percentage of the market controlled by the two largest firms before and after the merger. Prior to merger, the two largest firms controlled 44% of the market.[130] After the merger they controlled 59%.[131] Similarly, the *Rockford* court noted that the percentages after the hospital merger would have been either 64% (if beds were measured), 68.2% (if admissions were measured), or 72.4% (if patient days were measured).[132] Using a slightly different method of stating similar statistics, the *HCA* court found that the postmerger market share was approximately 25%, and that 12% of the market was eliminated.[133] In both these cases, the mergers were enjoined. Unfortunately, neither opinion details how much weight these figures played in their final decisions, leaving hospitals contemplating mergers to guess as to the significance of postmerger market share analysis.

In *Rockford*, the court noted that control over a large enough percentage of the market (if, for example, the entity resulting from the merger would control 90% of the market) was enough by itself to create an irrebuttable inference of decreased competition.[134] In fact, the concentration percentage does not have to be this dramatic for a court to find that a merger will likely foster collusion and, therefore, hurt competition. For example, in *HCA*, 12% of the market was eliminated and the acquiring firm ended up with a 25% share, leading the court to observe that "the fewer

130 *Philadelphia Bank,* 374 U.S. at 365.

131 *Id.*

132 *Rockford, supra* note 42, at 1281.

133 *HCA, supra* note 92, at 1387. The court did not specify which type of data it was using in these calculations.

134 *Rockford, supra* note 42, at 1281.

the remaining competitors of any significance . . . the easier market dominance and/or collusion can be achieved."[135]

However, it is important to note that straight numbers may not be dispositive. For example, in *HCA*, after the merger HCA owned or managed five of eleven hospitals in the area and their market share increased from 14% to 26%.[136] However, the court noted that if the percentages were smaller, the loss of four competitors "would not be very important."[137]

The HHI is also used to measure market concentration. The *Rockford* court measured the HHI using three different variables, the "state inventoried beds, inpatient admissions and inpatient days."[138] As mentioned, the application of HHI analysis to hospital mergers almost always results in a finding of a concentrated market.[139] In *Rockford* the court noted that "[a]s measured by the HHI the concentration of the relevant market almost doubles" and that this was "particularly significant."[140] The reference to doubling is an observation, not a standard, but it may indicate that the court would have found a lesser concentration less troubling.[141]

(b) Barriers to entry Another consideration used by both the enforcement agencies and the courts in determining the competi-

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135 *HCA, supra* note 92, at 1387. The district court in *Rockford* adopted this language in reaching its decision. *See supra* note 42, at 1280. It could be argued that if precedent is to be followed in the area of hospital mergers, the *HCA* court created an identifiable standard by which these mergers may be measured.

136 *HCA, supra* note 92, at 1384.

137 *Id.*

138 *Rockford, supra* note 42, at 1280.

139 *See supra* notes 82–83 and accompanying text.

140 *Rockford, supra* note 42, at 1280.

141 In the face of a high enough concentration, the HHI analysis may not be necessary for a finding of anticompetitive effect. In *HCA*, the HHI was not considered in detail because the court thought the analysis would not "alter the impression of a highly concentrated market." *HCA, supra* note 92, at 384.

tive effect of a merger is the existence of entry barriers. An entry barrier has been defined as "anything that provides an incumbent in the market an advantage over a new entrant."[142] The health care industry, however, has a unique set of entry barriers to new entrants.

Regulation of hospitals is pervasive, and compliance with these regulations is a prerequisite for opening a hospital. The most difficult requirement to meet is that of obtaining a certificate of need (CON). The CON is essentially a state license for the construction and operation of a new hospital, without which such construction and operation is illegal. The inability to obtain a CON is an absolute barrier in states where it is required, and therefore, a much more formidable barrier than scale economics or start-up costs or other such traditional entry barriers. The *Rockford,*[143] *HCA,*[144] and *University Health*[145] courts considered the barrier imposed by the CON in analyzing the mergers before them.[146] However, most states have now repealed their CON requirments,[147] and the *Mercy* court found that a competitor could

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142 *Rockford, supra* note 42, at 1282.

143 *Id.* at 1282.

144 *HCA, supra* note 92, at 1387.

145 *University Health, supra* note 79, at 1211.

146 Parties contemplating mergers also face another dilemma because excess capacity is often a factor in the affirmative defense arguments of efficiencies and failing firm. Therefore, once a party claims this type of affirmative defense, it may be precluded from arguing that the CON is not an entry barrier, because a CON will not be granted in the event there is insufficient demand. If competitors cannot enter the market because a CON is unattainable, it is more likely that the merger will lead to the likelihood of a substantial lessening of competition. This dilemma is discussed in *Rockford, supra* note 42, at 1282.

147 For example, by 1991 14 states had repealed the CON laws. Mark Smith, *Profitable Addictions: Marketing Blitz Straddles Line of Medical Ethics*, HOUS. CHRON., Sept. 8, 1991, at A21.

expand into a market by creating an outpatient clinic, rather than a new hospital.[148]

Another substantial barrier is the necessity of acquiring a trained staff and, more importantly, qualified physicians. Because the purchasers of health care, the patients, are referred to a given hospital by their physician, a competitive hospital must have the ability to lure qualified physicians to utilize its facilities. The district court in *Rockford* recognized that "[t]raditionally, hospitals competed on the basis of their attractiveness to physicians. Hospitals recognized that, in most cases, physicians controlled inpatient admissions to hospitals. Consequently, attracting competent physicians became a means to maintain and expand inpatient admissions."[149] The problem is that many physicians will already have admitting privileges at other hospitals, as well as other arrangements that will compromise their ability or willingness to change their practice from one hospital to another.

Another substantial barrier is obtaining contracts from third-party payors. As mentioned above,[150] third-party payors and HMOs amount to the majority of payments received by hospitals for patient care. Because these arrangements are usually under a contract, and assuming that these payors will not lightly assume the consequences of breaking a contract, the ability of third-party payors and HMOs to immediately shift to a new care provider is severely curtailed. A hospital will have a difficult time surviving without at least some revenue from third-party payors and

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148 The *Mercy* court noted that "other hospital merger cases have not considered the impact of outreach clinics in their discussions of barriers to entry into the geographic market. . . . However, entry would not necessitate the building of a new hospital, but merely requires that another entity be able to enter a market it was not previously serving. The regional hospitals are able to do this through the establishment of outreach clinics." *Mercy, supra* note 105, at 986; *see also id.* at 979–80.

149 *Rockford, supra* note 42, at 1283; *But see Mercy, supra* note 105, at 973, 978–79 (noting that this was the "traditional" view, and rejecting the argument that strong doctor-patient loyalty would facilitate an anti-competitive price increase).

150 *See supra* note 8 and accompanying text.

HMOs.[151] The new hospital must survive until these contracts with existing hospitals expire, and then must be able to competitively bid against these established entities.

(c) Nature of the competition The nature of the competition in the market is another factor in determining the likelihood of a substantial lessening of competition. Under this test, courts will analyze the nature of competition "in the acute inpatient hospital market in order to determine whether the market is susceptible to anticompetitive behavior."[152]

In *Rockford*, the district court found that in Illinois competition in the acute inpatient hospital market had been increasing both in price and in quality.[153] From this, a defendant could argue that competition exists in the market, making a merger less able to reduce competition.[154] The *Rockford* court looked at it in a different light, however, and held that increasing competition in the marketplace created an incentive to merge in order to eliminate this competition and achieve a level of market power that would lead to higher profits, noting that "hospitals in the relevant market could benefit from a variety of anti-competitive activity."[155]

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151 Along these lines, one district court noted in an action against a healthcare financing provider that threatened to terminate its contracting provider agreement with a hospital, that "[i]n general, the disadvantages associated with noncontracting status cut broadly and deeply, injuring everyone concerned. It is unsatisfactory to merely state the hospitals simply lose the benefits they are otherwise entitled to. The loss of periodic interim payments and direct payment of benefits . . . has a tremendous impact on the cash flow of a noncontracting hospital." Reazin v. Blue Cross & Blue Shield of Kansas, Inc., 635 F. Supp. 1287, 1295 (D.Kan. 1986).

152 *Rockford, supra* note 42, at 1283.

153 *Id.*

154 Perhaps the *Roanoke* court adopted a variation of this argument when it found that the hospitals "have found various ways in which more efficient operations can save money and thereby enable them to offer their services more competitively than ever, to patient's benefit." *Roanoke, supra* note 41 at 849.

155 *Rockford, supra* note 42, at 1284.

(d) Market participants—the nonprofit issue One argument made in response to claims that hospital mergers substantially lessen competition, advanced by defendants and commentators alike, is that mergers between nonprofit hospitals are not anti-competitive because these hospitals do not have the profit incentives creating the type of anticompetitive behavior found among private firms.[156] Simply put, the argument is that nonprofit entities are not driven by monetary goals, and "without a chance to share in the firm's surplus a not-for-profit decision-maker will not steer the firm into anti-competitive action."[157] While there may be some evidence supporting this argument,[158] it is not generally accepted by the courts, who prefer the argument that "the adoption of the non-profit forum does not change human nature."[159]

The *Rockford* court listed a number of motivations for non-profit hospitals to raise prices. Excess profits could be used for

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[156] This becomes an issue only if the hospital is, of course, nonprofit, and if the court has jurisdiction over nonprofit entities under the Clayton Act. In *Roanoke*, the disctrict court found that the Clayton Act was not applicable to nonprofit entities. *Roanoke, supra* note 42, at 841 n.1. The Fourth Circuit Court of Appeals declined to address this issue because the government contended that there was no distinction between the Clayton and Sherman Acts, and the court of appeals upheld the district court's finding that the merger did not violate the Sherman Act. *Supra* note 41, at *4 n.1. While this may have provided some hope to nonprofit hospitals contemplating merger, it was short lived. The Supreme Court denied certiorari in *Rockford*, where the Seventh Circuit had found that the Clayton Act applied to mergers between nonprofit entities, implying that the Seventh Circuit's analysis was correct. U.S. v. Rockford Memorial Corp., 898 F.2d 1278, 1280 (7th Cir. 1990), *cert. den.*, 498 U.S. 920 (1990). Even if it is not, the issue is undecided and nonprofit hospital mergers have, and will continue to be, challenged.

[157] *Rockford, supra* note 42, at 1284. *See also* Kopit & McCann, *supra* note 14, at 644, where the authors argue the "empirical research suggests that there is no support for a blanket presumption that charitable hospitals behave like commercial entities."

[158] Hersch, *Competition and the Performance of Hospital Markets*, 1 REV. INDUS. ORG. 324 (1984).

[159] *HCA, supra* note 92, at 1390 (cited in *Rockford, supra* note 42, at 1284).

the noneconomic goals such as, better equipment, specialists, higher salaries, or a reserve.[160] Another rationale for rejecting the argument that nonprofit hospitals are not competitive is that they could be collusive in order to allow for higher profits so as to have more funds for other charitable purposes.[161] Nor does nonprofit status change the incentive to collude in order to defeat third-party payors' cost containment efforts.[162] Finally, collusion may be attractive to nonprofit enterprises as a means to stifle competition from for-profit institutions.[163] This trend has continued, with the *Mercy* court rejecting the nonprofit argument, labeling it a "questionable legal proposition."[164]

Enforcement agencies also reject the argument that nonprofit hospitals somehow behave differently than their for-profit cousins. Robert Bloch of the Antitrust Division of the Justice Department has noted:

> Both common sense and economic theory demonstrate that the competitive behavior and financial performance of nonprofit hospitals—including the incentive to raise prices when faced with less competition—will not differ materially from investor-owned hospitals.[165]

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160 *Id.* Similar analysis was found in *HCA*, where the court noted that "non-profit hospitals, in fact, make rather sizable profits and these profits have been growing over time." *HCA, supra* note 92, at 1390 (citations omitted).

161 *Id.*

162 *Id.*

163 *Id.* The *Rockford* court also recognized the incentive to eliminate the "quality competition," that inevitably raises a hospital's costs. *Rockford, supra* note 42, at 1285.

164 *Mercy, supra* note 105, at 989 (holding that evidence of a funds transfer to a parent company was enough to demonstrate that the hospital "has operated in a fashion similar to a for profit corporation").

165 William J. Lynk, *Property Rights and the Presumptions of Merger Analysis*, 39 ANTITRUST BULL. 363 (1994). This is consistent with the position of previous administrations. In a January 1988 speech, Assistant Attorney General Charles F. Rule "emphasized that the not-for-profit status of most hospitals is irrelevant to merger enforcement." Kopit & McCann, *supra* note 14, at 640.

Accordingly, it appears well established that a hospital's status as a nonprofit organization will carry little weight with either the courts or the enforcement agencies.

(e) The inelasticity of inpatient care The elasticity of the relevant market is another important factor in determining the likelihood that any particular merger will be anticompetitive. Inpatient hospital services have been found to be inelastic, first "because people place a high value on their safety and comfort"[166] and also because many "treatment decisions are made by . . . [a] doctor, who doesn't pay hospital bills."[167] An equally plausible argument, not mentioned by courts, is that inpatient hospital services are inelastic because there are no alternatives to inpatient care.[168] The result is that "[t]he less elastic the demand for a good or service is, the greater are the profits that providers can make by raising price through collusion."[169] If the court or enforcement agency finds that the product market is limited to inpatient services, as the trend suggests they will, this will be a factor weighing in favor of a finding of an inelastic market because there are no alternatives to inpatient hospital care.

(f) Motivation to resist third-party payors Another factor in determining whether a merger is likely to be anticompetitive stems from the unique structure of the health care industry. Third-party payors are responsible for the majority of payments made for hospital care.[170] This places these third-party payors in a strong bargaining position. The result is an incentive for hospitals to join together to resist pressure placed upon them from third-party payors, particularly the federal government and insurance

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166 *HCA, supra* note 92, at 1388.

167 *Id.*

168 Note that the inclusion of outpatient services in the product market will result in a much more elastic market. A price increase for a service that is offered on an inpatient basis that can also be obtained on an outpatient basis should result in the consumer shifting to the outpatient supplier.

169 *HCA, supra* note 92, at 1388.

170 *Supra* notes 8–9 and accompanying text.

companies, who attempt to keep costs down through the use of the bargaining power they possess as a result of the large size of their purchases.[171] Hospitals will therefore collude in order to create a united front.[172]

C. *Affirmative defenses*

The New Guidelines explicitly delineate three affirmative defenses for hospital mergers,[173] and the courts have considered similar factors.[174] The New Guidelines identify three considerations that will defeat the presumption of anticompetitiveness. These considerations apply where the merger does not increase the likelihood of excessive market power due to remaining competition or because of sufficient differentiation between hospitals,[175] the hospitals would realize significant cost savings,[176] or the merger would eliminate a hospital that would fail anyway.[177] The first factor restates a combination of the product market analysis

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171 *See infra* notes 195–208, and accompanying text discussing the sophisticated buyer defense.

172 *HCA, supra* note 92, at 1399 (citing United States v. North Dakota Hospital Assn., 640 F. Supp. 1028 (D.N.D. 1986); *Rockford, supra* note 42, at 1284. However, this argument has been rejected where it has been shown that the third-party payors possess market power. *Mercy, supra* note 105, at 982–83.

173 As mentioned, the 1992 Guidelines include efficiencies and failing firm considerations. The New Guidelines essentially restate the role of these factors in the analysis.

174 However, no court or administrative agency has yet to allow a merger between two hospitals based upon one of these affirmative defenses. Even the *Ukiah* decision seemed to be based less on efficiencies than the "lessening of competition" analysis. *Ukiah, supra* note 44. This suggests the argument that perhaps a change in the burden of proof for the efficiencies and failing firm defenses is in order for hospital mergers.

175 *Id.*

176 *Id.*

177 *Id.*

and the likelihood of a substantial reduction in competition.[178] The second factor, cost savings, is another name for the more familiar efficiencies defense, and the third is the failing firm analysis.

1. THE EFFICIENCIES DEFENSE Although the Supreme Court has not explicitly recognized an efficiencies defense,[179] the enforcement agencies and federal courts[180] do. The New Guidelines consider whether "the merger would allow significant cost savings"[181] and the 1992 Guidelines contains a short section of efficiencies, and "will allow firms to achieve available efficiencies through mergers without interference from the Agency."[182] In the field of

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178 I have not found any reference to this particular "defense" since the issuance of the New Guidelines, perhaps because its elements are considered in the determination of product market and the likelihood of substantially lessening competition.

179 Note that the Clayton Act does not provide for any affirmative defenses, and "the Supreme Court has not explicitly recongnized an efficiencies defense in a merger case, and no adjudicated antitrust decisions indicate that efficiencies have been a determining factor." Steve Stockum, *The Efficiencies Defense for Horizontal Mergers: What Is the Government's Standard*, 61 ANTITRUST L. J. 829, 829–30 (1993). Stockum also notes that "[i]n FTC v. Proctor [sic] & Gamble Co., 386 U.S. 568 (1968), the Court held that 'possible economies cannot be used as a defense against illegality' [citation omitted]. But in this case, the defendant did not claim an efficiencies defense. The context of the remark is the Court's discussion of the *government's* claims of efficiencies as supporting an 'entrenchment' theory. Thus, the efficiencies defense issue was not before the court." *Id.* at 829 n.4.

180 *See Mercy, supra* note 105, at 986; *University Health, supra* note 78, at 1222; *Rockford, supra* note 42, at 1289.

181 New Guidelines, *supra* note 33, at 20,758.

182 1992 Guidelines, *supra* note 52, at 41,562. However, in order to prevail on this argument a party must prove that the merger is the least restrictive means for obtaining the efficiency. "[T]he Agency will reject claims of efficiencies if equivalent or comparable savings can reasonably be achieved by the parties through other means." *Id.* This restriction is not included in the New Guidelines. Because the New Guidelines refer to the 1992 Guidelines as the appropriate test for hospitals that fall outside of the "safety zone," the least restrictive means analysis probably continues to apply.

hospital mergers, there is a strong argument that hospitals can increase efficiency through certain types of cooperation.[183] However, because the threshold level of efficiency necessary for an effective affirmative defense remains undefined, the defense offers little guidance and therefore does not relieve the uncertainty that is arguably preventing hospital mergers.

The main problem for hospitals contemplating merger is "the experiences of the merging hospitals in Roanoke and Rockford strongly suggest that proposed efficiencies actually carry little weight and that the department's basic guidepost for litigation is the increase in HHI,"[184] although efficiencies may play a more important role in the decision to litigate in the first place.[185] First, the burden that must be overcome is substantial.[186] The defendants must:

> establish by clear and convincing evidence that the efficiencies provided by the merger produce a significant economic benefit to consumers, even in light of the possible anti-competitive effects of the merger.[187]

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[183] One study "concluded that the merged hospitals evidenced significantly greater cost savings than the non-merged hospitals." AHA White Paper, *supra* note 8, at 32 (citing OFFICE OF THE INSPECTOR GENERAL, UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES, EFFECTS OF HOSPITAL MERGERS ON COSTS, REVENUES AND PATIENT VOLUME (1992)). For more discussion of the various efficiencies, *see* AHA White Paper, *supra* note 8, at 31–4.

[184] Kopit & McCann, *supra* note 14, at 641. The same authors also note that because the guidelines focus on quantifiable efficiencies, they do not consider efficiencies such as an increase in quality of care, or patient outcomes. *Id.* at 641 n.15.

[185] For example, efficiencies played a role in the decision by the DOJ not to prosecute mergers in Danville, Illinois and Portsmouth, Ohio. Charles F. Rule, *Antitrust Enforcement and Hospital Mergers: Safeguarding Emerging Price Competition*, 21 J. HEALTH & HOSP. L. 125, 129–30 (1988).

[186] The *Rockford* court noted that it applied "a very rigorous standard" to the quantitative efficiencies argument. *Rockford, supra* note 42, at 1289.

[187] *Id.* The 1992 Guidelines provide that "[t]he expected net efficiencies must be greater the more significant are the competitive risks identified in sections 1–3." 1992 Guidelines, *supra* note 52, at 41,562.

Therefore, the efficiencies that accompany hospital mergers are probably insufficient to overcome this burden. The *Rockford* court noted that "with every merger or acquisition certain efficiencies and benefits will accrue. Otherwise, the merger probably would not have transpired in the first place."[188] Second, even if the burden of showing a level of efficiencies is met, the defendant must meet the additional burden of showing that these efficiencies can only be achieved by the proposed merger.[189] This is a substantial, and perhaps impossible, test.[190] Therefore, it is likely to be irrelevant whether the hospitals can prove efficiencies, or what level of savings may be possible—the defense is not likely to be enough to prevent expensive litigation at best, and a finding of a violation of the antitrust laws at worst.

2. THE FAILING FIRM DEFENSE If the hospital industry is correct, and mergers are necessary in order for certain hospitals to survive, the failing firm argument appears to be the strongest defense. As with the efficiencies defense,[191] the Clayton Act does not provide for any affirmative defenses.

Although the enforcement agencies explicitly provided for the failing firm defense in the New Guidelines, the standard that must

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188 *Rockford, supra* note 42, at 1289.

189 For example, the *Rockford* court refused to consider any efficiencies other than those that could be obtained *only* by the merger "because competition, not competitors, is protected under § 7, savings relevant for determining pro-competitive efficiencies must be made possible only through the merger and *in no other manner*" (emphasis added). *Rockford, supra* note 42, at 1289; *see also University Health, supra* note 78, at 1222 n.30; *Mercy, supra* note 105, at 987 n.4.

190 In fact, the only circumstance that may be sufficient to support this defense would be a situation where *both* hospitals will fail in the event that a merger is not allowed. Otherwise, the efficiencies could be achieved by a less than total merger, wherein only the inefficient departments are combined. This was the approach reached in the *Morton Plant* decision, *infra* notes 219–32 and accompanying text. Such a requirement is even more difficult to meet than the failing firm defense, and therefore would render this defense inapplicable in almost all situations.

191 *Supra* note 179.

be met is unclear. The New Guidelines note that the "Agencies often have concluded that an investigated hospital merger will not result in a substantial lessening of competition in situations where . . . the merger would eliminate a hospital that likely would fail with its assets exiting the market."[192] The 1992 Guidelines delineate three requirements that must be met for a firm to prevail under the failing firm defense,[193] but it is unclear whether these requirements apply to hospital mergers, since they are not included in the New Guidelines, but the New Guidelines refer hospitals that are not in the "safety zones" to the 1992 Guidelines.

Regardless of the answers to these difficult questions, the failing firm defense has not been successful in litigation, and therefore offers little certainty to hospitals contemplating a merger. As noted above, no court or administrative agency has ever accepted this defense. In practice, "[g]enerally, this is a very narrow defense . . . and requires that the failing firm be at the brink of bankruptcy and without hope of attracting an outside purchaser."[194]

The district court in *Rockford* provides what is perhaps the underlying rationale behind the rejection of the failing firm defense when it rejected the argument as too speculative, noting that the:

> "failing market" or "writing on the wall" defense [was] too broad and ungainly to ward off a Section 7 violation. The speculative nature of the defense allows too much abuse. . . . The relevant acute inpatient hospital market may be failing but then again it may not. To allow an anti-competitive merger to occur on this basis is untenable.[195]

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192 New Guidelines, *supra* note 33, at 20,758.

193 These are: (1) The firm would not be able to meet its financial obligations in the near future; (2) it could not successfully reorganize under chapter 11 of the Bankruptcy Act; and (3) it has been unsuccessful in receiving alternate offers of acquisition that would keep it in the market while posing less of a threat to competition. 1992 Guidelines, *supra* note 52, at 41,563.

194 Kopit & McCann, *supra* note 14, at 641.

195 *Rockford, supra* note 42, at 1289.

Accordingly, efforts to use this defense are almost certainly doomed to failure.

3. THE SOPHISTICATED BUYER DEFENSE The sophisticated buyer defense argues that large and sophisticated purchasers will "exert countervailing power even against a seller's oligopoly . . . by shifting a large proportion of the business to any firms that are willing to deviate from the coordinated behavior."[196] The defense has been considered in a number of cases,[197] and has been dispositive in rebutting a Clayton Act presumption of illegality.[198]

In the market for hospital services, the sophisticated buyers would be large third-party payors or HMOs. Market power held by these large purchasers could be enough leverage to offset any advantage hospitals could gain by collusion. The existence of a large health care purchaser is an incentive for hospitals in a collusive arrangement to defect, and offer health care at a lesser price in return for the security of a long-term contract. This argument may have merit because of the rise to prominence of large institutional purchasers of health care.[199]

However, a series of studies conducted in California suggests that third-party payors' ability to pressure hospitals exists "primarily in markets that have both multiple hospitals and excess capacity."[200] The excess capacity creates the economic incentive and the

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196 Mary Lou Steptoe, *The Power Buyer Defense in Merger Cases*, 61 ANTITRUST L. J. 493 (1993).

197 United States v. Baker Hughes, Inc., 908 F.2d 981 (D.C.Cir. 1990); United States v. Syufy Enterprises, 903 F.2d 659 (9th Cir. 1990); United States v. Archer-Daniels-Midland Co., 1991-2 Trade Cas. (CCH) ¶ 69,647 (S.D.Iowa 1991); United States v. Country Lake Foods, 754 F.Supp. 669 (D.Minn.1990); FTC v. R.R. Donnelley & Sons Co., 1990-2 Trade Cas. (CCH) ¶ 69,239 (D.D.C. 1990); Owens-Illinois, Inc., Dkt. No. 9212, 5 Trade Reg. Rptr. (CCH) ¶ 23,162 (F.T.C. 1992); Olin Corp. Dkt. No. 9196, 5 Trade Reg. Rptr. (CCH) ¶ 22,857 (F.T.C. 1990).

198 *Baker Hughes*, 908 F.2d at 986–87.

199 McCarthy & Weinstein, *supra* note 27, at 8.

200 Jack Zwanziger et al., *Hospitals and Antitrust: Defining Markets, Setting Standards*, 19 J. HEALTH POL., POL'Y & L. 423 (1994).

presence of other hospitals creates the risk of being "locked out" of a large part of the market.[201] In the hospital industry, therefore, the sophisticated buyer situation leans *against* allowing hospital mergers, because "[p]layers trying to assemble provider networks in concentrated hospital markets have few alternatives and consequently little leverage in negotiations with hospitals."[202]

Following this rationale, courts have rejected the sophisticated purchaser defense. In *HCA*, the court acknowledged that third-party payors exert substantial pressure on hospitals to cut prices, and that the federal government had already done so.[203] However, rather than find that this was a countervailing pressure that could offset anticompetitive behavior by hospitals, the court saw an incentive for hospital collusion, because "[t]he fewer the independent competitors in a hospital market, the easier they will find it, by presenting an unbroken phalanx of representations and requests, to frustrate efforts to control hospital costs."[204]

University Health also rejected the sophisticated buyer argument, using a slightly different rationale. Because third-party payors could not refuse to pay, argued the court, additional revenue was generated by simply passing the cost on to the individual consumer.[205] Finally, the court noted that in light of the "strong showing" of a likelihood of lessening competition, the existence of sophisticated buyers was not enough to overcome the presumption of illegality.[206]

However, the sophisticated buyer defense has prevailed at least in part. In *Mercy*, for example, the court considered the abil-

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201 *Id.*

202 *Id.*

203 *HCA, supra* note 92, at 1389, 1391.

204 *Id.*

205 *University Health, supra* note 78, at 1213 n.13.

206 *Id. But see Mercy, supra* note 105, at 984 (rejecting the rationale of *University Health* and *HCA* and noting that "these cases did not focus on managed care entities, but focused instead on traditional indemnity insurers").

ity of managed care entities to shift patients to other regional hospitals in the event they could obtain less expensive services.[207] Similarly, the concurring commisioners in *Ukiah* gave the argument a slightly different twist, supporting the efficiency arguments with the sophisticated buyer defense. The efficiency argument was considered "particularly appropriate . . . where large third-party payors will likely anticipate many of respondents' purported cost-saving efficiencies, and therefore, would likely protest any price increases in the face of such cost cuts."[208] Also, the same commissioners thought that the fact that third-party payors did not object to the merger was persuasive evidence that the merger would not mean higher prices since these entities would protest if they feared postmerger increases.[209]

Although *Ukiah* and *Mercy* suggest that the sophisticated buyer defense may prevail, or at least enter the calculation, other decisions indicate the opposite. For the hospital contemplating a merger, although the *Mercy* decision may offer some hope, it does little to alleviate the uncertainty that is reportedly hampering hospital mergers.

VII. Solutions

In response to the health care crisis many have urged both general and limited exceptions to the enforcement of antitrust law for hospital mergers. It is clear that in many respects the health care

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207 *Mercy, supra* note 105, at 982–83, 984–85. Although the *Mercy* court conducted its analysis in the context of considering the geographic market, the analysis has the flavor of a third-party payor defense or rebuttal evidence to presumed anticompetitive merger activity.

208 *Ukiah, supra* note 44, at 23,267–68 (Commissioners Owen and Yao, concurring).

209 The opinion found that "the absence of any third party payor opposition to the acquisition *weighs against* any finding that this acquisition will result in any anticompetitive effect." *Id.* at 23,267 (emphasis added). The degree of "weight" to be accorded to the lack of opposition by third-party payors, however, is not defined.

market in general, and hospitals in particular, comprise a unique type of market that causes difficulty for traditional antitrust analysis. Perceiving the problem is, however, the easy part of the process. Since solutions are much more difficult, any change in current enforcement practices should be specifically tailored to meet both hospital industry and health care consumer needs. A number of approaches are analyzed below.[210]

A. Legislative

1. FEDERAL—LEGISLATIVE EXEMPTION FOR SELECT MERGERS No court or enforcement agency can rewrite federal law.[211] Accordingly, to except hospital mergers from antitrust enforcement, federal legislation is necessary. Some limited exemptions are suggested below.

(a) Exemption for nonprofit hospitals Proponents contend that because nonprofit hospitals are not driven by the same motivations as for-profit institutions they should be excepted from antitrust enforcement. Since the argument that the courts and enforcement agencies do not have jurisdiction over nonprofit entities appears unlikely to succeed in the courts,[212] and enforcement

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[210] The focus of this article is reform of current antitrust enforcement policies. For a discussion of the proposal to treat hospitals as natural monopolies, exempt them from the antitrust laws, and to regulate the industry *see* Dayna B. Matthew, *Doing What Comes Naturally: Antitrust Law and Hospital Mergers*, 31 HOUS. L. REV. 813 (1994). For a brief discussion of the impact of such regulation, at least with regard to state regulatory policy, *see* Meyer & Rule, *supra* note 62, at 210.

[211] However, the DOJ and the FTC have issued their "guidelines," discussed in detail above. While courts have followed the guidelines, particularly when reviewing a decision originally before the FTC, the courts are not bound by these guidelines. *See, e.g.*, F.T.C. v. P.P.G. Industries, 798 F.2d 1500 (D.C. Cir. 1986); Fruehoff Corp. v. F.T.C., 603 F.2d 345 (2d Cir. 1979); F.T.C. v. Owens-Illinois Inc., 681 F.2d 27 (D.C. Cir. 1988).

[212] This argument has been consistently rejected when applied to hospital mergers. *See Freeman, supra* note 105, at 266; *University Health, supra* note 78, at 1214–15; *Rockford, supra* note 42, at 1252–58.

agencies do not appear receptive to excepting mergers between nonprofit hospitals from the antitrust laws, the only certain solution is a legislative mandate. Congress could simply excuse all entities that qualified as nonprofit[213] from Clayton Act coverage.

Of course, the arguments used by the courts to deny "nonprofit" defense are applicable.[214] While some institutions may well be motivated by altruistic motives, common sense suggests that many are not. There is, also, an additional consideration that must be considered. The effect of excepting nonprofit entities from antitrust enforcement would excuse the majority of hospitals from the antitrust laws.[215] The dangers of a broad exception are clear. If Congress miscalculated the likely behavior of nonprofit hospitals, the result would be a highly concentrated, noncompetitive market, and the resulting market structure would be difficult, if not impossible to undo. In addition, for-profit hospitals would be at a competitive disadvantage, and many may be forced out of existence.[216] Accordingly, the risks of a broad exception to the antitrust laws for nonprofit hospitals far outweigh the benefits.

If a general exception is to be rejected, perhaps exceptions should be granted on a case-by-case basis, under a reduction of competitive behavior analysis. However, it would be difficult to find an institution better able to make this determination than federal courts, which have adjudicated such issues since the passage of the Sherman Act. In fact, courts have already undertaken this

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213 The simplest method of making this determination would be to correspond nonprofit status for purposes of antitrust law enforcement to the IRS nonprofit requirements. Whether the IRS requirements would fit the rationale for excepting nonprofit entities from antitrust law is beyond the scope of this article.

214 *See supra* notes 156–58 and accompanying text.

215 "Eighty-six percent of all hospitals are nonprofit or public institutions, which have no private owners (shareholders) with a legal claim to a return on investment." AHA White Paper, *supra* note 8, at 36. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS, *supra* note 13, table 5A, at 20 (1991–1992 ed.).

216 Or, forced to merge with their nonprofit cousins because a merger with another for-profit hospital will continue to be presumptively illegal.

analysis, and have found that nonprofit entities do not behave differently.

(b) Selected collaboration—joint ventures Some commentators suggest exemptions from antitrust enforcement for certain types of activity. One approach would allow hospitals to collaborate to purchase expensive, underutilized equipment, or to reduce costs on the provision of support services. This approach has been supported by some representatives, such as Jim Cooper (D-Tenn.), who supported "an antitrust exemption for hospitals to share MRIs."[217] Representative Nancy Johnson (R-Conn.) supports relaxing enforcement in order "to eliminate the duplication of effort."[218] Similarly, the DOJ has acknowledged that a limited exception for certain joint efforts may be of some benefit, noting that "legislation to reduce antitrust uncertainty and risk in the joint venture area generally may be of benefit to hospitals that wish jointly to purchase high technology equipment or services."[219] Collaboration may also be appropriate in areas peripheral to acute inpatient care, where economies of scale may reduce costs.

The most innovative use of this concept is found in a settlement[220] between two hospitals in North Pinellas County,

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217 AHA White Paper, *supra* note 8, at 2 n.4 (citing *Antitrust Law Changes Needed for Collaboration*, HEALTHCARE FIN. RELATIONSHIPS, Oct. 7, 1992, at 7–8).

218 *Id.*

219 *Id.* at 16 (citing letter from W. Lee Rawls, Assistant Attorney General, U.S. Department of Justice, to Senator Nancy Kassebaum, United States Senate (March 10, 1992) (on file with the United States Department of Justice Antitrust Division)).

220 In fact, this is the first settlement of a case in the health industry since the New Guidelines were issued. Antitrust Division News Release, *Justice Department Settles Florida Hospital Merger Case, Deal Provides Lower Health Care Prices and Preserves Competition*, at 2 June 17, 1994 (on file w/author) (hereinafter News Release). As discussed below, the solution reached is entirely consistent with the thrust of the New Guidelines.

Florida.[221] The two hospitals, Morton Plant and Mease Health System, were the two largest[222] in the area and account for 60% of the market.[223]

Both the DOJ and the Florida attorney general opposed the merger, the first time that a joint action has been filed by federal and state officials.[224] The settlement is innovative because it is market specific and permits collaboration in areas that could be anticompetitive in a different product or geographic market. The hospitals were allowed to form a joint venture partnership for services that the government found not subject to competition,[225] expensive,[226] or for which patients were willing to travel.[227] The

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221 United States and State of Florida v. Morton Plant Health Systems, Inc. and Trustees of Mease Hospital, Inc., No. 94-748-CIV-T-23E (M.D. Fla., filed May 5, 1994).

222 Morton Plant was the largest in the area, with 672 beds, and Mease was its main competitor, with 378 beds at two locations. News Release, *supra* note 220, at 2.

223 *Id.*

224 However, it is probably not the last time. Anne K. Bingaman, head of the Antitrust Division of the Justice Department, has said that the joint prosecution "exemplifies the close cooperation between federal and state antitrust enforcement agencies that this Administration has emphasized. This case is an example of how federal-state cooperation can be used to prevent mergers that cause consumers to pay higher prices." Antitrust Division News Release, *First Joint Antitrust Prosecution Involving Justice Department and a State Will Challenge Proposed Florida Hospital Merger*, May 5, 1994, at 1.

225 These include outpatient services, laboratory services, and mental health services. Outpatient services, for example, are provided not only by hospitals but by clinics, ambulatory surgery centers and doctors' offices. Department of Justice, Final Consent Judgment and Competitive Impact Statement, United States and State of Florida v. Morton Plant Health Systems, Inc. and Trustees of Mease Hospital, Inc., No. 94-748-CIV-T-23E (M.D. Fla., filed May 5, 1994), *reprinted in* 59 Fed. Reg. 35,752 (1994).

226 *Id.*

227 A factor that considerably expands the geographic market. These services include open heart surgery, robotically assisted prosthetic

hospitals were also allowed to conduct a limited merger in administrative services such as human resources, medical staff organization and development, telephone services, accounting, billing and collections, medical records, and "all miscellaneous services not related to patient care and not exceeding an expenditure of $250,000 annually."[228] The decree provides appropriate confidentiality measures to insure that these combined activities do not allow for the exchange of marketing or pricing information that could contribute to collusion,[229] and preserves the right of private litigants who have been injured to bring a private suit.[230] The market for acute inpatient care, however, remains separate and distinct, and therefore competitive.

The *Morton Plant* settlement is the first since the issuance of the New Guidelines, and is entirely consistent with the purpose of encouraging cost saving joint ventures and purchasing agreements, while continuing to oppose anticompetitive mergers. The attractiveness of this innovative solution is that it recognizes the realities of antitrust enforcement in the area of hospital mergers. It takes advantage of economies of scale and reduces the underutilization of expensive technology and services in areas where there is little dispute that the current system is inefficient and therefore does not benefit either consumers or providers. Finally, this approach recognizes that each situation is unique, and considers the specific reality of the particular geographic and product

implantation, and special spinal instrumentation procedures, stem cell procedures, advanced linear accelerator equipment, stereotactic radio therapy, diagnostic and therapeutic radiology services (CAT scans, MRI, X-ray, etc.), and neonatal level III services. *Id.*

228 *Id.*

229 The "proposed Judgment requires the Partnership to establish protections to ensure that the joint operations of administrative services does not result in any sharing of information such as pricing or managed care contracting for Morton Plant or Mease, thus guarding against the risk of 'spillover' of competitively sensitive information from the Partnership to the independent hospitals." *Id.*

230 *Id.*

markets, avoiding the problem with blanket exceptions, discussed above.

The selective collaboration approach seems eminently reasonable, and, in fact, only two critiques were received during the 60-day public comment period[231] after the final consent judgment was reached.[232] It is notable that neither was from an entity that provided health care. The clear implication is that the solution is satisfactory to all parties involved in the provision of acute inpatient hospital services.

Similarly, the FTC in a number of consent decrees has created a limited exception for certain joint ventures. In South Carolina, the FTC prohibited one hospital from "consumat[ing] any joint venture or other arrangement with any other acute care hospital in the Charlotte County area" for the establishment of any new acute care hospital or similar service.[233] This order did not apply, however, if "the fair market value of the assets to be contributed to the joint venture or other arrangement by acute care hospitals not operated by Columbia does not exceed one million dollars," and the services are limited to a nonmedical nature. Specifically, these services were:

> laundry; data processing; purchasing; materials management; billing and collection; dietary; industrial engineering; maintenance; printing; security; records management; laboratory testing; personnel education,

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231 Pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. § 16(b)–(h) (1980).

232 The first critique was from the Textile Rental Services Association, arguing that the settlement would allow Morton Plant and Mease to conduct laundry services as a tax exempt organization. The other was from an employment agency that provides temporary nursing services. However, neither critique attacked the effectiveness of the settlement with regard to its purpose—insuring the competitiveness in the provision of acute inpatient care. Notices, Department of Justice Antitrust Division, Public Comments and Response on Proposed Final Consent Judgment, September 30, 1994.

233 *In re* Columbia Hospital Corporation, Docket No. 9256, May 5, 1994 5 CCH Trade Reg. Rep. ¶ 23,548 at 23,223.

> testing or training; or health care financing (such as through a health maintenance organization or preferred provider organization).[234]

In the event that a collaborative effort is to take place in an area outside the scope of this limited list, the parties are required to provide notification pursuant to section 7A of the Clayton Act.[235] The rationale behind this limited exception is not articulated, but perhaps the commission is less concerned about market concentration in the area of logistical support than in the provision of actual inpatient care, just as in *Morton Plant.*

States have also given approval to similar approaches. Recently, Pennsylvania allowed three hospitals to form a common board in response to claims that the hospitals could reduce costs by eliminating duplicate services, and therefore saving an estimated $40 million.[236] The state's approval was not automatic, however. If the hospital fails to save the estimated amount, it must pay the state the difference.[237]

However, collaborative activities are not subject to automatic approval. When the president of the Wichita Chamber of Commerce wrote to the FTC to inquire as to its response to Wichita hospitals meeting to discuss the allocation of services, equipment or facilities, the FTC replied that "[a]n agreement among competitors to divide or allocate markets . . . is per se illegal under the Sherman Act."[238]

These solutions suggest that limited exceptions to the enforcement of antitrust policy exist with regard to certain expensive and underutilized medical procedures, administrative or logistical costs, or services that compete in a geographic market beyond that

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234 *Id.*

235 *Id.*

236 Feinstein & Whittier, *supra* note 34, at 18–19.

237 *Id.* at 19.

238 AHA White Paper, *supra* note 8, at 9 (citing Letter from Mark J. Horoschak, Assistant Director, Federal Trade Commission, to F. Tim Witsman, President, Wichita Area Chamber of Commerce (May 22, 1991) (on file with the Federal Trade Commission)).

of acute inpatient hospital care. Such an approach leaves the bulk of "acute inpatient care" services, that is, the actual provision of medical care, subject to continued scrutiny under the antitrust laws, while allowing savings that benefit both hospitals and consumers. Hospitals contemplating mergers should perhaps engage in similar activities, rather than a complete merger.[239] The proposal could then be placed before either the FTC or DOJ using one of the administrative review procedures. This approach offers hope for approval where a complete merger would most likely be illegal; it also offers some greater certainty for hospitals contemplating mergers.

(c) Administrative—new guidelines This approach is based upon an acknowledgment of the importance of market concentration in determining the anticompetitive effects of mergers, and the corresponding importance of the HHI in calculating market concentration. Congress[240] could pass a new set of guidelines that would supplant the Clayton Act with regard to hospital mergers, substituting a different threshold for what would be considered a "highly concentrated" market.[241] It has been argued that this approach would supplant the difficult problem of analyzing efficiencies, and that "enforcement agencies [could] take efficiencies into account by increasing the level of market concentration at which a merger is challenged, rather than engaging in case by case weighing of efficiencies."[242]

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239 For suggested steps in engaging in joint ventures, *see* Meyer & Rule, *supra* note 62, at 193.

240 Congress must engage in this activity, rather than the agencies, because although the agencies have the authority to promulgate guidelines, these guidelines are not the law. Also, it is unclear whether the courts, which do not always follow the standards set in the guidelines, would continue to do so in the event that the agencies decided to unilaterally change the applicable standard.

241 In fact, such legislation has been proposed by Senators Orrin G. Hatch (R-Utah) and Strom Thurmond (R-S.C.). Feinstein & Whittier, *supra* note 34, at 31–32.

242 F.T.C. v. University Health, 938 F.2d at 1223, n.30 (citing Fisher & Lande, *Efficiency Considerations in Merger Enforcement*, 71 CALIF. L.

The assumption that any merger that results in a HHI of greater than 1800 is presumptively anticompetitive would be changed, making a higher HHI necessary for a merger to be presumptively anticompetitive. While this approach is certainly novel, it initially appears to have some advantages. The main argument for this approach is that it could be structured to provide greater leeway to certain hospitals contemplating mergers, while preserving clear, enforceable standards for harmful mergers. The difficulty, however, is twofold. First, a new line must be drawn, and it must be meaningful. Second, the idea rests upon the assumption that a merger with a concentration ratio that is anticompetitive in other industries would not be anticompetitive in the hospital industry.[243]

Both issues are problematic. First, because of the nature of the hospital industry, drawing a meaningful line at a higher HHI will be difficult, and must necessarily abandon some of the flexibility found under the case-by-case analysis currently applied. Certainly, the line should not be drawn so high as to be almost meaningless. The value of the current flexibility can be demonstrated by comparing the results of the HHI analysis in the *Rockford* and *Roanoke* decisions.[244] In *Rockford*, the court found that the merger resulted in a significant increase in the HHI,[245] ranging from 2048 to 2621. The court offered no guidance as to the significance of

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REV. 1580, 1670–77 (1983); R. BORK, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF 129 (1978); R. POSNER, ANTITRUST LAW: AN ECONOMIC PERSPECTIVE 112–13 (1976)).

243 Part of this argument could be taken from the proponents of the nonprofit exception—the idea being that a higher concentration ratio is not anticompetitive in an industry involving actors whose motivations are not traditional.

244 This is based on the perhaps arguable assumption that both circuits were correct—that is, the *Rockford* merger was anticompetitive and the *Roanoke* merger was not.

245 Specifically, using the number of beds, admissions, and patient days, the court calculated the following numbers:

(*footnote 245 continued*)

these results, however, noting only that where the HHI doubled, such a result was "particularly significant."[246] In *Roanoke*, the merger was found to be legal under the Sherman Act, due to the finding that the Clayton Act was not applicable to nonprofit hospitals. However, for purposes of this example, accept the government argument that the "merged entity [would] have in excess of 70%" of the market, and the result would be a two-firm market instead of a three-firm market.[247] Assuming that the two hospitals were of equal size, the postmerger HHI would be 5800.[248] The difference between the pre- and postmerger concentration ratios would be 3350,[249] yielding an increase in the HHI of 2450.

The increase in concentration ratios in both situations are within the same ballpark—*Rockford* was between 2048 and 2621. The numbers computed for the *Roanoke* situation are squarely in the middle, at 2450. Despite the similarity in numbers, two courts reached different results after analyzing other factors. Assuming

	Beds	Admissions	Days
Before merger	2555	2789	3026
After merger	4603	5111	5647
Net increase	2048	2322	2621

Rockford, supra note 42, at 1280.

246 *Id.*

247 This example also accepts the government's argument that the relevant geographic area was limited to Roanoke, Virginia. The court did not accept this argument, but that result is irrelevant to this analysis, the sole purpose of which is to demonstrate the loss of flexibility a strict change in the guidelines would create.

248 Calculated as follows:

$$(70 \times 70) + (30 \times 30) = \text{HHI}$$
$$4900 + 900 = 5800$$

249 The premerger HHI is calculated as follows:

$$(35 \times 35) + (35 \times 35) + (30 \times 30) = \text{HHI}$$
$$1225 + 1225 + 900 = 3350$$

this analysis was valuable, and that both decisions were correct,[250] it is clear that the application of a bright-line HHI test would by necessity lose much of the flexibility currently in the antitrust laws.

The second and more significant problem with legislatively changing the HHI presumption is the difficulty in deciding where to draw the line for a presumptively illegal concentration ratio. Because of the already concentrated nature of the hospital industry[251] a more permissive line would have to be drawn rather high—perhaps in the neighborhood suggested by the analysis of the *Rockford* and *Roanoke* numbers. However, this result would have the effect of allowing most mergers to proceed, the type of blanket exception that may encourage anticompetitive behavior.

Finally, this approach rests on the assumption that what would be anticompetitive in one industry would not be anticompetitive in the hospital industry. This is an assumption that is open to question, but does not appear to be generally accepted by either the enforcement agencies or the courts. Accordingly, the novel solution of selectively raising the HHI for mergers in the hospital industry does not appear to be appropriate.[252]

(d) Expedited review of proposed mergers Under the Hart-Scott-Rodino Antitrust Improvements Act[253] (HSRA), any entities that are planning to undertake a merger that is beyond a certain size[254] must notify the DOJ and FTC. Both the Commission and

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250 An assumption that is arguable, depending upon whether one consulted the hospitals or the enforcement agencies.

251 *See supra* notes 82–85.

252 This article does not address the policy implications of this decision, but they are clear. Each industry would believe that it deserved a special exemption, just as many industries began clamoring for their own set of guidelines after the health care guidelines were published. This poses the risk of a slow erosion of antitrust enforcement, and is therefore not good public policy.

253 15 U.S.C. § 18a (1984).

254 The mandatory review process is invoked if one party to the transaction has annual net sales or total assets of $100 million or more, and

staff of the FTC will offer advisory opinions.[255] The DOJ has a similar process, called a Business Review.[256] In addition, the New Guidelines pledged to complete the review process of proposed mergers and issue advisory opinions within 90 days.[257]

In response, the AHA has argued that the review process is not a satisfactory solution,[258] and this attitude probably reflects that of many hospital administrators. One critique is that even after a review, a challenge is not necessarily precluded[259] or may not, in fact, result in a definitive opinion at all.[260] However, it is difficult to conceive of a process that would be quicker or less expensive and would still involve a comprehensive review of the factors

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the other party has total assets of $10 million or more. 15 U.S.C. § 18a(a)(2) (1984). The process is also invoked if the controlling entity owns at least $15 million or 15% of the acquired entities stock or assets. 15 U.S.C. § 18a(a)(3) (1984).

255 16 C.F.R. §§ 1.1–1.4 (1992).

256 28 C.F.R. § 50.6 (1992).

257 The New Guidelines commit the enforcement agencies to respond to requests for advisory opinions within 90 days "after all necessary information is received . . . *except requests relating to hospital mergers outside the antitrust safety zone*." New Guidelines, *supra* note 33, at 26,758 (emphasis added). There appear to be two caveats by which the agencies could escape a strict 90-day requirement—the 90-day limit appears to apply only to mergers within the safety zones, and the agencies could always claim that they had not received "all necessary information." However, in practice the enforcement agencies have completed all such reviews within the 90-day period. *See supra* note 67.

258 AHA White Paper, *supra* note 8, appendix C. In sum, the AHA contends that the mandatory notification under the Hart-Scott-Rodino Act "does not establish or modify the substantive standards for review" and that "the time and expense of HRSA review is often substantial." *Id.* at 24–25. The AHA also critiques the process for seeking an advisory opinion, asserting that the "utility of these voluntary review processes is extremely limited. Perhaps most important, the process is simply too slow to be useful in many situations and provides little real help for hospitals seeking prompt and efficacious guidance. . . ." *Id.*

259 *Id.* at appendix C, p. 3.

260 *Id.* at appendix C, p. 8.

involved in a hospital merger. The analysis involves a close review of data that are not easily or quickly ascertainable, and must be collected on a case-by-case basis. The AHA believes this a compelling argument for an exemption from the antitrust laws for certain hospital mergers.

One possible solution would be to make these opinions binding on the agencies. However, several problems are quickly evident with this approach. First, the enforcement agencies are likely to refuse to approve a merger unless they have sufficient information. It is unlikely that the enforcement agencies will believe that all relevant information was submitted in a short time, as evidenced by the critiques already leveled at the process. Therefore, the difficulty of making this approach workable appears to be a substantial obstacle. Second, even if the process were quick enough, it is still likely to involve significant costs as the necessary information will need to be gathered in an expedited manner. Third, it is unlikely that hospitals contemplating merger would want the findings of an administrative agency to be binding, particularly when the agency is charged with the duty of preventing anticompetitive mergers. Finally, this sort of approval would grant immunity to hospitals who engaged in anticompetitive activity down the road, after receiving the binding approval of the enforcement agencies. Given this risk, and the tradition of erring on the side of caution when considering anticompetitive behavior, this solution does not appear superior to the current administrative review process.

2. STATE HOSPITAL COOPERATION ACTS In response to lobbying from health care providers,[261] a number of states have passed state hospital cooperation acts[262] that grant limited immunization

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261 David Marx Jr., *State Hospital Cooperation Acts: Are They Sufficient Antitrust Shelter for Hospital Collaborations?*, HEALTHSPAN (No. 9, Oct. 1993) at 3.

262 "Since March 1992, 18 states have attempted to provide immunity from federal and state antitrust laws for some activities of hospitals and other health care providers." GAO REPORT, *supra* note 31, at 10. These states are Colorado, Florida, Georgia, Idaho, Kansas, Maine, Minnesota, Montana, Nebraska, New York, North Carolina, North Dakota, Ohio,

against antitrust enforcement for some cooperative actions among hospitals. The goal of such statutes is to create immunity from federal and state antitrust laws[263] for certain activities that have the blessing of the state legislature. All of these statutes apply at least in part to hospitals,[264] and by May of 1994 "12 states had passed legislation creating regulatory programs for hospitals forming joint ventures, 5 states created programs for joint ventures and mergers, and the regulatory program in the 18th state covers only mergers."[265] If the passage of the act and the accompanying grant of immunity qualify as state action, the state may have a tool that would allow it to avoid federal antitrust laws when regulating the provision of hospital services in the name of the health needs of their particular citizens.

Generally, the process of receiving state-granted immunity for cooperative behavior among hospitals follows a pattern similar to the following scenario. To invoke the protection of these acts, the hospital must apply for and receive a "certificate of public advantage." The application for the certificate of public advantage must describe a specific form of cooperation in which the hospitals wish to engage. A state agency, such as the attorney general's office, is then authorized to conduct an investigation of the possible effects of the proposed cooperation to determine the competitive effect. The burden of proof varies from state to state.[266] If the

Oregon, Tennessee, Texas, Washington and Wisconsin. *Id.* at 12. For a list of the specific statutes, *see id.* at 23–58.

263 For example, the Minnesota statute explicitly says that "an arrangement approved by the commissioner . . . shall not be subject to state and federal antitrust liability." MINN. STAT. § 62J2911 (1992). The Colorado legislature found that "[f]ederal and state antitrust laws have inhibited the formation of cooperative health care agreements involving hospitals," COLO. REV. STAT. ANN. § 24-32-2702(2) (West 1993), and went on to state that parties to an approved agreement "shall be immune from *any* civil or criminal antitrust action." COLO. REV. STAT. ANN. § 24-32-2712(1) (West 1993) (emphasis added).

264 GAO REPORT, *supra* note 31, at 11.

265 *Id.* at 10–11.

266 For example, some states require a showing that the benefits outweigh any disadvantages by "clear and convincing evidence" (Maine,

attorney general grants the certificate of advantage, the cooperative behavior is deemed "lawful."[267]

At this point, however, the real issue arises. Should an action be brought, the state cooperation act and the grant of immunity must be found to be "state action" in order to provide protection from federal antitrust law. The doctrine was first developed in *Parker v. Brown*,[268] where a statute designed to protect the California agriculture system and reduce economic waste was found immune from the Sherman Act.[269] This doctrine has been considered in the merger context[270] and provides protection from enforcement of the Clayton Act. In order to qualify as state action, the legislation must meet a two prong test.[271] First, there must be clear evidence of a state policy to displace competition.[272] This is not much of a requirement, as it appears that this prong

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Idaho, Nebraska, North Carolina, North Dakota, Tennessee) or "substantially meet" certain objectives (New York). Others have a lower standard, requiring a balancing of benefits against disadvantages (Kansas, Texas, Washington). Still others require only that it be "likely" that the benefits outweigh the disadvantages, the result will be beneficial, or the activity will achieve the goals of the legislation (Colorado, Florida, Minnesota, Montana, Ohio, Oregon). Georgia, by contrast, does not list any particular advantages or disadvantages that must be considered. GAO REPORT, *supra* note 31, at 23–59.

267 And, even if the certificate of advantage is denied, the negotiations preceding the agreement are also considered lawful. Marx, *supra* note 261, at 4 n.18.

268 317 U.S. 341 (1943).

269 *Id.* at 352.

270 Cableamerica Corp. v. Federal Trade Com'n, 795 F. Supp. 1082, 1992-1 Trade Cas. ¶ 69,780 (N.D.Ala., Apr. 13, 1992) (No. CV-91-N2932-NE); U.S. v. Waste Management, Inc., 588 F. Supp. 498, 1983-1 Trade Cas. ¶ 65,347 (S.D.N.Y., Apr. 29, 1983) (No. 81 CIV. 1113); U.S. v. Pacific Southwest Airlines, 358 F. Supp. 1224, 1973-1 Trade Cas. ¶ 74,492 (C.D.Cal., May 8, 1973) (No.72-2901-DWW).

271 California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

272 *Id.*

can be easily met with a statement of purpose at the beginning of the statute.[273] For example, the Maine statute includes a legislative finding that:

> [c]ooperative agreements among hospitals in the provision of hospital and hospital-related services may foster further improvements in the quality of health care for Maine citizens, moderate increases in cost, improve access to needed services in rural parts of Maine and enhance the likelihood that smaller hospitals in Maine will remain open in services to their communities. . . .[274]

Similarly, the Colorado legislation notes that "it is the intent of the general assembly to displace competition."[275]

Meeting the second prong of the test is more difficult. For the regulated activity to be immune from prosecution under federal antitrust laws, the state must "actively supervis[e]" the collusive behavior. In *Federal Trade Commission v. Ticor Title Insurance Company*,[276] the Supreme Court refined the requirements of the active supervision prong, holding that the purpose of the test:

> is to determine whether the State has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not sim-

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273 One enterprising defendant attempted to invoke the protection of the state action doctrine by arguing that the CON requirement "evinces a state policy favoring the displacement of unfettered competition among hospitals for health-care services." F.T.C v. University Health, Inc., 938 F.2d 1206, 1213 n.13 (11th Cir. 1991). The 11th Circuit rejected this argument on the grounds that "[i]ntent to repeal the antitrust laws is much clearer when a regulatory agency has been empowered to authorize or require the type of conduct under antitrust challenge." *Id.* (citations omitted).

274 Marx, *supra* note 261, at 4 (citing 1992 Me. Laws 814, § 2). However, the Maine statute specifically excludes hospital mergers from its protection. M.R.S.A., 22 § 1886(4) (West Supp. 1995).

275 COLO. REV. STAT. ANN. § 24-32-2706(2)(i) (West 1993). It must be noted that despite this clear statement of purpose, the Colorado legislation covers "cooperative agreements," including joint ventures and other collaborative efforts between hospitals, but does not include mergers in this definition. GAO REPORT, *supra* note 31, at 24.

276 119 L. Ed. 2d 410 (1992).

> ply by agreement among private parties. . . . the analysis asks *whether the state has played a substantial role in determining the specifics of the economic policy*. The question is not how well the state regulation works but whether the anticompetitive scheme is the State's own.[277]

It is unclear whether the provision of acute inpatient care, where price is not regulated by a government agency, will meet this test.

To avoid this problem, states have attempted to implement a policy of "deliberate state intervention" with regard to the prices charged by hospitals acting under the authority of a certificate of advantage. However, under *Ticor*, regulation cannot be passive. The Court clarified:

> Where prices or rates are set as an initial matter by private parties, subject only to a veto if the State chooses to exercise it, the party claiming the immunity must show that state officials have undertaken the necessary steps to determine the specifics of the price-fixing or ratesetting scheme. The mere *potential for state supervision is not an adequate substitute for decision by the State.*[278]

In other words, the state must *actually* review the prices or policies that would result from a hospital merger, not simply establish a mechanism for doing so. This supervision should be ongoing, as price adjustments for hospital services will be constant.

The states appear aware of the actual supervision requirement. For example, the Colorado legislation provides that:

> The board shall promulgate rules requiring the parties to any approved cooperative agreement to submit annual reports that provide information reasonably necessary to enable the board to evaluate the impact of the agreement on the availability, cost effectiveness, quality, and delivery of hospital or health care services and to determine whether such parties have complied with the terms of the agreement.[279]

Similarly, the Minnesota legislation mandates that the approved "arrangements be accompanied by appropriate conditions, super-

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277 *Id.* at 423 (emphasis added).

278 *Id.* at 425 (emphasis added).

279 COLO. REV. STAT. ANN. § 24-32-2708(1) (West 1993).

vision and regulation to protect against private abuses of economic power."[280] The ability of these provisions to immunize mergers between private[281] hospitals is unclear,[282] and will remain unclear until the Supreme Court decides the issue.[283] However, such ongoing regulation has been held sufficient to provide immunity.[284] Given these decisions, it appears that the state legislation includes sufficient mechanisms for ongoing regulation to immunize state condoned activity. Finally, it appears that the enforcement agencies are aware of this aspect of the puzzle, and they "are apparently drafting guidelines concerning the application of the

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280 MINN. STAT. ANN. § 62J2911 (West 1993). Specific procedures are established that mandate the submission of certain data at least once a year. MINN. STAT. ANN. § 62J2920 (West 1993).

281 The state action doctrine has been successful in protecting the purchase of a private hospital by a county hospital. F.T.C. v. Hospital Bd. of Directors of Lee County, 38 F.3d 1184 (11th Cir. 1994). The decision does not, however, clarify the ability of private hospitals to invoke the protection of the state action doctrine.

282 "[T]he effectiveness of state-initiated reforms at insulating private conduct from the federal antitrust laws remains far from clear." Meyer & Rule, *supra* note 62, at 174.

283 As of August 1994 the GAO was not aware of any challenge to these laws. GAO REPORT, *supra* note 31 at 15.

284 *See* Yeager's Fuel v. Pennsylvania Power & Light, 22 F.3d 1260, 1271 (3d Cir. 1994) (holding that the government agency "affirmatively approved [the rate], after considered study which included more than a review for mathematical accuracy"); DFW Metro Line v. Southwest Bell, 988 F.2d 601, 606 (5th Cir. 1993) (finding that "the record reflects numerous references to the PUC's inquiry into the reasonableness of Bell's rates," and the government agency conducted proceedings and provided a forum for complaints); Sandy River Nursing Care v. Nat. Council, 798 F. Supp. 810, 816 (D.Me. 1992) (finding that "[t]he Superintendent of Insurance held adjudicatory hearings each year to review the rate proposals submitted by insurers; and each year, after thorough review, the Superintendent approved rate increases smaller than those insurers suggested").

state action doctrine in cases 'where a state seeks to grant antitrust immunity to hospitals.' "[285]

There are a number of advantages to this approach. First, the process allows hospitals contemplating cooperative action to test the waters without risking a government or civil lawsuit.[286] Not only does this allow hospitals to investigate methods of creating more efficient operations, it grants them some degree of predictive certainty with regard to the results of their actions. If their application is approved, they are immune, and if it is not, the activity is probably not recommended.

Perhaps the optimum solution for hospitals contemplating merger in states that have hospital cooperation acts, is to attempt to fall within the purview of the act while at the same time arranging an agreement similar to that reached in *Morton Plant*. Hospitals that managed to gain this dual protection would be doubly safe from lawsuits, perhaps creating the kind of certainty that the hospital industry and commentators have found lacking under current antitrust law and policies. At the same time, concerns over anticompetitive behavior will be addressed, creating an optimum solution for the health care consumer as well.

However, there are a number of problems that may prevent state hospital cooperation acts from being the solution the hospital industry needs to reduce the uncertainty created by the present antitrust laws.[287] First, "the uncertainty associated with the legal

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285 Meyer & Rule, *supra* note 62, at 208 (citing Clinton Administration Description of President's Health Care Reform Plan, *American Health Security Act of 1993*, dated Sept. 7, 1993, Obtained by BNA, Daily Lab. Rep. (BNA) No. 175 (Sept. 13, 1993)).

286 Provided, of course, that they follow the statutory procedural requirements necessary to invoke immunity for their preapplication negotiations.

287 There are practical, as well as legal considerations that may prohibit hospitals from seeking to obtain certificates of public advantage, including the unwillingness to allow competitors access to private information during the application process, the logistical burdens of producing evidence and personnel for the hearings, and the challenge of a higher burden of proof than defending a traditional antitrust suit by the Attorney General or a private party. Marx, *supra* note 261, at 6.

issues could substantially weaken the legislation's intended benefits"[288] because "it is not entirely clear that these efforts will insulate from federal scrutiny all of the contemplated state-approved, private collaborative conduct."[289] Until the legislation is tested in the courts in the circuit where the hospital finds itself, the hospitals may proceed as if immune, only to discover the state legislation is inadequate to provide immunity.[290] At the least, a challenge to the legislation may be likely because, at least in practice, "[t]he federal enforcement agencies have specifically declined to provide approval for . . . efforts" by hospitals to voluntarily allocate health care resources, despite the fact that they "are undertaken pursuant to planning programs sponsored and encouraged by state or local government or local business leaders."[291] Thus, hospitals contemplating mergers may still be subject to challenge by the enforcement agencies, an expensive prospect that may act as a barrier to merger, at least until the Supreme Court defines specifically what kind of state involvement is necessary to grant immunity for hospital mergers or other collaborative activity.[292] Finally, many hospitals may not be prepared to risk the automatic determi-

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288 *Id.* at 6 n.20.

289 Meyer & Rule, *supra* note 62, at 209.

290 One author has noted that this issue "is not likely to be resolved without litigation." Marx, *supra* note 261, at 6. In response, it should be remembered that if the burden of obtaining a certificate of public advantage is higher than that of a civil suit, and if a hospital could legitimately prove the necessary efficiencies by "clear and convincing" evidence, it should be able to prevail in a traditional antitrust challenge using the same evidence. However, each case is different, and the problem of uncertainty will remain, particularly where a jury may be involved. Nor will the potential cost of litigation be eliminated.

291 AHA White Paper, *supra* note 8, at 7 (citing letter from Sanford M. Litvack, Assistant Attorney General, United States Department of Justice Antitrust Division, to William K. Kopit, partner, Epstein Becker & Green, P.C. (May 6, 1980) (on file with the United States Department of Justice Antitrust Division)).

292 For a brief discussion of one hospital's attempt to avoid federal antitrust scrutiny under the state action doctrine, *see Hospital Plan in Maine Tests Antitrust Law*, WALL ST. J., Aug. 25, 1993, at B1.

nation that the proposed transaction is void in the event a certificate of public advantage is denied.

In sum, the ability of state cooperation acts to solve the dilemma faced by hospitals contemplating merger remains unclear. First, none of the legislation has yet been challenged, so the ability of any of the statutes to immunize hospital mergers is uncertain. Even if one statute is upheld, the differences between the legislation of the different states is such that a decision in one state is not a guarantee that another state's legislation will receive the same treatment. Therefore, the passage of such legislation and the corresponding grant of immunity does not cure the problematic uncertainty facing those hospitals contemplating merger. An application process that may be lengthy and expensive and that offers no certain outcome is still necessary. Accordingly, while state legislation offers some solace, it is not the type of clear national policy sought by the hospital industry as a whole.

B. Maintain the status quo

The solution of remaining with the status quo seems anticlimactic. However, the proposed solutions all have some shortcomings. A solution that does not allow the enforcement agencies or private parties to challenge anticompetitive mergers is imprudent and risks exacerbating the health care crisis facing America today. Certainly, the danger of anticompetitive behavior leading to higher costs and inefficiencies must be avoided. At the same time, activities that lead to efficiency and lower costs must be promoted. Unfortunately, from the perspective of antitrust enforcement, a blanket solution does not appear able to meet both these goals.

Because of the nature of the hospital care market, a case-by-case analysis of each merger seems particularly appropriate—each market, provider, and customer base is different. This is supported by the different results of litigation around the country. Similar mergers led to different results in *Rockford* and *Roanoke*,[293] and a

[293] Again, the reasons for the different decisions are widely disputed. It could be a result of the application of the Clayton Act to the merger in

concentration level that was clearly unacceptable under any of the guidelines was found to pose no threat to consumers in *Ukiah*. The structure for conducting such a case-by-case analysis is already in place—it is existing antitrust law as applied by the courts and enforcement agencies. Perhaps James Egan, the Director of Litigation for the FTC, summarized it best when he stated:

> [C]ompetition is important to containing costs and ensuring quality, and . . . antitrust enforcement is flexible enough to prevent harmful conduct without interfering with efficient joint conduct that benefits consumers.[294]

This solution may not eliminate the uncertainty faced by hospitals contemplating mergers. However, as the law develops and more precedent is made, more guidance becomes available. In the meantime, hospitals may engage in negotiations to embark on joint ventures as in *Morton Plant*, and may seek administrative review through existing mechanisms. In states with hospital cooperation acts, hospitals contemplating merger may seek the protection of state legislation.

After consideration, the hospital industry's complaint that uncertainty and the potential or actual costs of litigation or administrative review are prohibitive is hard to swallow. If the potential savings are not enough to outweigh the cost of seeking an advisory opinion or litigating, perhaps the efficiencies and savings from the proposed merger are not enough to offset the risk of anticompetitive behavior—which is clearly disfavored as poor public policy. Perhaps the solution is found in the time-honored American tradition of competition—to the victor go the spoils. Inefficient hospitals that are unable to compete should be allowed to quietly die, and the remainder to compete with one another under

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Rockford and the Sherman Act in *Roanoke*, the different product markets, or different geographic markets. But the analysis of the anticompetitive effect of the merger must involve some sort of value judgment by the decisionmaker. Perhaps the result is due to intangible differences that, for policy reasons, it is better to have independent decisionmakers decide based on the individual circumstances of the case.

294 Marx, *supra* note 261, at 6 (quoting James C. Egan Jr., Director of Litigation).

the continued scrutiny of the enforcement agencies and current antitrust law.

VIII. Conclusion

The United States is undoubtedly facing a health care crisis. One component of this crisis is an increase in the number of hospital mergers, as the hospital industry attempts to restructure in response to the changing American health care market. Some commentators believe this trend signals a crisis in the hospital industry, and want hospitals to receive some sort of special treatment under the antitrust laws. However, another perspective is that the hospital industry is merely undergoing some restructuring in response to the changing dynamics of a leaner more competitive market, just as virtually all industry must do from time to time. Indeed, it would be as specious to argue that the result of this trend will be the end of the hospital industry as it would be to argue that people will soon no longer need hospital services. Accordingly, it would appear unwise to revise the antitrust laws on the basis of this "crisis." Both the hospital industry and the enforcement agencies should continue to explore innovative approaches under current law, as was done in *Morton Plant*, and should continue to seek solutions acceptable to both camps. Under this approach, efficiency can be sought without sacrificing antitrust enforcement.