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## Comments: Hospital Mergers Versus Consumers: An Antitrust Analysis

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## HOSPITAL MERGERS VERSUS CONSUMERS: AN ANTITRUST ANALYSIS

### I. INTRODUCTION

The hospital industry has recently experienced an unprecedented wave of mergers, acquisitions, and other forms of consolidation. In 1996, 235 transactions involving 768 hospitals took place.<sup>1</sup> From 1994 through 1996, nearly 40% of the nation's 5,200 non-federal hospitals were involved in some type of merger or acquisition activity.<sup>2</sup> Although the numbers for 1997 dropped, they were still significant: 217 transactions involving 627 hospitals.<sup>3</sup> In addition, the size of mergers and the number of hospitals controlled by one system are rising.<sup>4</sup>

The merger wave includes for-profit hospitals, non-profit hospitals, and religiously affiliated hospitals.<sup>5</sup> Catholics for a Free Choice ("CFFC") identified fifty-seven mergers and affiliations between Catholic and non-Catholic providers between 1990 and 1995.<sup>6</sup> In a 1998 study update, CFFC identified an additional thirty-eight completed consolidations between Catholic and non-Catholic hospitals, with twenty more pending.<sup>7</sup> This trend subsided in 1999, as the total number of mergers and acquisitions declined 28% from the previous year,

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1. Bruce Japsen, *Another Record Year for Dealmaking: Activity Among Medium-Size Companies Fuels Continued Drive Toward Consolidation*, MODERN HEALTHCARE, Dec. 23, 1996, at 37.
  2. *Id.* Merger or acquisition activity includes full-asset mergers, acquisitions, lease agreements, joint ventures, and partnerships in which control or a significant equity stake in a hospital changes hands. See Bruce Japsen, *An Off Year for Consolidation: '97 Tally Shows Sharp Cutback in Big Corporate Deals*, MODERN HEALTHCARE, Jan. 12, 1998, at 40.
  3. See Japsen, *An Off Year for Consolidation*, *supra* note 2, at 40.
  4. See Japsen, *Another Record Year*, *supra* note 1, at 37.
  5. Japsen, *An Off Year for Consolidation*, *supra* note 2, at 40.
  6. JUDITH C. APPELBAUM, NATIONAL WOMEN'S LAW CENTER, *HOSPITAL MERGERS AND THE THREAT TO WOMEN'S REPRODUCTIVE HEALTH SERVICES: USING ANTI-TRUST LAWS TO FIGHT BACK* 7 (1998).
  7. *Id.*

to 142.<sup>8</sup> In addition, the number of hospitals involved dropped 23% to 530.<sup>9</sup>

Despite the decrease in the number of transactions in 1999, ten very large transactions were completed, several of which involved secular and non-secular hospitals. Of the ten corporate health care mergers, the largest was the merger of Daughters of Charity National Health System and Sisters of St. Joseph Health System.<sup>10</sup> The merger of these two Roman Catholic organizations created Ascension Health, which is now comprised of seventy-three hospitals, with more than six billion dollars in revenue.<sup>11</sup>

Hospital mergers are complicated because such mergers inevitably affect a patient's choices and preferences. Patient choice of hospitals is determined by many different variables, including: (1) patients who want only a particular doctor to perform the necessary services or procedures;<sup>12</sup> (2) others who choose a hospital based on their perception of quality;<sup>13</sup> and (3) other patients who wish to remain near their home and choose a hospital within close proximity.<sup>14</sup> Further, the patient's managed care organization (MCO), commonly known as the insurance company or third-party payor, is an increasingly important variable in a patient's choice of hospital.<sup>15</sup> MCOs can influence, or even change, a patient's behavior.<sup>16</sup>

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8. Deanna Bellandi, *Spinoffs, Big Deals Dominate in '99: Despite Some High-Volume Mergers, Total Hospital Transactions Dipped 28% Compared With the Previous Year*, MODERN HEALTHCARE, Jan. 10, 2000, at 36. The tally includes "mergers, acquisitions, joint ventures, long-term leases and other partnerships in which control changed significantly or an equity stake transferred ownership." *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. See Sharla Lichtman, *Ontario Doctors Talk Back*, FINANCIAL POST, Feb. 21, 2000, at CO7; see also *United States v. Mercy Health Services*, 902 F. Supp. 968, 973 (N.D. Iowa 1995) (indicating that patients consider many factors when deciding where to receive inpatient care).

13. See *Medical Centers of Excellence: An Idea Ripe for Implementation in Today's Health Care Industry*, HEALTH CARE STRATEGIC MANAGEMENT, Jan. 1, 2000, at 24. See also *Mercy*, 902 F. Supp. at 973.

14. See *Medical Centers of Excellence*, *supra* note 13, at 24. See also *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990); Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 LAW & CONTEMP. PROBS. 93, 142-143 (1988).

15. See *Mercy*, 902 F. Supp. at 973-974 (indicating that managed care has forced individuals to consider the amount of their out-of-pocket expenses).

16. See *id.*

When two or more hospitals merge, many concerns arise: what happens to the patient's choice? What does the patient do in an emergency when the doctor of choice no longer has privileges at the merged hospital, but does have privileges at a hospital forty miles away? What does a patient do when certain services are eliminated as a result of the merger or when the patient wishes to remain in a hospital close to home, but the insurance company steers the patient to a hospital thirty miles away because services are less expensive? Furthermore, what happens when there is a merger between the only two hospitals in a rural area or when a Catholic and non-Catholic hospital merge?

In a hospital merger case, a governmental agency, either the Federal Trade Commission (FTC) or the Department of Justice (DOJ) (collectively referred to as "the Agencies"), must assess any anti-competitive effects of the merger.<sup>17</sup> In addition, the relevant market, the merged parties' relevant share in that market, the market concentration, and, if applicable, any efficiency rebuttals must be examined.<sup>18</sup> The issue of patient choice, i.e. consumer choice, can generally be addressed in any part of this analysis, however, it is typically overlooked when hospitals merge.

Although limited consumer choice may prove to be a fatal factor in some merger cases,<sup>19</sup> hospital merger cases have been evaluated differently. In a hospital merger case, the consumer choice issue appears to be overlooked when defining the geographic market, and also when the parties prove that substantial efficiencies<sup>20</sup> will result from the merger.<sup>21</sup>

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17. See DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION, 1992 HORIZONTAL MERGER GUIDELINES, 57 Fed. Reg. 41552, 41554 (1992).

18. See *id.*

19. *E.g.*, National Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 692 (1978) (stating that agreements limiting consumer choice impede the workings of the marketplace); Full Draw Productions v. Easton Sports, Inc., 182 F.3d 745, 755 (10th Cir. 1999) (citing limited consumer choice as a factor in finding that the defendant's behavior was anticompetitive). *But see* F.T.C. v. Sperry & Hutchinson Co., 405 U.S. 233, 248 (1972) (stating that while limiting consumer choice is a factor to be considered, it alone would not support a finding of unfair trade practice).

20. See *infra* Part V.B.2.

21. See Richard D. Raskin & Bruce M. Zessar, *Telling the Efficiencies Story: Practical Lessons from the Hospital Merger Field*, 13 ANTITRUST 21, 23 (1999) (stating that the FTC has indicated that the "hospital industry is an area in which efficiencies can be of particular significance" as "[c]ertain characteristics of hospitals lend themselves to effective efficiencies cases").

Due to the uniqueness of the hospital market,<sup>22</sup> the Agencies often misconstrue the geographic market in which hospitals and consumers are located.<sup>23</sup> This misconception, combined with various ways to include consumers in the market, draws attention away from consumer choice. Instead of arguing the nuances of the geographic market, the Agencies should set a standard definition that focuses on maintaining consumer choice.

Furthermore, the two issues, limited consumer choice and efficiencies, can often contradict each other. For example, in order for the newly-merged hospital to be more efficient, it may curb or cut some services previously available at either one, or both, of the hospitals.<sup>24</sup> Although curbing a service may lead to cost savings, some consumers will be unable to obtain a necessary service, or unable to visit the most convenient location.

Consumer choice is especially relevant in mergers involving a Catholic and non-Catholic hospital where reproductive services may be curbed or eliminated.<sup>25</sup> As hospitals find it increasingly necessary and cost-efficient to consolidate,<sup>26</sup> the issue of limited consumer choice should be placed at the forefront of any agency's analysis.

Analyses of hospital merger cases tend to focus on the efficiencies defense raised by the defendants.<sup>27</sup> In other merger cases, this defense is usually unacceptable because efficiencies are difficult to measure and are even more difficult to prove.<sup>28</sup> Surprisingly, in hospital merger cases, the courts are often inclined to accept an efficiencies defense as an absolute defense, thereby precluding any scrutiny by either of the Agencies.<sup>29</sup>

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22. See William G. Kopit & Tanya B. Vanderbilt, *Unique Issues in the Analysis of Non-Profit Hospital Mergers*, 35 WASHBURN L.J. 254, 254-59 (1996).

23. See *infra* Part V.C.1.b.

24. See Raskin & Zessar, *supra* note 21, at 23; see also Jonathan Choslovsky, *Agency Review of Health Care Industry Mergers: Proper Procedure or Unnecessary Burden?*, 10 ADMIN. L.J. AM. U. 291, 294-295 (Spring 1996); Baker, *supra* note 14, at 99-100.

25. See Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1088 (1996); see also APPLEBAUM, *supra* note 6, at 9.

26. See Raskin & Zessar, *supra* note 21, at 21; see also Choslovsky, *supra* note 24, at 293-94.

27. See, e.g., *United States v. Long Island Jewish Medical Center*, 983 F. Supp. 121 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd in unpublished opinion*, 121 F.3d 708 (6th Cir. 1997) (table).

28. See *FTC v. Staples*, 970 F. Supp. 1066, 1089 (D.D.C. 1997).

29. See *Long Island Jewish Medical Center*, 983 F. Supp. at 137; *Butterworth Health Corp.*, 946 F. Supp. at 1300; see also HORIZONTAL MERGER GUIDELINES, *supra* note 17, 57 Fed. Reg. at 41562.

In addition, the Agencies, through their guidelines, and the courts, through case law, have severely impaired a party's ability to challenge a rural hospital merger. The rural exception,<sup>30</sup> in large part, is a spin-off of the efficiencies defense. Currently, this exception, in effect, encourages health care monopolies in rural areas. Thus, because monopolies completely eliminate choice, consumers in rural areas are left with no options when hospitals merge.

As a result of these factors, when the Agencies challenge a merger, consumers get lost amid a mass of definitions and speculations. For example, consumers are repeatedly lost in battles over what constitutes a geographic market and in the guesses that comprise the efficiencies defense. Though patients are the group most affected by a merger, patients are a secondary consideration for decision-makers who evaluate the effects of the merger. Consumers and their choice, however, should be at the forefront of all merger analyses. Through a careful look at case history, the governmental agencies challenging mergers should be able to create a case that focuses on, and ultimately protects, consumers.

Section II of this Comment provides a general discussion and background of the health care industry and gives a brief overview of hospital mergers.<sup>31</sup> Section III discusses the antitrust environment as it relates to the health care industry.<sup>32</sup> In Section IV, this Comment discusses horizontal merger regulations as promulgated by the Agencies.<sup>33</sup> Section V examines merger analysis under the Clayton Act.<sup>34</sup> Section VI explains the exception allowing rural hospitals to merge, despite the consumer choice consequences, without scrutiny by either of the Agencies.<sup>35</sup> In Section VII, this Comment briefly describes the convergence of the Clayton and Sherman Acts, and provides an analysis of merger cases under the Sherman Act.<sup>36</sup> Finally, the conclusion in Section VIII discusses how the Agencies can and should advocate consumer choice.<sup>37</sup>

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30. See *infra* Part VI.

31. See discussion *infra* Part II.

32. See discussion *infra* Part III.

33. See discussion *infra* Part IV.

34. See discussion *infra* Part V.

35. See discussion *infra* Part VI.

36. See discussion *infra* Part VII.

37. See discussion *infra* Part VIII.

## II. BACKGROUND

### A. *The Evolution of the Health Care Industry Encouraged Mergers, Eviscerating Patient Choice*

Since the 1980s, the health care industry experienced dramatic changes. Most notably, changes occurred in the regulatory environment, which affected hospital merger analysis.<sup>38</sup> Regulatory changes were a result of cost escalation, changes in insurance, changes in hospital reimbursement and patient lack of information.<sup>39</sup> These regulatory changes resulted in increased hospital merger and acquisition activity during the early 1980s.<sup>40</sup>

The changes in the health care field began with insurance and hospital reimbursement under the Medicare and Medicaid programs. During the 1960s and 1970s, hospitals had very little incentive to minimize costs or compete on cost-basis because health care insurance incorporated retrospective cost-based or charge-based reimbursement.<sup>41</sup> This prepaid health insurance led to both an over-utilization of health care services provided by hospitals and physicians and to increased health care prices.<sup>42</sup>

The patients' lack of information exacerbated the inefficient high costs and over-utilization associated with the provision of health care services.<sup>43</sup> Doctors decided the amount of care needed, where that care would be administered, and then administered the necessary care.<sup>44</sup> Given that physician compensation was related to the level and amount of care selected for a patient, the cost-based reimbursement system encouraged overuse of services and extended lengths of stays. Thus, the cost of health care rose to inefficient levels.<sup>45</sup>

Health care cost escalation was also a result of the regulatory scheme established in the 1960s.<sup>46</sup> Continued increases in cost, in

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38. Baker, *supra* note 14, at 94. The "regulatory environment" in the health care industry takes into consideration patients, hospitals, doctors, and insurance companies.

39. *See infra* notes 41-63 and accompanying text.

40. Baker, *supra* note 14, at 94.

41. *Id.* at 95. Cost-based reimbursement was a fee-for-service concept, whereby Medicare or Medicaid reimbursed hospitals based on the institution's charges for all services rendered. *See* JOSEPH SNOE, AMERICAN HEALTH CARE DELIVERY SYSTEMS 620 (West Group 1998).

42. Baker, *supra* note 14, at 95.

43. *See id.*

44. *Id.*

45. *See id.*

46. *Id.* at 96. Under cost-based reimbursement, patients were entitled to full reimbursement for medical care with the exception of opportunity costs, which included travel and time away from work or leisure. *Id.*

part due to Medicare and Medicaid reimbursement, prompted Congress to address the issue. In the late 1970s and early 1980s, Congress enacted the main elements of the health care regulatory scheme.<sup>47</sup>

Congress limited the quantity of health care provided to consumers in order to control increasing costs.<sup>48</sup> State regulatory boards were created to supervise large hospital capital expenditures through the use of Certificate of Need ("CON") applications.<sup>49</sup> Congress also created peer review programs to monitor and limit physician choice of care to further decrease costs.<sup>50</sup> These changes were cumbersome to most states, and did not effectively control spiraling health care costs.

The Prospective Payment System ("PPS"), introduced in 1983 and in effect today, replaced the 1970s monitoring system. Under the PPS, Medicare and Medicaid provide a standardized payment, based on a predetermined formula, to every hospital for each patient with a given diagnosis.<sup>51</sup> This cap, or standardized payment, guarantees that every hospital will recover the average cost of treating each patient.<sup>52</sup> Since a hospital will only receive a fixed cost, a longer length of stay causes a hospital to lose money. Conversely, providing minimal services to a patient in a shorter time frame (known as under-utilization) allows the hospital to profit from the fixed payment.<sup>53</sup> As a result, hospitals must lower treatment costs or shorten lengths of stay in order to increase profits.<sup>54</sup> Thus, the current payment system encourages hospitals to contain costs.

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47. *Id.*; see also National Health Planning and Development Act, Pub. L. No. 93-641 (codified at 42 U.S.C. § 300k (repealed 1986)). This Act, *inter alia*, subjected large hospital expenditures to the supervision of regulatory boards through the requirement of a Certificate of Need in order to add services, facilities, or beds. See *infra* note 49 for a brief discussion of Certificate of Need.

48. Baker, *supra* note 14, at 96.

49. *Id.* Essentially, CONs are entry barriers. See *FTC v. University Health, Inc.*, 938 F.2d 1206, 1219 (11th Cir. 1991). In order to build a new facility, add a service, add beds, or open a new hospital, the state must approve the addition or change through the CON process. CON attempts to coordinate the development of new health care facilities by preventing unnecessary health care costs. *Id.* CON laws regulate the supply of equipment and facilities because normal market forces of supply and demand are thought not to work in the health care market. See SNOE, *supra* note 41, at 308.

50. Baker, *supra* note 14, at 97.

51. *Id.* The standardized payment is based on the average costs associated with the treatment of the patient's diagnostic related group (DRG). *Id.*

52. *Id.*

53. See SNOE, *supra* note 41, at 621.

54. See Baker, *supra* note 14, at 98.



The overall result of these changes to the regulatory environment increased competition among hospitals.<sup>55</sup> This increased competition led to a variety of alternatives within the structure of the health care industry.<sup>56</sup> For example, the rapid growth of multi-hospital systems may be a direct result of the cost-cutting pressures created by the evolving regulatory environment.<sup>57</sup> In addition, peripheral centers have entered the market as competition for hospitals.<sup>58</sup> Due to technology advancements, alternative providers, such as outpatient treatment centers, now provide some treatment that was previously only available on an inpatient basis.<sup>59</sup> As a result, the demand for inpatient treatment has declined and hospitals are left to administer, strictly on an inpatient basis, the most expensive, technologically dependent, and complex forms of services.<sup>60</sup>

Given the current reimbursement system, PPS, hospitals continue to lose profits. Many hospitals now find a merger the most attractive alternative in order to curb costs and profit losses.<sup>61</sup> Ultimately, this changing environment may have induced the wave of hospital mergers and acquisitions that require antitrust analysis.<sup>62</sup> These changes have set the stage for an increasing number of acquisitions and mergers in a struggle to survive the financial constraints of the current health care system.<sup>63</sup>

## B. *What Happens When Hospitals Merge?*

### 1. The Negative Effect on Consumers

When hospitals merge, a major consolidation of facilities and services usually takes place.<sup>64</sup> For example, if both hospitals have excess

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55. *See id.*

56. *See id.* at 99.

57. *Id.* at 99-100. Hospitals often form large systems to adjust to managed care costs, enhance purchasing power, and acquire capital for increased borrowing power. *See SNOE, supra* note 41, at 818; *see also Choslovsky, supra* note 24, at 292.

58. Choslovsky, *supra* note 24, at 293-94. Peripheral centers include outpatient treatment centers owned by managed care organizations or physician groups. *Id.*

59. *Id.* at 293. For example, many surgeries such as orthoscopic knee operations, typically an inpatient procedure, are now performed in an outpatient treatment facility.

60. *Id.* at 294.

61. *See SNOE, supra* note 41, at 813.

62. *See Baker, supra* note 14, at 100.

63. *See Choslovsky, supra* note 24, at 298.

64. Consolidation of services and facilities can include the following: laboratory services can be combined at one facility in order to eliminate duplicative

bed capacity, all general acute-care services may be moved to one facility, using the other facility for different services, or closing it altogether. If state and CON<sup>65</sup> laws permit, the second facility may become a different health care institution, such as a skilled nursing facility. The most common result is that one hospital is closed and all services are consolidated into the remaining hospital.

The ultimate result of consolidation is that patients lose their ability to choose a hospital or doctor. For example, the hospital nearest to a patient's home may have closed, while the newly-merged facility is located thirty miles away. The patient's doctor may not have been granted privileges at the merged hospital, thereby forcing the patient to find a new doctor or to travel to the hospital where the doctor has privileges.

## 2. Catholic and Non-Catholic Hospital Mergers—the Detrimental Impact on Consumers

Although the merger of a Catholic and non-Catholic hospital will have the same results as described above, these mergers have the additional burden of creating compromises on the issue of reproductive services. Most Catholic hospitals follow the “Ethical and Religious Directives for Catholic Health Care Services” (“Directives”).<sup>66</sup> These Directives require Catholic facilities, and professionals practicing in those facilities, to adopt and adhere to them as a condition of medical privilege and employment.<sup>67</sup> The practical effect of the Directives is limiting services in accordance with the beliefs of the Catholic faith.

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testing facilities; various medical units can be consolidated, which results in a significant reduction in staff members; the dietary department of both hospitals can be consolidated using one central food production facility; purchasing and management can be consolidated and achieve a reduction in personnel through negotiating volume discounts with vendors that the hospitals could not obtain separately; laundry services can be consolidated so that one hospital can process both hospitals' linens; management information services personnel can be reduced; computer services can be consolidated to one operating system; administration can be consolidated to one umbrella for both hospitals or the one remaining hospital, depending on the circumstances of the merger; and technical services, such as obstetrics or cardiology, may be consolidated at the most advanced facility, or the facility where the service is currently in place. See Raskin & Zessar, *supra* note 21, at 22.

65. See *supra* note 49 and *infra* notes 258-59 for a discussion of CON.

66. See APPELBAUM, *supra* note 6, at 7-8. The Directives “provide ‘authoritative guidance’ to Catholic health care institutions and professionals on standards of behavior that flow from church doctrine.” *Id.* at 7.

67. *Id.* at 7-8.

For example, the Directives prohibit abortion, contraceptive services or counseling, sterilization procedures, and infertility treatments.<sup>68</sup> Thus, if a Catholic hospital and non-Catholic hospital merge, the effect on services available can be even greater than that of a merger between two secular hospitals.

In a merger involving a Catholic hospital and a non-Catholic hospital, the secular hospital may be required to abide by the Directives.<sup>69</sup> As a result, services such as abortion, surgical sterilization, tubal ligation, and distribution of the "morning-after" pill for rape victims may be eliminated.<sup>70</sup> Consequently, patients seeking these services may be unduly burdened with excess costs and travel time to facilities that will provide the necessary service.

### III. THE ANTITRUST ENVIRONMENT SURROUNDING THE HEALTH CARE INDUSTRY

#### A. *Evolution of Antitrust Regulation Envelops the Health Care Industry and its Consumers*

While the health care industry, particularly in the 1980s, experienced some dramatic changes, the legal environment also experienced some changes making antitrust principles more applicable to the health care industry.<sup>71</sup> First, the Supreme Court, in *Goldfarb v. Virginia State Bar*,<sup>72</sup> held that antitrust principles embodied in the Sherman Act apply to the activities of "learned professionals."<sup>73</sup> Thus, doctors, their practices, and the hospitals in which they worked, were no longer exempt from antitrust law.

Second, in *Hospital Building Co. v. Trustees of Rex Hospital*,<sup>74</sup> the Supreme Court held that a restraint on competition, even in a local hospital market, can "substantially and adversely affect interstate commerce."<sup>75</sup> Therefore, hospitals were subject not only to the Com-

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68. *Id.* at 8.

69. *Id.* at 7-8. This can often be the breaking point for a secular/non-secular merger, where some merger negotiations have broken down over the Catholic hospital's staunch stand on the Directives.

70. *Id.* at 8.

71. See Baker, *supra* note 14, at 106.

72. 421 U.S. 773 (1975).

73. *Id.* at 787 (indicating that the nature of an occupation or profession does not provide "sanctuary" from the antitrust laws).

74. 425 U.S. 738 (1976).

75. *Id.* at 743 (quoting *Gulf Oil Corp. v. Copp Paving Co.*, 419 U.S. 186, 195 (1974)). In this case, "the restraint allegedly affected the interstate flow of a hospital's medicine and supplies, third-party payment and management fees . . ." John J. Miles & Mary Susan Philp, *Symposium: Current Developments*

merce Clause, but also to the government's jurisdiction under the antitrust laws.

Finally, in *National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City*,<sup>76</sup> the Supreme Court held that the National Health Planning and Resources Development Act<sup>77</sup> does not provide blanket immunity to activities that arguably fall under the rubric of health planning.<sup>78</sup> The repeal of the Act left states with the option to regulate their respective health care industries.<sup>79</sup> A state's authority to approve a CON for a hospital merger does not, however, immunize the merger from judicial review under the applicable antitrust laws.<sup>80</sup> As a result of these decisions, the FTC and DOJ became increasingly interested in antitrust enforcement in the health care industry.<sup>81</sup>

#### B. Congressional Action to Protect Consumers in this Merger Market

Congress sought a way to protect consumers and small businesses from the anticompetitive effects of mergers.<sup>82</sup> In 1914, Congress passed the Clayton Act<sup>83</sup> to prevent economic concentration and to protect interstate commerce.<sup>84</sup> This Act prohibited persons engaged in, or affecting, interstate commerce from acquiring "stock or other share capital" of another.<sup>85</sup>

Under this Act, corporations were able to avoid scrutiny by acquiring non-stock assets.<sup>86</sup> This change reflected congressional concern that the economy had become too concentrated in the hands of a few large companies,<sup>87</sup> and sought to limit increases in economic concen-

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*in Health Law; Hospitals Caught in the Antitrust Net: An Overview*, 24 DUQ. L. REV. 489, 496 (1985).

76. 452 U.S. 378 (1981).

77. Pub. L. No. 93-641 (codified at 42 U.S.C. § 300k (repealed 1986)). See *supra* note 47 and accompanying text for a brief description of this Act.

78. See *National Gerimedical Hosp.*, 452 U.S. at 393 (indicating that the Act is not so incompatible with antitrust laws so as to create a "'pervasive' repeal of the antitrust laws as applied to every action taken in response to the health-care planning process").

79. See Baker, *supra* note 14, at 107.

80. See *id.*

81. See Miles & Philp, *supra* note 75, at 496.

82. See S. Rep. No. 81-1775, at 2-3 (1950), reprinted in 1950 U.S.C.C.A.N., for a discussion of the legislative history of the Sherman Act.

83. 15 U.S.C.A. §§ 12-19, 21-27 (West 1997).

84. See generally *United States v. Von's Grocery Co.*, 384 U.S. 270, 275 (1966); *Karseal Corp. v. Richfield Oil Corp.*, 221 F.2d 358, 365 (9th Cir. 1955).

85. 15 U.S.C.A. § 18 (West 1997).

86. S. REP. NO. 81-1775, at 2.

87. See *id.* at 3.

tration that resulted from corporate mergers.<sup>88</sup> Congress later amended the Clayton Act by passing the Celler-Kefauver Act,<sup>89</sup> which afforded further protection for consumers by eliminating a corporation's ability to acquire the assets of another corporation.<sup>90</sup> The Celler-Kefauver Act sought to prevent those acts, which would tend to lessen competition at their incipiency.<sup>91</sup>

#### IV. DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ANTITRUST REGULATION

##### A. *Horizontal Merger Guidelines*

In 1992, the Agencies issued the Horizontal Merger Guidelines ("Guidelines").<sup>92</sup> The Guidelines describe the Agencies' uniform enforcement policy concerning the Sherman Act,<sup>93</sup> the Clayton Act,<sup>94</sup> and the Federal Trade Commission Act,<sup>95</sup> and outlines a five-step methodology for analyzing mergers under the Clayton Act.<sup>96</sup>

The first step in the analysis is to decide whether the firm exceeded its lawfully permissible market power; the greater the market concentration, the greater market power a firm can exert.<sup>97</sup> To analyze this relationship, the market power<sup>98</sup> is defined first, then the market concentration is determined. Next, the Agencies must ascertain the product market, which is the market where: (1) the same products or services are sold by competitive firms; (2) close substitutes exist; or (3) other firms can produce or sell the same products or services with little effort.<sup>99</sup>

88. *See id.*

89. Ch. 1184, 64 Stat. 1125 (1950) (codified in 15 U.S.C.A. §§ 18, 21 (West 1997)).

90. *See* S. REP. NO. 81-1775, at 2.

91. *See id.* at 4. *See generally* *Transamerica Corp. v. Board of Governors of Federal Reserve System*, 206 F.2d 163, 166 (3rd Cir. 1953).

92. HORIZONTAL MERGER GUIDELINES, *supra* note 17, 57 Fed. Reg. 41552.

93. 15 U.S.C.A. §§ 1-7 (West 1997).

94. *Id.* §§ 12-19, 21-27 (as amended by Celler-Kefauver Act of Dec. 29, 1950, 15 U.S.C.A. §§ 18, 21 (West 1997)).

95. *Id.* §§ 41-77.

96. 57 Fed. Reg. at 41553 (1992).

97. *Id.* § 1.0.

98. Market power is defined as the ability of a seller to maintain prices above the competitive level for a significant period of time, or to depress prices below the competitive price level. HORIZONTAL MERGER GUIDELINES, *supra* note 17, 57 Fed. Reg. at 41553. The result of exercise of market power is a transfer of wealth from buyers to sellers. *See id.*

99. *Id.* § 1.11.

The second step in the analysis is to examine the market shares held by the participants, in the markets just defined,<sup>100</sup> according to the Herfindahl-Hirshman Index ("HHI").<sup>101</sup> Both the post-merger HHI and the HHI change from pre-merger to post-merger are analyzed.<sup>102</sup>

In the third step, ease of entry into the market is reviewed.<sup>103</sup> If other firms can easily enter the market in a timely fashion and with significant force, then they could deter the anticompetitive effects of high market concentration and the increased market power of the merging firms.<sup>104</sup>

Step four affords the merging firms the opportunity to demonstrate significant efficiencies as a result of the merger. If efficiencies could be achieved by means other than a merger, the Agencies will reject those efficiencies.<sup>105</sup> If not, then the Agencies will not challenge that merger.<sup>106</sup>

The final step in the analysis is for the Agencies to consider, first, whether one of the merging firms will fail absent the merger, and second, whether that firm's assets will exit the relevant market.<sup>107</sup> To determine whether the firm will fail, the Agencies will closely assess whether the "failing firm" has explored all possible alternatives to merger or acquisition.<sup>108</sup> If the merger will not enhance the market power of the merging firms, the Agencies will not challenge the merger.<sup>109</sup>

#### *B. Statements of Antitrust Enforcement Policy in Health Care*

In 1993, the Agencies issued the "Statements of Antitrust Enforcement Policy in Health Care" ("Statements").<sup>110</sup> The Agencies subse-

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100. *Id.*

101. *Id.* § 1.5. The Agencies generally characterize market concentration as unconcentrated (less than 1,000), moderately concentrated (between 1,000 and 1,800), and highly concentrated (greater than 1,800). *Id.*

102. *Id.* § 1.51. In a highly concentrated market (HHI greater than 1,800), an increase of over fifty points will raise concern, and an increase over 100 will create a presumption of market power. *Id.* § 1.51(c).

103. *Id.* § 3.0.

104. *Id.*

105. *Id.* § 4.0 (1997).

106. *Id.*

107. *Id.* § 5.0.

108. *Id.* § 5.1.

109. *Id.* § 5.0.

110. DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTHCARE (1993).

quently revised the Statements in 1994 and 1996.<sup>111</sup> The 1996 Statements reflect the goal of "ensur[ing] a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices . . . ."<sup>112</sup>

To effectuate this goal, Statement 1, entitled "Merger Among Hospitals," creates an antitrust safety zone and describes the analysis of mergers among hospitals that fall outside of this zone.<sup>113</sup> A merger falling within the antitrust safety zone will not be challenged. For example, if two general acute-care hospitals merge where one hospital has: (1) an average of fewer than 100 licensed beds over the three most recent years; and (2) an average daily inpatient census of fewer than forty patients over the three most recent years,<sup>114</sup> then the Agencies will not challenge the hospital merger.

The Agencies follow the procedures set forth in the Guidelines to analyze mergers that fall outside of the antitrust safety zone. If the analysis reveals that the merger will not result in a substantial lessening of competition, the Agencies will not challenge the merger.<sup>115</sup> Situations precluding a challenge include transactions where: (1) the merger will not increase market power because of the post-merger presence of strong competitors or because the merging hospitals are sufficiently differentiated; (2) the merged hospitals could achieve savings not otherwise possible; or (3) the merger will eliminate a hospital that is likely to fail.<sup>116</sup>

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111. *Id.* at 2.

112. DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION, *Introduction to Statements of Antitrust Enforcement Policy in Healthcare* (1996) (hereinafter "1996 STATEMENTS"); see also Richard C. Wade, *Hospital Horizontal Mergers and Antitrust*, 1997 DET. C.L. REV. 1281, 1291 (1997). The 1996 Statements contain the following enforcement policies: (1) mergers among hospitals; (2) hospital joint ventures involving high technology or other expensive health care equipment; (3) hospital joint ventures involving specialized clinical or other expensive health care services; (4) providers' collective provision of non-fee-related information to purchasers of health care services; (5) providers' collective provision of fee-related information to purchasers of health care services; (6) provider participation in exchanges of price and cost information; (7) joint purchasing arrangements among health care providers; (8) physician network joint ventures; and (9) multiprovider networks. See 1996 STATEMENTS. This comment will only focus on Statement 1: Mergers Among Hospitals.

113. 1996 STATEMENTS, *supra* note 112, at Statement 1, *Introduction*.

114. *Id.* at Statement 1, § A.

115. *Id.* at Statement 1, § B. See also *supra* notes 92-109 and accompanying text for a description of the five-step methodology used to analyze mergers.

116. See 1996 STATEMENTS, *supra* note 112, at Statement 1, § B.

Hospitals that are considering mergers can seek preliminary review under the DOJ's business review procedure<sup>117</sup> or the FTC's advisory opinion procedure<sup>118</sup> for a determination of the Agencies' probability of challenging the merger.<sup>119</sup>

## V. THE CLAYTON ACT ENSURES CONSUMER CHOICE WHEN HOSPITALS MERGE

If a hospital merger is questioned as a result of limiting consumer choice, the Agencies have several cases for guidance.<sup>120</sup> These cases strongly support an argument to block a hospital merger that would limit consumer choice and, in effect, undermine the Agencies' goal of "ensur[ing] a wide range of choices."<sup>121</sup>

### A. Maximization of Consumer Choice and the Clayton Act

The Clayton Act,<sup>122</sup> enacted in 1914,<sup>123</sup> and amended by the Celler-Kefauver Act<sup>124</sup> in 1950,<sup>125</sup> prohibits one company from acquiring part or all of the assets, stock, or other capital of a competitor where the effect of such action may substantially lessen competition or create a monopoly.<sup>126</sup> Hospital mergers, involving the acquisition of one company's assets by another, are generally analyzed under this act.<sup>127</sup>

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117. See 28 C.F.R. § 50.6 (1999).

118. See 16 C.F.R. §§ 1.1-1.4 (2000).

119. See 1996 STATEMENTS, *supra* note 112, at Statement 1, § B.

120. See *infra* Part V.A.

121. 1996 STATEMENTS, *supra* note 114, at *Introduction*.

122. 15 U.S.C.A. §§ 12, 13, 14-19, 21, 22-27 (West 1997).

123. 15 U.S.C.A. § 12 (West 1997).

124. Ch. 1184, 64 Stat. 1125 (1950) (codified as 15 U.S.C.A. §§ 18, 21 (West 1997)).

125. See *supra* notes 89-91 and accompanying text for a discussion of the Celler-Kefauver Act.

126. 15 U.S.C.A. § 18 (West 1997). The Clayton Act provides in pertinent part: No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.

*Id.*

127. See generally *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121 (E.D.N.Y. 1997).



When assessing a merger under section 7 of the Clayton Act, the test of a competitive market is "not only whether small companies flourish but also whether consumers are well served."<sup>128</sup> This test was articulated and subsequently applied in *United States v. Tidewater Marine Service, Inc.*<sup>129</sup>

*Tidewater Marine* is important because it recognizes the impact on customers in issues surrounding mergers.<sup>130</sup> While the focus of hospital mergers may also be the customer, those customers are distinguishable from the consumers in *Tidewater Marine*. Consumers in hospital merger cases are patients who are not able to simply switch services or perform the services on their own, given the specialized services they seek. In a hospital merger case, the uniqueness of consumers and their lack of bargaining power pose a significant threat to the patient's ability to choose. Thus, the Agencies should challenge hospital mergers that limit, or have the potential to limit, consumer choice.

In order to challenge such a merger, the FTC must first establish that it has jurisdiction over the merger and the parties.<sup>131</sup> Once the jurisdictional requirement is satisfied, the FTC analyzes the merger for anticompetitive effects, the relevant market, market concentration, ease of entry, and potential defenses such as efficiencies or failing company.<sup>132</sup>

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128. *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 367 n.43 (1963). Section 7's fundamental purpose is to "arrest the trend toward concentration . . . before the consumer's alternatives disappeared through merger." *Id.* at 367; *see also* *United States v. Tidewater Marine Serv., Inc.*, 284 F. Supp. 324, 338 (E.D. La. 1968) (citing *United States v. Bethlehem Steel Corp.*, 168 F. Supp. 576, 588 (S.D.N.Y. 1958) (stating that when measuring the anticompetitive effect of a merger, "we must examine its effect on the competitors as well as the customers of the merged companies"))).

129. 284 F. Supp. 324 (E.D. La. 1968). There, the court determined that the customers were not harmed by the merger of companies that supplied boats for transporting supplies and equipment to offshore drilling sites. *Id.* at 340. The companies that supplied the boats were much smaller than the oil companies that required the boats. *Id.* Therefore, the boat suppliers had to remain subservient to the needs of their customers. *Id.* The large oil companies could, if necessary, own and operate their own supply boats if they became dissatisfied with the price or service of the charter boats. *Id.*

130. *See id.* at 338-340.

131. *See, e.g.*, *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278 (7th Cir. 1990).

132. 57 Fed. Reg. 41553, 41554 (1992).

*B. FTC Jurisdiction*

The Clayton Act authorizes FTC jurisdiction over corporate acquisitions where the parties are engaged in commerce or in any activity affecting commerce.<sup>133</sup> Hospitals engage in, or affect, interstate commerce by contracting with MCOs, treating patients who live in other states, contracting with pharmaceutical companies to buy drugs, or paying management fees.<sup>134</sup> Hospitals involved in mergers thus fall under the FTC's jurisdiction.<sup>135</sup>

Jurisdiction over for-profit hospitals has not been an issue because they have assets. However, a question eventually arose about the jurisdictional status of non-profit hospitals. Non-profit organizations do not have stock or assets. The Clayton Act, as amended by the Celler-Kefauver Act, prohibits the acquisition of stock or other assets in a merger that would limit competition.<sup>136</sup> Thus, the FTC's jurisdiction over non-profit organizations was questioned.

In dicta, the court in *United States v. Rockford Memorial Corp.*<sup>137</sup> stated that the FTC had jurisdiction over non-profit hospitals.<sup>138</sup> In that case, the DOJ brought suit under section 7 of the Clayton Act<sup>139</sup> and section 1 of the Sherman Act<sup>140</sup> to enjoin the merger of the two largest non-profit hospitals in Rockford, Illinois.<sup>141</sup> The lower court held that the merger violated section 7 of the Clayton Act, but did not address the Sherman Act charge.<sup>142</sup> The hospitals appealed, arguing that the Clayton Act did not apply to a merger between non-profit entities.<sup>143</sup>

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133. 15 U.S.C.A. § 18 c.

134. *See, e.g.*, *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 425 U.S. 738 (1976).

135. *See* *FTC v. Freeman Hosp.*, 69 F.3d 260, 266 (8th Cir. 1995) (citing *FTC v. University Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991)); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278 (7th Cir. 1990)).

136. 15 U.S.C.A. § 18 (West 1997).

137. 898 F.2d 1278 (7th Cir. 1990).

138. *Id.* at 1281.

139. Section 7 of the Clayton Act prohibits asset-acquisition mergers that lessen competition. 15 U.S.C.A. § 18 (West 1997).

140. Section 1 of the Sherman Act prohibits mergers if they restrain trade. 15 U.S.C.A. § 1 (West 1997).

141. *Rockford*, 898 F.2d at 1281.

142. *Id.* at 1280.

143. *Id.* As noted above, the Clayton Act prohibits asset-acquisition mergers. *See supra* note 139. The hospitals, as non-profit entities, argued that, by definition, they did not have "assets." *Rockford*, 898 F.2d at 1280.

Section 11 of the Clayton Act<sup>144</sup> gives authority to five agencies to enforce the Clayton Act; one of these agencies being the FTC.<sup>145</sup> As such, the court determined that the asset-acquisition provision of section 7 of the Clayton Act exempted only those mergers in regulated industries enumerated in section 11,<sup>146</sup> of which the hospital industry was not included.<sup>147</sup> Ultimately, the court held that the merger was not subject to section 7 of the Clayton Act because the non-profit hospitals did not have assets in the form of stock or share capital.<sup>148</sup> Nonetheless, the court held that the merger was a violation of the Sherman Act.<sup>149</sup>

Although not raised by the DOJ, the court determined, in dicta, that the merger was subject to section 7 of the Clayton Act.<sup>150</sup> The

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144. 15 U.S.C.A. § 21 (West 1997).

145. *Rockford*, 898 F.2d at 1280. At the time of this case, 15 U.S.C.A. § 21 stated, in relevant part: "Authority to enforce compliance with sections 2, 3, 7, and 8 of this Act by the persons respectively subject thereto is hereby vested in . . . the Federal Trade Commission where applicable to all other character of commerce." *Id.* (quoting 15 U.S.C.A. § 21). However, the substance remains the same: "Authority to enforce compliance with sections 13, 14, 18, and 19 of this title by the persons respectively subject thereto is vested in . . . the Federal Trade Commission where applicable to all other character of commerce." *Id.* See also 15 U.S.C.A. § 21(a) (West 1997).

146. *Rockford*, 898 F.2d at 1280. The regulated industries not subject to FTC jurisdiction include: common carriers (as regulated by the Interstate Commerce Commission, the Federal Communications Commission and the Civil Aeronautics Board), and banks (as regulated by the Federal Reserve Board). See *id.*

147. *Rockford*, 898 F.2d at 1280.

148. *Id.* at 1281 (concluding that "as the parties have framed the issues the merger is not subject to section 7"). The court, although believing the merger was subject to the Clayton Act, declined to extend its interpretative powers. *Id.*

149. *Id.* at 1281 (affirming on alternative grounds and determining that although the district court judge did not reach a conclusion on the Sherman Act, it could do so since the findings demonstrate a violation of section 1). The court doubted whether there was a substantive difference between the standard for judging a merger under section 1 of the Sherman Act and the standard for judging the same merger under section 7 of the Clayton Act. See *id.* at 1282. If a transaction restrains trade, it violates section 1. *Id.* If the effect of the transaction substantially lessens competition, it violates section 7. *Id.* The court went on further to say that the judicial interpretations of the two acts have converged. *Id.* (citing 2 Areeda & Turner, *Antitrust Law*, ¶ 304 (1978); 4 Areeda & Turner, *Antitrust Law*, ¶ 906); see also Miles & Philp, *supra* note 75, at 665 (noting that leading commentators suggest there is little difference between section 1 of the Sherman Act and section 7 of the Clayton Act); see *infra* notes 375-81 and accompanying text.

150. *Rockford*, 898 F.2d at 1281.

court said that the reference in the Clayton Act to the jurisdiction of the FTC should refer to section 11 of that Act, and not section 4 of the Federal Trade Commission Act (the "FTC Act").<sup>151</sup>

Later, the court in *FTC v. University Health, Inc.*,<sup>152</sup> conclusively determined that non-profit hospitals are subject to the FTC's jurisdiction.<sup>153</sup> The court determined that the Clayton Act's reference in section 7 to the "jurisdiction of the [FTC]" referred to the limitation set forth in that same act, not to the FTC Act.<sup>154</sup>

The *University Health* court also looked at Congress' intent when creating the Clayton Act. First, Congress did not provide an explicit exemption to non-profit hospitals for asset acquisitions in section 7.<sup>155</sup> Second, the court concluded that section 11 is evidence of Congress' intent to exempt only certain entities regulated by other governmental agencies from the FTC's enforcement of section 7.<sup>156</sup> Congress specifically exempted certain transactions governed by other federal agencies, but it declined to limit the FTC's jurisdiction in enforcing the Clayton Act to the jurisdiction set forth in the FTC Act.<sup>157</sup> Therefore, all other entities, including non-profits, are subject to FTC jurisdiction.<sup>158</sup>

As a result of this case, although many hospitals and other entities are non-profit, the FTC can exercise jurisdiction over them in accordance with the asset-acquisition provision contained in section 7 of the Clayton Act.<sup>159</sup> The FTC cannot, however, challenge a merger under the FTC Act where one party is non-profit because the FTC Act only applies to for-profit businesses.<sup>160</sup> Despite the fact that the FTC Act is the fundamental charter for the FTC,<sup>161</sup> the Clayton Act pro-

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151. *Id.* Section 4 of the FTC Act declares that unfair methods of competition are illegal. 15 U.S.C.A. § 45(a)(1) (West 1997). It empowers and directs the FTC to "prevent persons, partnerships, or corporations . . . from using unfair methods of competition in or affecting commerce and unfair or deceptive acts or practices in or affecting commerce." 15 U.S.C.A. § 45(a)(2).

152. 938 F.2d 1206 (11th Cir. 1991).

153. *Id.* at 1215.

154. *Id.* The FTC Act gives the FTC jurisdiction over corporations, defined as any entity designed to carry on business "for its own profit or that of its members." *Id.* at 1214.

155. *Id.* at 1214-15.

156. *Id.* at 1215. See also *supra* notes 144-45 and accompanying text for further discussion of section 11.

157. *University Health, Inc.*, 938 F.2d at 1216-17.

158. *Id.* at 1215.

159. See *Baker*, *supra* note 14, at 112.

160. See *id.*

161. *University Health, Inc.*, 938 F.2d at 1214.

vides an additional independent basis for FTC challenges.<sup>162</sup> Therefore, non-profit hospitals are subject to FTC jurisdiction under section 7 of the Clayton Act.

### C. *Adverse Competitive Effects*

"The underlying theme of the Guidelines is that mergers should not be permitted to create or enhance market power or to facilitate its exercise."<sup>163</sup> A merger can diminish competition in one of two ways. The first is when the merger reduces the total number of firms in a market so that the remaining firms are able to collectively exercise market power, such as collusion to raise prices.<sup>164</sup> The second is through unilateral action that prevents consumers from finding substitutes.<sup>165</sup> In order to establish a prima facie case of an antitrust violation, the Agencies must determine that the merger will have anticompetitive effects, such as, limitation of choice, on consumers.<sup>166</sup>

#### 1. Relevant Market

Determining the relevant market is a necessary predicate to finding an antitrust violation,<sup>167</sup> because a merger's effect on competition cannot be evaluated without a well-defined market.<sup>168</sup> The relevant market consists of two elements: the product market and the geographic market.<sup>169</sup>

##### a. *Product Market*

"General acute care inpatient hospital services is a product market that has been commonly used to evaluate the competitive effects of hospital mergers."<sup>170</sup> The FTC characterizes these services as a "com-

162. See Baker, *supra* note 14, at 112.

163. HORIZONTAL MERGER GUIDELINES, *supra* note 17, 57 Fed. Reg. at 41553.

164. See *id.* at 41558.

165. See *id.* at 41560.

166. See *id.* at 41553.

167. See *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995).

168. See *id.* at 268 n.12.

169. See HORIZONTAL MERGER GUIDELINES, *supra* note 17, 57 Fed. Reg. at 41553 (defining the relevant market as a "group of products and a geographic area that is no bigger than necessary to satisfy" the "small but significant and non-transitory" increase in price test); see *e.g.*, *FTC v. University Health, Inc.*, 938 F.2d 1206, 1211, 1290 (11th Cir. 1991); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290 (W.D. Mich. 1996), *aff'd in unpublished opinion*, 121 F.3d 708 (6th Cir. 1997) (table); *United States v. Mercy Health Services*, 902 F. Supp. 968, 976 (N.D. Iowa 1995), *vacated* 107 F.3d 632 (8th Cir. 1997); see also *Freeman Hosp.*, 69 F.3d at 268.

170. *Freeman Hosp.*, 69 F.3d at 268.

mon host of distinct services and capabilities that are necessary to meet the medical, surgical, and other needs of patients, e.g., operating rooms, anesthesia, intensive care capabilities, 24-hour nursing care, lodging, and pharmaceuticals.”<sup>171</sup>

There are several different levels of care that can also comprise the relevant product market, such as primary, secondary, or tertiary care services. Primary care services include basic or routine inpatient hospital services available at most general acute-care hospitals, such as normal childbirth, general medicine, and general surgery.<sup>172</sup> Secondary care services include certain specialties and more difficult procedures, such as orthopedics, ophthalmology, and cardiac catheterization.<sup>173</sup> Tertiary care services include the most specialized, complex and expensive procedures, such as high-risk obstetric services, neonatal care, neurosurgery, heart or orthopedic surgery, advanced cancer treatment, and burn care.<sup>174</sup>

In general, demand substitutability for health care services is very limited.<sup>175</sup> Patients who need a particular procedure are not able to substitute another procedure to cure their problem.<sup>176</sup> For example, a patient requiring coronary bypass surgery cannot elect a hip replacement to fix the patient’s heart simply because it is less expensive.<sup>177</sup> Hence, defining the relevant product market is crucial not only to an antitrust analysis, but also to ensuring that consumers have choices among health care providers.

#### *b. Geographic Market*

##### (1) Definition

In accordance with the Guidelines, the Agencies will determine the geographic market to be the smallest region in which the monopoly would find it profitable to impose a “small but significant and non-transitory increase in price” (“SSNIP”).<sup>178</sup> The extent to which consumers respond to the SSNIP must be evaluated within the context of the geographic market.<sup>179</sup> If a firm outside the region could prevent that price increase, through the exercise of competitive restraint, then

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171. *Butterworth*, 938 F.2d at 1288 n.2.

172. *Id.*

173. *Id.*

174. *Id.*

175. *See Baker*, *supra* note 14, at 123.

176. *See id.*

177. *See Rockford*, 898 F.2d at 1284.

178. HORIZONTAL MERGER GUIDELINES, *supra* note 17, 57 Fed. Reg. at 41556.

179. *Id.* at 41554 n.8.

the geographic market must be expanded to include that firm.<sup>180</sup> If, however, a firm outside the region could not prevent that price increase, then the firm is excluded and the initial region alone constitutes the geographic market.<sup>181</sup> Thus, a narrowly defined geographic market with a limited number of hospitals could substantially limit consumer choice; however, a broadly defined geographic market could imply that patients are willing to travel to visit the doctor of their choice.<sup>182</sup> Therefore, a precise definition is necessary to protect consumers.

## (2) Composition of the Geographic Market

### (a) *Third-Party Payors*

One aspect of the uniqueness of the hospital market—the heavy influence of third-party payors—is particularly relevant when defining the geographic market.<sup>183</sup> Competition makes it easier for health plans, such as health maintenance organizations (HMOs) and preferred provider networks (PPOs), “to steer their enrollees towards those hospitals that offer the most attractive contract terms.”<sup>184</sup> The benefits that the health plan receives are designed to pass to the third-party payors’ consumers, employers, and employees.<sup>185</sup> Therefore, when determining the geographic market, it is also important to ask whether health plans, in the face of a price increase, would steer their enrollees to hospitals outside that region so that the monopolist would find the price increase unprofitable.<sup>186</sup>

### (b) *Patients and Patient Flow Data*

The geographic market does not only consider health plans. It also consists of patients in the form of patient flow data, showing where each discharged patient lives.<sup>187</sup> One variant of patient flow data is the Elzinga-Hogarty (E-H) approach, which examines the numbers of “import” patients and “export” patients from one region to an-

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180. *Id.* at 41555.

181. *Id.*

182. *See infra* Part V.C.1.b.(3).

183. *See* Gregory S. Vistnes, *Defining Geographic Markets for Hospital Mergers*, 13 ANTITRUST 28, 28 (1999). Dr. Vistnes was the Deputy Director for Antitrust, Bureau of Economics, Federal Trade Commission.

184. *Id.*

185. *Id.*

186. *See id.*

187. *Id.* at 31.

other.<sup>188</sup> The premise of the E-H approach states that if a few consumers are willing to go to another region, then more consumers will cross boundaries in the event of a price increase.<sup>189</sup> As applied to hospitals, the E-H approach requires a small amount of patient outflow and inflow from another region.<sup>190</sup>

A variant of the E-H approach is the zip code approach, which involves identifying the zip codes of where a given percentage of residents travel to hospitals outside the region for health care services.<sup>191</sup> The rationale behind the contestable zip code approach is similar to that of the E-H approach—if some patients are willing to use outside hospitals, other patients, in contestable zip codes, will also use hospitals outside the region, in the event of a price increase.<sup>192</sup>

The court in *United States v. Mercy Health Services*<sup>193</sup> used the zip code approach to define a very broad geographic market.<sup>194</sup> Mercy Health Center and Finley Hospital, the only two general acute-care hospitals in Dubuque, Iowa, agreed to merge.<sup>195</sup> The DOJ asserted that the geographic market consisted of a “half-circle with a 15 mile radius” that included Mercy, Finley, and one of seven rural hospitals.<sup>196</sup> The hospitals contended that the relevant geographic market comprised a 70 to 100 mile area which included Mercy, Finley, the seven closest rural hospitals, and the regional hospitals located in Cedar Rapids, Waterloo, Iowa City, Davenport and Madison.<sup>197</sup>

The court criticized the DOJ’s reliance on the E-H test, stating that the test is only a starting point that indicates current conditions; it does not consider what would happen if one of the market participants attempted to exercise market power.<sup>198</sup> Considering the de-

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188. *See id.* The E-H approach rests on the notion that there should be few “imports” and few “exports.” *See id.*

189. *See Vistnes, supra* note 183, at 28.

190. *See id.*

191. *Id.*

192. *See id.* A contestable zip code is a zip code where residents may choose one of several hospitals. The percentage of residents that consistently go to one hospital (over another hospital in the area) is low.

193. 902 F. Supp. 968 (N.D. Iowa 1995), *vacated* 107 F.3d 632 (8th Cir. 1997). The case was vacated because the hospitals ultimately decided not to merge.

194. *Id.* at 979-80.

195. *Id.* at 971.

196. *Id.* at 976.

197. *Id.*

198. *Id.* at 978.



tailed zip code analysis provided by the hospitals,<sup>199</sup> the court determined that the government failed to establish a relevant geographic market.<sup>200</sup> Therefore, it held that the government failed to prove that the merger would result in anticompetitive effects.<sup>201</sup>

In contrast, the court in *United States v. Long Island Jewish Medical Center*<sup>202</sup> discredited patient origin data.<sup>203</sup> An expert for the DOJ defined the geographic market as a region approximately five miles from the merging hospitals.<sup>204</sup> The hospitals, Long Island Jewish Medical Center and North Shore Manhasset, defined the geographic market according to patient origin data.<sup>205</sup>

Rejecting both parties' definitions, the court stated, "[a]s is often the case with such complex, fact sensitive issues, the reality lies somewhere between the two versions."<sup>206</sup> It further indicated that both the DOJ and the hospitals oversimplified the issue, each for their own benefit.<sup>207</sup> The court concluded that two geographic markets existed: the first for primary and secondary care and the second for tertiary care.<sup>208</sup>

While the E-H and patient inflow data approaches have flaws, agencies and hospitals still use them.<sup>209</sup> Despite the relatively high patient inflow and outflow in the Long Island Jewish Medical Center and North Shore Manhasset merger, the DOJ's decision to challenge those mergers suggests that the government is giving less weight to patient flow analyses.<sup>210</sup> Based on the above mentioned holdings, however,

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199. *Id.* at 979-80 (indicating that hospitals outside the DOJ's defined area were attracting patients).

200. *Id.* at 987 (accepting the hospitals' 70 to 100 mile geographic market definition).

201. *Mercy*, 902 F. Supp. at 987.

202. 983 F. Supp. 121 (E.D.N.Y. 1997).

203. *Id.* at 141.

204. *Id.* at 140. Both hospitals were located on Long Island, just a short distance from Manhattan. *Id.* at 125.

205. *Id.* at 141 (showing that the hospitals drew patients from Queens, Nassau, and Suffolk, and "that patients residing in these areas seek health care in western Suffolk, Nassau, Queens, and Manhattan").

206. *Id.*

207. *Id.*

208. *Id.* at 141-42. See *supra* notes 172-74 and accompanying text for an explanation of primary, secondary and tertiary care.

209. See, e.g., *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 978 (N.D. Iowa 1995), *vacated* 107 F.3d 632 (8th Cir. 1997) (noting that the government relied too heavily on "past health care conditions" and that the E-H test is merely a starting point in determining the actual geographic market); *Long Island*, 983 F. Supp. at 134.

210. See *Vistnes*, *supra* note 183, at 33.

courts appear willing to accept both approaches or, at least, to consider both approaches.<sup>211</sup> Thus, the Agencies should not solely rely on patient flow data, but should construct their cases around ensuring that consumers have a range of choices in a competitive market.

(3) Defining the Geographic Market Fails to Protect Consumer Choice

The geographic market in a hospital merger case is not as easily defined as the product market. A geographic market can consist of several different consumers, namely patients and third-party payors or health plans, which could include employers, employees and government payors.<sup>212</sup> The definition of the geographic market can depend on the number of additional hospitals in the area, the availability of alternatives, and the definition of consumers.<sup>213</sup> In any case, the geographic market should be based on a variety of information and evidence that is market and fact-specific.<sup>214</sup>

Further, patients can be forgotten during the process of defining the geographic market.<sup>215</sup> Courts do consider patients and third-party payors as consumers of hospital services.<sup>216</sup> Patients, however, have much less leverage with hospitals. Conversely, third-party payors have very powerful leverage with hospitals.<sup>217</sup> Managed care payors have the ability to negotiate contracts for services with hospitals and are more concerned with lower prices.<sup>218</sup> Some patients may also be con-

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211. See, e.g., *Mercy*, 902 F. Supp. at 977-78 (analyzing, then criticizing the government's use of the E-H test); *Long Island*, 983 F. Supp. at 134 (“[A]s is often the case with such complex, fact sensitive issues, the reality lies somewhere in between the two versions.”); see also *Vistnes*, *supra* note 183, at 33.

212. See *Long Island*, 983 F. Supp. at 134; see also *Vistnes*, *supra* note 183, at 33.

213. See *Baker*, *supra* note 14, at 141-43.

214. See *Vistnes*, *supra* note 183, at 33.

215. See *id.* at 28 (indicating that “while health plans’ enrollees (as well as the employers who contract with the health plans) affect how health plans will respond to hospital price increases, individual enrollees are generally not viewed as the buyer [of health care services] under a Guidelines analysis of a hospital merger”).

216. See *Long Island*, 983 F. Supp. at 134; see also *Vistnes*, *supra* note 183, at 28. While Dr. Vistnes indicates that the geographic market definition depends on health plans, he also notes that patient flow data is also used in determining the definition, thereby conceding that patients are also consumers. *Id.*

217. See *Long Island*, 983 F. Supp. at 134 (indicating that managed care plans are driving hospital decisions on whether to merge, on what services to provide, and concerning prices).

218. See *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 973-74 (N.D. Iowa 1995), *vacated* 107 F.3d 632 (8th Cir. 1997) (indicating that MCOs

cerned about the escalating costs of health care services, while others are more concerned about being able to see the doctor of their choice, obtaining the services they desire or need, or going to the hospital of their choice.<sup>219</sup>

In addition, payors may exacerbate the problems patients experience. Although payors are supposed to pass benefits onto their consumers, this does not always happen, as payors are very conscious of the bottom line.<sup>220</sup> Payors are able to direct patients to other facilities and physicians,<sup>221</sup> even though those facilities and physicians may not be the patient's choice.

For example, a cancer patient's doctor only has privileges at a recently merged hospital, and the payor has a contract with that merged hospital, but the hospital has raised its prices. If a patient requires chemotherapy, the payor may refuse to pay for the services if those services are performed by the doctor of the patient's choice at the hospital of the patient's choice. Subsequently, either the patient pays for the treatments out of the patient's own pocket, or the patient is "steered" by the payor to a different hospital with lower prices.<sup>222</sup>

A merger with a broadly defined geographic market will be harder to challenge.<sup>223</sup> A large market means that a larger number of competing providers are deemed alternative, sufficient substitutes and thus can provide similar services.<sup>224</sup> This implies that consumers are willing to travel long distances to receive the required treatment. Therefore, a successful challenge will require evidence indicating that patients in need of services will not travel long distances due to the costs, or that the nature of the services needed is time-sensitive, or that

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shop on the basis of price and are able to induce hospitals to discount charges in return for the payor's promise to direct more patients to the hospital, and that MCOs will negotiate the best rates and greatest discounts with hospitals). Individual patients clearly do not have this level of leverage with hospitals.

219. See *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990).

220. See *Mercy*, 902 F. Supp. at 974.

221. See *Vistnes*, *supra* note 183, at 28.

222. See *generally* *Blue Cross & Blue Shield United of Wisc. v. Marshfield Clinic*, 65 F.3d 1406, 1410, 1412 (7th Cir. 1995) (noting "[g]enerally you must pay more for higher quality" and "the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible").

223. See *APPELBAUM*, *supra* note 6, at 18.

224. See *id.*

the patient is unfamiliar with a distant area.<sup>225</sup> In sum, the basis for a challenge of this nature should be patient choice.

#### (4) Market Share, Market Concentration, and Market Power

When evaluating a merger, the Agencies will calculate market shares for all firms in the relevant market.<sup>226</sup> The market share of each firm is calculated for the firm's *future* competitive significance.<sup>227</sup>

The Agencies will also calculate market concentration, which is a function of the number of firms in a relevant market and their respective market shares.<sup>228</sup> The Agencies use the Herfindahl-Hirschman Index ("HHI") to calculate market concentration.<sup>229</sup> The spectrum of market concentration is divided into three parts: (1) unconcentrated if the HHI is below 1,000; (2) moderately concentrated if the HHI is between 1,000 and 1,800; and (3) highly concentrated if the HHI is above 1,800.<sup>230</sup> The Agencies also consider the post-merger market concentration and the increase in HHI resulting from the merger.<sup>231</sup> Mergers resulting in an HHI increase of 100 points or more raise concerns of potential anticompetitive behavior.<sup>232</sup>

The merger of two hospitals in a three or four hospital market may create a presumption of anticompetitive effects. However, a merger does not necessarily have to create market power in order for the FTC to look into the legality of the acquisition. One of the most important hospital mergers cases analyzed under the Clayton Act, *Hospital Corporation of America v. FTC*,<sup>233</sup> illustrates this point.

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225. *See id.* For example, in a Catholic/non-Catholic hospital merger, the Agencies would have to show that patients in need of reproductive health services could not, or would not, travel longer distances to obtain these services. *See id.* In addition, the Agencies would have to show that the reason patients could not travel is due to the time-sensitive nature of the service needed (i.e., the "morning-after" pill or postpartum tubal ligation). *See id.*

226. *See* HORIZONTAL MERGER GUIDELINES, *supra* note 17, 57 Fed. Reg. at 41557.

227. *Id.* Possible indicators include dollar sales, unit sales and physical capacity. *Id.*

228. *Id.*

229. *Id.* "HHI is calculated by summing the squares of" each participant's market share. *Id.*

230. *Id.*

231. *Id.* at 41558. The increase in HHI is calculated by multiplying the market shares of the merging firms together, then multiplying that number by two. *Id.* at n.18.

232. *See* HORIZONTAL MERGER GUIDELINES, *supra* note 17, 57 Fed. Reg. § 1.51.

233. 807 F.2d 1381 (7th Cir. 1986).

Hospital Corporation of America ("HCA") owned one hospital in Chattanooga, Tennessee, and through the acquisitions of two health care corporations, it acquired two more hospitals.<sup>234</sup> In addition, HCA assumed contracts to manage two other hospitals in the same locale.<sup>235</sup> After the acquisitions, HCA owned or managed five of eleven hospitals in the Chattanooga area.<sup>236</sup>

The FTC challenged the acquisitions under section 7 of the Clayton Act.<sup>237</sup> The FTC concluded that the acquisitions could substantially lessen competition in the Chattanooga hospital market.<sup>238</sup> In addition, the FTC indicated that hospital mergers would not be analyzed differently from mergers involving other industries.<sup>239</sup>

On appeal, the United States Court of Appeals for the Seventh Circuit noted that the decisions in *Brown Shoe Co. v. United States*,<sup>240</sup> *United States v. Aluminum Co. of America*,<sup>241</sup> *United States v. Von's Grocery Co.*,<sup>242</sup> and *United States v. Pabst Brewing Co.*,<sup>243</sup>

[s]eemed, taken as a group, to establish the illegality of any nontrivial acquisition of a competitor, whether or not the acquisition was likely either to bring about or shore up collusive or oligopoly pricing. The elimination of a significant rival was thought by itself to infringe the complex of social and economic values conceived by a majority of the Court to inform the statutory words "may . . . substantially . . . lessen competition."<sup>244</sup>

In addition, the court noted that all that is necessary to initiate an inquiry under section 7 of the Clayton Act is that the merger creates an "appreciable danger" of higher prices in the future.<sup>245</sup>

The court also determined that the evidence supported the FTC's conclusion that the acquisitions were likely to encourage collusive

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234. *Id.* at 1383.

235. *Id.* at 1383-84.

236. *Id.* at 1384.

237. *Id.* at 1383.

238. *Id.* The acquisitions did not result in a firm of monopoly proportions. See Miles & Philp, *supra* note 75, at 661 (referring to FTC record at 3 TRADE REG. REP. (CCH) ¶ 22,301 (FTC Oct. 25, 1985)).

239. See *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1390 (7th Cir. 1986).

240. 370 U.S. 294 (1962).

241. 377 U.S. 271 (1964).

242. 384 U.S. 270 (1966).

243. 384 U.S. 546 (1966).

244. *Hospital Corp. of Am.*, 807 F.2d at 1385.

245. *Hospital Corp. of Am.*, 807 F.2d at 1389.

practices that would harm consumers.<sup>246</sup> The court reached its decision by validating what the FTC found.<sup>247</sup> First, the market was highly concentrated.<sup>248</sup> Second, a reduction in the number of competitors made it easier for the remaining hospitals to collude or coordinate pricing.<sup>249</sup> Third, the Chattanooga area hospitals had a documented history of collusion.<sup>250</sup> Fourth, the hospital market lacked competitive alternatives.<sup>251</sup> Fifth, the demand for hospital services is inelastic under competitive conditions.<sup>252</sup> Finally, in order to resist pressure from the federal government to cut costs, the hospitals could (and did) present a united front,<sup>253</sup> even without a monopoly share of the market.

Therefore, a monopoly share of the market is not necessarily a prerequisite for the FTC to invalidate a merger. The focus should be on the effects the merger has on consumers, given the power hospitals have over them.<sup>254</sup> As mentioned previously, consumers have very little leverage as compared with managed care organizations and third-party payors to deal with hospitals.<sup>255</sup> *Philadelphia National Bank* and

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246. *Id.* at 1389. The only question before the court was whether the evidence was sufficient to substantiate the FTC's finding. *Id.* at 1385. It is irrelevant that the court may find differently. *Id.* at 1386.

247. *Id.* at 1389.

248. *Id.* at 1384 (indicating that HCA's market share rose from 14% to 26% as a result of the acquisitions and made it the second largest health care provider in a market where the four largest firms had 91% of the market share).

249. *Id.* at 1387. The court added that the consequence of collusion would be the creation of excess capacity because higher prices would cause some patients to shorten their stay and others to postpone, or even reject, elective surgery. *Id.*

250. *Id.* at 1388 (noting that since the hospitals were prone to cooperate, they would be prone to collude, and that the management contracts gave HCA virtual control over pricing and other decisions).

251. *Id.* (suggesting that: (1) going to a nearby city is often out of the question in medical emergencies; (2) doctors will not send patients to another city where the doctor does not have hospital privileges; and (3) most hospital services cannot be provided by non-hospital providers).

252. *Id.* (reasoning that people place a high value on their safety, doctors make most treatment decisions for their patients, and insurance companies or the federal government, not the patient, pay most medical bills). A lower elasticity of demand enables providers to make more profits by raising prices through collusion. *Id.*

253. *Id.* at 1389 (suggesting that through this form of collusion, hospitals are able to frustrate efforts to control hospital costs).

254. *See supra* Part II.B.1.

255. *See supra* notes 183-86, 220-25 and accompanying text for a discussion of the heavy influence of third-party payors.

*Tidewater Marine Services* suggest that *consumers* should be considered when testing the competitive market under section 7 of the Clayton Act.<sup>256</sup>

## (5) Entry Barriers in the Hospital Market

Ease of entry is not usually addressed in hospital merger cases, however, entry into the hospital market is generally difficult. Entry is often controlled by state imposed CON laws.<sup>257</sup> In order for a company to build a new hospital and enter the market, it must go through an arduous process, which can take as long as two to three years.<sup>258</sup> The state health facility's regulatory agency must approve the addition of any new facility, service, or beds.<sup>259</sup> CON laws are essentially state imposed entry barriers.<sup>260</sup>

## 2. Efficiencies Created by a Merger

### a. *Efficiencies as Defined by the Agencies*

The Agencies recognize that a merger may create significant efficiencies that permit better utilization of assets and enable the merged

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256. *See supra* notes 128-30 and accompanying text.

257. *See, e.g.*, MD. CODE ANN., HEALTH-GEN. II § 19-123 (1999 and Supp. 2000). *See supra* note 49 and *infra* notes 258-59 and accompanying text for an explanation of CON.

258. In Maryland, for example, a company wishing to build a new facility would first write a letter of intent, which is valid for 180 days. A formal application must be filed with the Maryland Health Care Commission (formerly the Maryland Health Resources Planning Commission) within this 180 day period. The Commission Staff then reviews the application within ten days of submission, and may request additional information if necessary. After the application is complete and docketed, the applicant has fifteen days from receipt of the comments to file a written response. The Commission Staff then prepares a recommended decision. Interested parties who previously submitted written comments may also submit written exceptions to the proposed decision. The applicant and interested parties have an opportunity to present oral arguments on the proposed decision before the full Commission. The Commission must make a final decision on the application within 150 days of being docketed. After the administrative review process has been exhausted, parties may then seek relief from the courts. *See* COMAR 10.24.01 (1978 and Supp. 1999).

259. *See* MD. CODE ANN., HEALTH-GEN. II, § 19-103 (2000). In Maryland, the Maryland Health Care Commission would have to approve the new hospital. In addition, the Health Services Cost Review Commission would be involved. Both of these agencies are under the umbrella of the Maryland Department of Health and Mental Hygiene.

260. *FTC v. University Health, Inc.*, 938 F.2d 1206, 1219 (11th Cir. 1991).

firm to achieve lower costs.<sup>261</sup> If the FTC establishes a prima facie case of potential anticompetitive behavior, then the hospitals may overcome this presumption by demonstrating that efficiencies, resulting from the merger, offset any anticompetitive effects.<sup>262</sup> The Agencies, however, will only consider those efficiencies likely to be achieved with the merger and unlikely to be achieved without the merger.<sup>263</sup>

The Guidelines indicate that efficiencies are difficult to verify and quantify because only the merging firms possess the information relating to the efficiencies, and that despite being projected in good faith, the efficiencies may not be realized.<sup>264</sup> Therefore, the merging firms must substantiate their efficiency claims so they can be reasonably verified by the Agencies.<sup>265</sup>

The FTC and DOJ will only consider cognizable, merger-specific efficiencies.<sup>266</sup> These are efficiencies that are of sufficient "character and magnitude" to offset any anticompetitive effects of the merger.<sup>267</sup> If they have been verified and do not arise from anticompetitive reductions in service or output, then the Agencies will not challenge the merger.<sup>268</sup>

The Agencies must determine whether the efficiencies would reverse potential harm to the consumers in the relevant market.<sup>269</sup> If the potential adverse effects of the merger are great, the cognizable efficiencies must be comparable to prevent the merger from being anticompetitive.<sup>270</sup>

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261. See Revision to HORIZONTAL MERGER GUIDELINES § 4, 1997 WL 166999 (Apr. 8, 1997). Only section 4 was revised in 1997. See *id.*

262. See *id.*

263. See *id.*

264. See *id.*

265. See *id.* Verification of efficiencies by reasonable means involves an assessment of: (1) the likelihood and magnitude of each efficiency; (2) how and when each efficiency will be accomplished; (3) how each efficiency will enhance the firm's ability to compete; and (4) why each efficiency is merger-specific. *Id.*; see also Debra A. Valentine, Address at St. Louis University School of Law Conference on Antitrust and Health Care: Current Antitrust Issues for the Health Care Provider (Nov. 14, 1997) in 1997 WL 721916 (F.T.C.).

266. See MERGER GUIDELINES, 4 Trade Reg. Repts. ¶ 13,104 (1992) (with April 8, 1997 revision to § 4).

267. *Id.*

268. *Id.*

269. MERGER GUIDELINES, *supra* note 266, ¶ 13,104.

270. See *id.* ("The greater the potential adverse competitive effect of a merger . . . the greater must be cognizable efficiencies in order for the Agency to con-



Nevertheless, the Agencies do find some efficiencies more acceptable than others.<sup>271</sup> For example, the Guidelines state that “efficiencies resulting from shifting production among facilities formerly owned separately, which enable the merging firms to reduce the marginal cost of production, are more likely to be susceptible to verification, merger-specific, and substantial, and are less likely to result from anticompetitive reductions in output.”<sup>272</sup> This explains why efficiencies in hospital merger cases are given great deference. In particular, the FTC Chairman, Robert Pitofsky, said that the hospital industry is an area where efficiencies can be of great significance.<sup>273</sup>

*b. The Deference Given to the Efficiencies Defense Fails to Protect Consumer Choice*

Most courts follow the two-part test established in *University Health* when analyzing an efficiencies defense.<sup>274</sup> The merging hospitals must prove that: (1) the acquisition will result in significant efficiencies; and (2) these efficiencies will be passed on to consumers.<sup>275</sup>

Applying the *University Health* test, the court in *FTC v. Butterworth Health Corp.*,<sup>276</sup> denied the FTC’s motion for an injunction and allowed Butterworth Health Corporation and Blodgett Memorial Medical Center to merge.<sup>277</sup> The court determined that the relevant market, as alleged by the FTC, consisted of general acute-care and primary-care inpatient hospital services in the Greater Kent County area.<sup>278</sup> The court accepted the FTC’s market concentration analysis,

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clude that the merger will not have an anticompetitive effect in the relevant market.”).

271. *See id.*

272. *Id.*

273. Raskin & Zessar, *supra* note 21, at 22.

274. *See* *FTC v. University Health, Inc.*, 938 F.2d 1206, 1223 (11th Cir 1991).

275. *Id.*

276. 946 F. Supp. 1285 (W.D. Mich. 1996), *aff’d in unpublished opinion*, 121 F.3d 708 (6th Cir. 1997) (table).

277. *Id.* at 1303. Butterworth and Blodgett were two of four general acute care hospitals in Grand Rapids, Michigan. *Id.* at 1288. Both hospitals were non-profit and offered comprehensive medical and surgical care, consisting of primary, secondary, and tertiary care services. *Id.* The Hillman Commission recommended that Blodgett reorganize its existing facilities by consolidating inpatient services with other area hospitals. *Id.* Subsequently, Blodgett and Butterworth initiated discussion and eventually decided to merge. *Id.* The FTC sought an injunction to block the merger under section 7 of the Clayton Act. *Id.* (alleging that the proposed merger would substantially lessen competition).

278. *Id.* at 1291. “Greater Kent County” included Grand Rapids and the area within a thirty mile radius of Grand Rapids; in total, this area contained

which indicated that the proposed merger would result in a significant increase in the concentration of power in two significant markets.<sup>279</sup> Further, the court concluded that the FTC established a prima facie case that the merger would violate section 7.<sup>280</sup>

Butterworth and Blodgett used an efficiencies defense to rebut the presumption of illegality established by the FTC's prima facie case.<sup>281</sup> Blodgett and Butterworth estimated that their capital expenditures would be \$187 million and \$73.9 million, respectively (for a total of \$260.9 million), if the merger was blocked, and, collectively, only total \$161.7 million if the merger was allowed to proceed.<sup>282</sup> In addition, the hospitals estimated that they would save \$68.5 million in operating expenditures during the first five years following the merger.<sup>283</sup>

Despite the FTC's contention that the hospitals' estimates were over-exaggerated, the court, noting that the savings would be passed on to consumers, accepted the efficiencies defense.<sup>284</sup> In reaching its decision, the court also relied on the hospitals' "Community Commitment," in which the hospitals committed to freeze prices, limit margins, and provide medical services to the underserved and the medically needy.<sup>285</sup> In addition, the court relied on the hospitals'

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nine hospitals, all of which provided general acute care inpatient services.  
*Id.*

279. *Id.* at 1294. According to this analysis, the hospitals would have a 47 to 67% market share of the general acute care inpatient services, and the post-merger HHI would range from 2,767 to 4,521. *Id.* (depending on whether that market share was measured in terms of licensed beds, discharges, or inpatient revenues and indicating an expected increase of between 1,064 and 1,889 points). Further, a post-merger HHI of greater than 1,800 is considered to indicate a highly concentrated market. *Id.* A merger which results in an increase in the HHI of more than 100 points is considered "likely to create or enhance market power or facilitate its exercise." *Id.* For a more detailed discussion of HHI, see *supra* notes 229-32 and accompanying text. The hospitals would also have a 65 to 70% market share of the primary care inpatient hospital market, and the post-merger HHI would range between 4,506 and 5,079. *Id.*

280. *Id.*

281. *Id.* at 1300 (noting that evidence of efficiencies benefiting consumers is useful in evaluating the merger's overall effect on competition); see also *University Health, Inc.*, 938 F.2d at 1222.

282. *Butterworth*, 946 F. Supp. at 1300-01 (indicating a capital expenditure savings of \$99.2 million in the event of the merger).

283. *Butterworth*, 946 F. Supp. at 1301.

284. *Id.* (indicating that the efficiencies, in the form of capital expenditure avoidance and operating efficiencies, would be passed on to consumers, given the hospitals' non-profit status and the Community Commitment).

285. *Id.* at 1298.

non-profit status and gave substantial weight to the evidence, presented by the hospitals, indicating that mergers of non-profit hospitals tend to reduce costs.<sup>286</sup>

The court went even further to criticize the FTC's analysis of the efficiencies defense presented by the hospitals.<sup>287</sup> The court concluded that the FTC failed to show that the hospitals would exercise their market power to the detriment of consumers,<sup>288</sup> and that the public interest was best served by allowing the hospitals to merge.<sup>289</sup>

Similarly, the defendants in *United States v. Long Island Jewish Medical Center*,<sup>290</sup> successfully asserted the efficiencies defense to defeat the federal government's claim of an illegal merger. Long Island Jewish Medical Center and North Shore Health Systems decided to merge.<sup>291</sup> Both hospitals, located only two miles apart, were non-profit teaching institutions that delivered primary, secondary, and tertiary care.<sup>292</sup>

The court determined that the consumers in this case consisted of: (1) patients who self-pay or have indemnity insurance; (2) physicians and physician groups who exercise control over the selection of the hospital network; (3) managed care plans; (4) employers who exert control over the selection of a hospital network; and (5) government payors, such as Medicare and Medicaid.<sup>293</sup> The court defined the relevant product market as general acute-care inpatient hospital services.<sup>294</sup> It also determined the relevant geographic market to be: (1) primary and secondary care provided by the two hospitals in Queens and Nassau; and (2) tertiary care provided in Manhattan, Queens, Nassau, and western Suffolk County.<sup>295</sup> The court did not find any anticompetitive effects of the merger, such as reduced service to, or

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286. *Id.* at 1295-1302. *But see* Hospital Corp. of Am. v. FTC, 807 F.2d 1381, 1390 (7th Cir. 1986) (indicating that non-profit status does not mean the firm will refrain from acting in an anticompetitive manner, and that non-profit status does not necessarily demonstrate the firm's willingness to cooperate in reducing prices).

287. *Butterworth*, 946 F. Supp. at 1302 (giving deference to the hospitals' efficiency analysis and condemning the FTC's mere critique of the hospitals' analysis).

288. *Id.* at 1302.

289. *Id.* at 1303.

290. 983 F. Supp. 121 (E.D.N.Y. 1997).

291. *Id.* at 125. Long Island Jewish Medical Center is located in eastern Queens County. *See id.* North Shore Manhasset, the major hospital in the North Shore System, is located in northwestern Nassau County. *See id.*

292. *Id.*

293. *Long Island*, 983 F. Supp. at 134.

294. *Id.* at 139.

295. *Id.* at 141-42 (noting that some residents of Queens, Nassau and Suffolk will go to Manhattan for treatment).

treatment of patients.<sup>296</sup> The court reached this conclusion despite both hospitals being teaching hospitals, direct competitors, and potential acquisition targets of MCOs.<sup>297</sup>

Although the court did not have to proceed with its discussion, as it determined that the DOJ failed to establish that the merger would result in a substantial lessening of competition in any relevant market, the court went on to discuss the efficiencies that further supported its decision.<sup>298</sup> Despite the fact that the DOJ successfully disproved some of the claimed efficiencies, the court agreed with the hospitals that the merger would create substantial efficiencies, noting, however, that the amount of savings directly relating to the merger was difficult to ascertain.<sup>299</sup> In addition, the court relied on the hospitals' written agreement with the Attorney General of New York, indicating their commitment to pass savings onto the community.<sup>300</sup>

*Long Island* and *Butterworth* are examples of the deference given to hospitals' efficiencies defense.<sup>301</sup> In particular, both courts gave great weight to the hospitals' written commitment to their respective communities. These written commitments contained promises to maintain prices and to continue to serve the poor and indigent population.<sup>302</sup>

Although the DOJ did not succeed in establishing a prima facie case in *Long Island*, the court explained that the efficiency defense was still sufficient to warrant discussion and approval. In *Butterworth*, the FTC established a prima facie case; however, the court determined that the hospitals' efficiencies defense successfully rebutted the presumption of illegality.<sup>303</sup>

It appears, from these cases, that a written community commitment is sufficient to overcome a merger challenge. These types of commitments, however, are not binding on a hospital. While the community (consumers) may pressure the hospital to abide by its commitment, third-party payors may also exert pressure on the hospital. As discussed, these organizations have much greater leverage than consumers, and can more easily and effectively cause the hospital to limit consumer choice.

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296. *Id.* at 142 (indicating, however, that the DOJ failed to show a lack of alternatives if prices increased).

297. *Id.* at 145.

298. *Id.* at 146-49.

299. *Id.* at 148.

300. *Id.* at 149; *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1301 (W.D. Mich. 1996).

301. See *Long Island*, 983 F. Supp. at 149; *Butterworth*, 946 F. Supp. at 1301.

302. See *Long Island*, 983 F. Supp. at 126-27; *Butterworth*, 946 F. Supp. at 1298.

303. *Butterworth*, 946 F. Supp. at 1302.

Moreover, the American Hospital Association (AHA) recently conducted a study to examine hospital mergers in the 1980s and 1990s to assess how the effects of increased market power balanced against increased economic efficiency.<sup>304</sup> The study addressed two questions: (1) to what extent and under what circumstances have hospital mergers improved efficiency; and (2) who benefits from hospital mergers—consumers in terms of lower prices, hospitals in terms of greater profits, or both?<sup>305</sup>

The study indicates that the top five reasons hospitals merge are: (1) to strengthen their financial position; (2) to achieve operating efficiencies; (3) to consolidate services; (4) to expand market share; and (5) to expand access to care.<sup>306</sup> The second and third reasons relate directly to efficiencies. The fourth reason, to expand market share, is especially noteworthy in a merger analysis.

The study found that 58% of acquired hospitals continued to offer acute inpatient care following a merger, but 17% of the acquired hospitals closed.<sup>307</sup> While closure may be “efficient,” it can severely limit consumer choice.

The AHA study concluded that “hospital mergers offer opportunities for achieving efficiencies through a variety of means.”<sup>308</sup> While the strategies for achieving efficiencies varied, none were universally adopted, and most depended on the organizational structure of the merging hospitals.<sup>309</sup>

*c. FTC v. Staples: The Agencies Preferred Efficiency Analysis Which Protects Consumers*

The FTC indicated that it prefers an analysis of the efficiencies defense in accordance with *FTC v. Staples, Inc.*<sup>310</sup> In 1996, Staples and Office Depot entered into an agreement whereby Marlin Acquisition Corporation, a wholly-owned subsidiary of Staples, “would merge with and into Office Depot, and Office Depot would become a wholly-owned subsidiary of Staples.”<sup>311</sup> At that time, Office Depot and Staples were the first and second largest office superstore chains, re-

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304. See AMERICAN HOSPITAL ASSOCIATION, EFFECTS OF HOSPITAL MERGERS ON MARKET POWER AND EFFICIENCIES, at [http://www.aha.org/hret/r\\_ehm.asp](http://www.aha.org/hret/r_ehm.asp) (last visited Jan. 9, 2000).

305. *Id.*

306. *Id.* at Exhibit 1.

307. *Id.* at Exhibit 2.

308. *Id.* at Discussion and Conclusion.

309. *Id.*

310. 970 F. Supp. 1066 (D.D.C. 1997); see also Valentine, *supra* note 265, at \*6. The FTC was successful in preventing the Staples-Office Depot merger.

311. *Staples*, 970 F. Supp. at 1069.

spectively, in the United States.<sup>312</sup> The FTC sought a preliminary injunction to enjoin the merger under the FTC Act.<sup>313</sup> In order to succeed on a motion for preliminary injunction, the FTC only had to prove that there was a “reasonable probability” that the challenged merger would have anticompetitive effects.<sup>314</sup>

The FTC defined the relevant geographic market as forty-two metropolitan areas where consumers could practically turn for alternatives and where the defendants faced competition.<sup>315</sup> The defendants did not dispute the FTC’s definition and the court, therefore, accepted the geographic market as defined by the FTC.<sup>316</sup> The court found that the relevant product market was the sale of office supplies through office supply superstores.<sup>317</sup> The court also found that the merger would allow Staples to increase prices or maintain prices at an anticompetitive level because the merger would effectively eliminate Staples’ only rival and competition.<sup>318</sup>

As to the efficiencies, the court found that the defendants’ efficiencies defense did not rebut the presumption that the merger would have anticompetitive effects.<sup>319</sup> The defendants submitted an “Efficiencies Analysis” in support of its asserted savings between \$4.9 and \$6.5 billion over the first five years of the merger.<sup>320</sup> Staples and Office Depot argued that as suppliers became more efficient, the suppliers would be able to lower prices to other retailers, and also that two-thirds of the savings realized by the merged Staples and Office Depot would be passed on to consumers.<sup>321</sup>

As evidenced in the opinion, the court looked closely at the credibility of the defendants’ documents.<sup>322</sup> First, the court indicated that the cost savings were unreliable because the numbers were inflated by almost 500%.<sup>323</sup> Second, the court determined that the savings were unverified, or at least the defendants neglected to produce the imper-

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312. *Id.*

313. *Id.* (pending the FTC’s final determination in its administrative proceedings to determine whether the merger would violate section 7 of the Clayton Act and section 5 of the Federal Trade Commission Act).

314. *Id.* at 1072. *Accord* FTC v. University Health, Inc., 938 F.2d 1206, 1218 (11th Cir 1991).

315. *Staples*, 970 F. Supp. at 1073.

316. *Id.*

317. *Staples*, 970 F. Supp. at 1080.

318. *Id.* at 1082.

319. *Id.* at 1090.

320. *Id.* at 1089.

321. *Id.*

322. *See id.*

323. *Id.*

ative documentation for verification.<sup>324</sup> Third, the defendants did not precisely calculate which savings were merger-specific.<sup>325</sup> Fourth, the defendants' methodology in making some of the projected savings was problematic.<sup>326</sup> Finally, the court determined that the two-thirds savings projected to be passed on to consumers was unrealistic.<sup>327</sup>

Given the court's detailed analysis of the defendants' projected efficiencies, it is clear why the FTC prefers an analysis of this sort. In addition, the defendants' evidence was highly inflated,<sup>328</sup> catching the immediate attention of the court. The apparent inaccuracies of the defendants' efficiency evidence indicate the difficulty in presenting, and winning, an efficiencies defense and the need for the most accurate information possible.

*d. What the Agencies can do to Protect Consumers*

Although hospitals do not technically "produce" anything, they do offer services. When hospitals merge, they either consolidate all services in one facility and close the remaining facility, or they offer certain services at one facility and different services at the other facility.<sup>329</sup> In either case, the services are consolidated to reduce duplication and costs.<sup>330</sup> However, the question remains whether the consolidation is "efficient" given that patients may lose their ability to choose.

The efficiencies defense presented by hospitals may be the most difficult obstacle the FTC and DOJ must overcome in order to protect consumer choice. The Agencies should use the *Staples* case as a model to rebut efficiencies offered by the merging hospitals. In accordance with *Staples*, the Agencies should: (1) ensure that cost savings are reliable; (2) verify those savings; (3) separate merger-specific savings from those savings that can be achieved without a merger; (4) define a methodology for calculating savings; and (5) ensure that the savings, which will be passed to the consumers, are reliable.

Considering the deference courts give to merging hospital's "community commitment" plans, the Agencies should carefully scrutinize these plans in accordance with a model rebuttal that they adopt. The

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324. *Id.* at 1089-90 (noting that the defendants' efficiencies witness was unable to explain the methods used to calculate many of the savings).

325. *Id.* at 1090 (indicating that some of the projected efficiencies could be realized without the merger).

326. *Id.* (noting that cost savings from select vendors were extrapolated to all vendors).

327. *Id.* (indicating that Staples' historical pass through rate is only 15 to 17%).

328. *Id.* at 1089-90.

329. *See supra* notes 64-66 and accompanying text.

330. *See Choslovsky, supra* note 24, at 292, 296.

most accurate information possible is the key to a successful rebuttal by the Agencies. More importantly, consumers should be the center of each step of the rebuttal.

In addition, given the strong influence of managed care, the Agencies should question whether projected savings will actually be passed to consumers or whether the savings will ultimately be usurped by the MCOs. Consumers have far less bargaining power with hospitals, while MCOs directly negotiate rates and reimbursement. In the event that an MCO reduces the reimbursement for a hospital, the hospital and consumers are required to pay more, thereby effectively reducing any savings that should have passed to consumers.

In sum, if merging hospitals are unable to specifically identify and quantify the efficiencies resulting from a merger, they should not be allowed to limit consumer choice. In order to prevent hospitals from limiting consumer choice, the Agencies must present a stronger case against the merger. Again, the focus of any challenge should be ensuring and protecting consumer choice.

#### VI. THE RURAL EXCEPTION: THE *UKIAH* CASE AND ITS IMPACT ON CONSUMERS

The 1996 Statements of Antitrust Enforcement Policy in Healthcare provide an exception for hospital mergers in rural areas.<sup>331</sup> The Agencies recognize that rural hospitals with less than 100 beds and fewer than a daily average of 40 inpatients are unlikely to achieve efficiencies enjoyed by larger hospitals.<sup>332</sup> Some of those cost-saving efficiencies may be realized, however, through a merger with another hospital.<sup>333</sup> The 1996 Statements indicate that rural hospitals are more likely to achieve economies of scale if they are allowed to merge.<sup>334</sup> This exception further undermines consumer choice. A recent California case further explains the rural exception.

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331. 1996 DOJ/FTC STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, available at <http://www.ftc.gov/reports/hlth3s.htm>, at Statement 1. Statement 1 provides:

The Agencies recognize that in some cases a general acute care hospital with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients will be the only hospital in a relevant market. As such, the hospital does not compete in any significant way with other hospitals. Accordingly, mergers involving such hospitals are unlikely to reduce competition substantially.

*Id.*

332. *Id.*

333. *Id.*

334. *Id.*



Ukiah, California is located in Mendocino County in a valley separated by the Coastal Range from the Pacific Ocean.<sup>335</sup> Nearby towns include Willits, twenty-three miles to the north, and Lakeport, thirty-four miles to the southeast.<sup>336</sup> The closest urban centers are Santa Rosa, sixty miles to the south, and San Francisco, 120 miles away.<sup>337</sup>

Ukiah was originally the home to three hospitals, however one closed in 1992.<sup>338</sup> The only two remaining hospitals located in Ukiah were Ukiah Adventist Hospital (UAH) and Ukiah General Hospital (UGH).<sup>339</sup> Two other small hospitals, both offering primary care services, were located in Willits and Lakeport.<sup>340</sup> The largest hospitals in the area included those in Santa Rosa and San Francisco.<sup>341</sup>

In 1988, UAH entered into an agreement to purchase UGH.<sup>342</sup> UAH was a forty-three bed hospital that offered primary care services and some ancillary services, but no obstetrical services.<sup>343</sup> UGH was a fifty-one bed hospital that offered similar services, but also included an obstetrical unit and neonatal care services.<sup>344</sup> The FTC Staff challenged the merger on the basis that it violated section 7 of the Clayton Act because Adventist Health System/West ("AHS/West") controlled three of five area hospitals, including UAH.<sup>345</sup>

In determining the relevant geographic market, the FTC Commission examined the likely response of health insurance plans, patients, patient discharge statistics, alternative hospitals, and physician privi-

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335. *Adventist Health Sys./West*, 117 F.T.C. 224, 285 (1994). This case was challenged and reviewed according to the FTC's administrative process. The FTC Staff first brought the case before an Administrative Law Judge (ALJ). After the ALJ dismissed the case, the Staff appealed to the FTC Commission. It was not subsequently litigated in court. Accordingly, "FTC Staff" refers to the FTC employees challenging the merger. "FTC Commission" refers to the administrative panel that rendered this decision.

336. *Id.*

337. *Id.*

338. *Id.* at 286-87.

339. *Id.* at 286.

340. *Id.* at 287.

341. *Id.*

342. *Id.* at 286. UAH was managed and controlled by Adventist Health System/West (AHS/West). *Id.*

343. *Id.* at 286-87.

344. *Id.*

345. See Erwin A. Blackstone and Joseph P. Fuhr, Jr., *Rural Hospital Mergers, Anti-trust Policy, and the Ukiah Case*, 23 J. HEALTH POLITICS POL'Y & L. 949, 955-56 (1998). The merger of UAH and UGH increased AHS/West's market share from 38% to 71% and increased the HHI from about 3,100 to 5,600. See *id.* at 955-56; *Adventist Health Sys./West*, 117 F.T.C. at 288-97.

leges.<sup>346</sup> The FTC Staff argued that the relevant geographic area was Ukiah-Willits-Lakeport, or in the alternative Ukiah-Willits.<sup>347</sup> The FTC Commission, and, previously, the Administrative Law Judge rejected this argument.<sup>348</sup>

First, the FTC agreed that insurers are sensitive to price increases, and as a result, may seek to steer patients to lower cost hospitals.<sup>349</sup> The FTC Commission could not, however, determine from the record the degree of price sensitivity that would undermine an anticompetitive price increase.<sup>350</sup> Second, the FTC determined, according to E-H statistics, that the geographic market was not confined to the Ukiah-Willits-Lakeport area.<sup>351</sup> Finally, the FTC Commission determined that there was no plausible reason to exclude Lakeport from the Ukiah-Willits geographic market.<sup>352</sup>

The decision stated that the FTC Staff failed to prove that Ukiah-Willits-Lakeport or Ukiah-Willits were the relevant geographic markets,<sup>353</sup> although what is not stated in the decision is equally as important. The decision implicitly supports wide geographic markets for rural hospitals.<sup>354</sup> In addition, the willingness of 25% of Ukiah residents to travel to distant areas for health care does not protect the 75% of residents unwilling to travel for health care services.<sup>355</sup> Furthermore, testimony indicated that the presence of two hospitals in Ukiah made administrators more sensitive to quality concerns and physician requests for new equipment.<sup>356</sup> The decision, however, implies that the merged Ukiah facility will be responsive to competition

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346. *Adventist Health Sys./West*, 117 F.T.C. at 288-97. The parties did not disagree about the definition of the relevant product market, and the FTC Commission accepted the ALJ's decision that the relevant product market consisted of acute inpatient care hospital services. *Id.* at 288.

347. *Id.* at 285.

348. *Adventist Health Sys.*, 117 F.T.C. at 284-85.

349. *Id.* at 291.

350. *Id.*

351. *Id.* at 292-93. The statistics indicated that although the hospitals drew 91 percent of their patients from the area, approximately 25 percent of patients sought hospital services outside of these three areas. *Id.* at 294.

352. *Id.* at 293-94 (noting the lack of testimony indicating that patients could not go to Lakeport). The FTC's expert advocated the Ukiah-Willits-Lakeport market, not the Ukiah-Willits market. *Id.* In addition, the hospital in Willits was an affiliate of AHS/West and was unlikely to be a competitive alternative if the merged Ukiah hospitals raised prices. *Id.*

353. *Id.* at 297.

354. See Blackstone and Fuhr, *supra* note 345, at 959.

355. See *id.*; see also *Adventist Health Sys./West*, 117 F.T.C. at 294.

356. *Adventist Health Sys./West*, 117 F.T.C. at 294; Blackstone and Fuhr, *supra* note 345, at 960.

located sixty miles away.<sup>357</sup> While the merger produced some efficiencies, such as the elimination of duplicate services, the merger also eliminated local competition that served to bolster the quality of hospital services. It appears unwise to assume that a small rural hospital, offering only primary care services and obstetric services, will remain conscious of what a larger urban tertiary care facility sixty miles away is doing with respect to quality and prices.<sup>358</sup>

The general rule, that competition fosters lower costs and more efficient services, does not apply to a merger between two entities located in a rural area.<sup>359</sup> This is known as the rural exception. In effect, this exception promotes anti-competitive behavior and allows rural hospitals to merge regardless of the consequences to consumers. In the *Ukiah* case, the Administrative Law Judge determined, however, that the duplication of services in a rural area actually increased the cost of health care because the duplicated services sparked a "medical arms race."<sup>360</sup>

In a rural merger case, economies of scale often justify and provide support for the merger of the only two providers.<sup>361</sup> Small rural hospitals often suffer from higher costs, making it more difficult to realize an economy of scale.<sup>362</sup> The merger of two rural hospitals can eliminate inefficiency and overcapacity (an excess number of beds) and achieve an economy of scale.<sup>363</sup>

Two additional standards can also justify a rural hospital merger: (1) the minimum efficient size for a hospital is at least 100 beds,<sup>364</sup> and (2) a new standard is one and one-half to two beds per 1000 people.<sup>365</sup> If applied to the *Ukiah* case, these standards support the merger. First, UAH and UGH combined have ninety-four beds,<sup>366</sup> just six beds short of the efficient size.<sup>367</sup> Second, Ukiah's population of 40,000 justifies between sixty and eighty beds.<sup>368</sup> The numbers indi-

357. See Blackstone and Fuhr, *supra* note 345, at 969.

358. See generally Blackstone and Fuhr, *supra* note 345.

359. See *id.* at 969-70.

360. See *id.* at 961.

361. See *id.* at 966.

362. See *id.* at 964.

363. See *id.* at 964-66.

364. See *id.* at 964.

365. See *id.*

366. See *Adventist Health Sys./West*, 117 F.T.C. at 286; see also Blackstone and Fuhr, *supra* note 363, at 955 (indicating that UAH had forty-three beds and UGH had fifty-one beds).

367. See Blackstone and Fuhr, *supra* note 363, at 964.

368. See *id.*

cate that Ukiah can efficiently support only one hospital, and the merger succeeded.

The rural exception, as set forth in the 1996 Statements,<sup>369</sup> is contradictory to the goal of providing consumers with a wide range of choices.<sup>370</sup> Choice in a rural area can be completely eliminated, yet the merger is allowed to proceed. The merger essentially dictates where patients must go for care and what services the patients can easily obtain. Efficiencies and economies of scale prevail over consumer choice. The focus may still be on the consumer by providing lower prices through an economy of scale, but the focus is not on consumer choice.

## VII. THE SHERMAN ACT

The Sherman Act prohibits “every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce” in interstate commerce.<sup>371</sup> The main purpose of the Sherman Act is to prevent combinations, such as mergers or acquisitions, and conspiracies, such as those to raise prices, in undue restraint of trade or tending to monopolize the free market.<sup>372</sup> The FTC’s jurisdiction under the Sherman Act is very broad, and is “generally coextensive with Congressional authority under the Commerce Clause.”<sup>373</sup> The FTC’s jurisdiction under the Clayton Act is more limited,<sup>374</sup> however, the purposes of each act are similar. The Sherman Act and the Clayton Act both seek to prohibit combinations of companies that would interfere with the free market and thus lessen competition.

### A. *Possible Convergence of the Clayton and Sherman Acts*

The Clayton Act’s purpose is to stop restraints of trade in their incipiency.<sup>375</sup> The purpose of the Sherman Act is to nullify agreements

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369. See *supra* note 331 for the text of Statement 1.

370. But see 1996 DOJ/FTC STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, available at <http://www.ftc.gov/reports/hlth3s.htm> at *Introduction* (stating that a goal of the exception is to provide consumers with a range of choices).

371. 15 U.S.C.A. § 1 (West 1997).

372. See generally *D.R. Wilder Mfg. Co. v. Corn Prods. Ref. Co.*, 236 U.S. 165 (1915); *United States v. Am. Optical Co.*, 97 F. Supp. 66 (N.D. Ill. 1951).

373. *Bhan v. NME Hosp., Inc.*, 669 F. Supp. 998, 1010 (E.D. Cal. 1987).

374. See *supra* notes 133-62 and accompanying text.

375. See *supra* notes 122-26 and accompanying text; see also *Baker*, *supra* note 14, at 113.

currently restraining trade.<sup>376</sup> Hence, the intent of the two acts is different, but the practical distinction between them is insignificant.<sup>377</sup>

The court's application of the Clayton Act in *Hospital Corporation of America v. FTC*<sup>378</sup> explained that mergers are forbidden if they are likely to "hurt consumers, as by making it easier for the firms in the market to collude, expressly or tacitly, and thereby force price above or farther above the competitive level."<sup>379</sup> A merger with the effect of increasing prices would also violate section 1 of the Sherman Act<sup>380</sup> because, "[b]oth statutes as currently understood prevent transactions likely to reduce competition substantially."<sup>381</sup>

Given the unresolved nature of the difference, if any, between judging the lawfulness of a transaction under section 1 of the Sherman Act or section 7 of the Clayton Act, an analysis of cases decided under the Sherman Act will be discussed. Sherman Act cases may provide additional guidance for the agencies when challenging a hospital merger case that lessens consumer choice.

#### *B. Case Law Under the Sherman Act Applying the Rule of Reason Analysis*

In the following Sherman Act cases that will be examined, the courts applied the Rule of Reason analysis. The Rule of Reason analysis was adopted from common law<sup>382</sup> and prohibits acts, agreements, or contracts that prejudice public interest, obstruct the due course of trade, or injuriously restrain trade.<sup>383</sup> The test of legality under the Rule of Reason is whether the restraint imposed regulates and perhaps promotes competition, or whether it suppresses or destroys competition.<sup>384</sup> Absent some pro-competitive virtue, such as the creation

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376. See 15 U.S.C.A. § 1 (West 1997); see also Baker, *supra* note 14, at 113.

377. See Baker, *supra* note 14, at 113.

378. 807 F.2d 1381 (7th Cir. 1986).

379. *Id.* at 1386.

380. See *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1285, 1283 (7th Cir. 1990); see also 15 U.S.C.A. § 1 (West 1997).

381. *Rockford*, 898 F.2d at 1283.

382. See 54 AM. JUR. 2D *Monopolies, Restraints of Trade, and Unfair Trade Practices* § 48 (1996). The Supreme Court adopted the Rule of Reason analysis in *United States v. E. I. du Pont de Nemours & Co.*, 351 U.S. 377, 386-87 (1956) and *Standard Oil Co. v. United States*, 221 U.S. 1, 61-62 (1911).

383. See 54 AM. JUR. 2D *Monopolies, Restraints of Trade, and Unfair Trade Practices* § 48 (1996).

384. See *id.* This test was articulated in *National Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 691 (1978) (quoting *Board of Trade of Chicago v. United States*, 246 U.S. 231, 238 (1918)), and *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447, 458-59 (1986) (holding that a refusal to compete with respect to a package of services offered to customers impaired "the ability of the

of efficiencies, conduct that impairs the natural ability of the market to provide desired goods or services cannot be sustained under the Rule of Reason analysis.<sup>385</sup>

This analysis requires a determination of the particular facts of each case.<sup>386</sup> In some cases, a determination of reasonableness may depend on the intent of the conduct and the method used to obtain control over commerce or competition.<sup>387</sup> A good intention, however, will not evade scrutiny under section 1 of the Sherman Act.<sup>388</sup> Conduct violates section 1 of the Sherman Act if an unreasonable restraint is either its intent or effect.<sup>389</sup>

1. *National Society of Professional Engineers v. United States*

*National Society of Professional Engineers v. United States*<sup>390</sup> specifically addresses the issue of consumer choice. The National Society of Professional Engineers (Society) was a society that dealt with the non-technical aspects of the engineering practice.<sup>391</sup> Such aspects included the promotion of its members' professional, social, and economic interests.<sup>392</sup> In pertinent part, section 11 of the Society's Code of Ethics states:

The Engineer will not compete unfairly with another engineer by attempting to obtain employment or advancement or professional engagements by competitive bidding . . . . He shall not solicit or submit engineering proposals on the basis of competitive bidding . . . . An Engineer requested to submit a fee proposal or bid prior to the selection of an engineer or firm subject to the negotiation of a satisfactory contract, shall attempt to have the procedure changed to conform to ethical practices, but if not successful he shall withdraw from consideration for the proposed work.<sup>393</sup>

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market to advance social welfare by ensuring the provision of desired goods and services to consumers at a price approximating the marginal cost of providing them").

385. See 54 AM. JUR. 2D *Monopolies, Restraints of Trade, and Unfair Trade Practices* § 48 (1996).

386. See *id.*

387. See *id.*

388. See *id.*

389. See *id.*

390. 435 U.S. 679 (1978).

391. *Id.* at 682.

392. *Id.*

393. *National Soc'y of Prof'l Eng'rs*, 435 U.S. at 683 n.3 (quoting section 11(c) of Society's Code of Ethics).

The Society forbade its members from negotiating or discussing fees until after the prospective client selected an engineer.<sup>394</sup>

The DOJ filed a complaint under section 1 of the Sherman Act alleging that price competition among the members was suppressed and that customers were deprived of the benefits of the free market.<sup>395</sup> The Society argued that section 11 of their Code of Ethics was reasonable because competition among professional engineers was contrary to the public interest, and the prohibition of competitive bidding was necessary to protect the public's health, safety, and welfare.<sup>396</sup>

The Court, however, disagreed.<sup>397</sup> In its analysis, the Court applied the Rule of Reason analysis to determine whether the proscription on competitive bidding impacted competitive conditions.<sup>398</sup> "[T]he purpose of the analysis is to form a judgment about the competitive significance of the restraint . . . ."<sup>399</sup>

The Court determined that the agreement in section 11 constituted an absolute ban on competitive bidding.<sup>400</sup> The Court agreed with the district court ruling that the ban "'impedes the ordinary give and take of the market place,' and substantially deprives the customer of 'the ability to utilize and compare prices in selecting engineering services.'"<sup>401</sup> The ban on competitive bidding prevented customers from making price comparisons when initially attempting to select an engineer, and also imposed the Society's views of costs and benefits on the entire market.<sup>402</sup>

## 2. *FTC v. Indiana Federation of Dentists*

*FTC v. Indiana Federation of Dentists*<sup>403</sup> is a case closer on point because it directly relates to the health care industry. In an effort to contain costs, dental health insurers implemented "alternative benefits" plans that required an evaluation by the insurer of the treating

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394. *Id.* at 684.

395. *Id.*; see also 15 U.S.C.A. § 1 (West 1997).

396. *National Soc'y of Prof'l Eng'rs*, 435 U.S. at 684-85.

397. *Id.* at 693-94.

398. *Id.* at 688. The analysis under the Rule of Reason is to determine whether the restraint promoted or suppressed competition. *Id.* at 691. See also *supra* notes 386-89 for a discussion of the Rule of Reason analysis.

399. *Id.* at 692.

400. *Id.*

401. *Id.* at 692-693 (quoting *United States v. National Soc'y of Prof'l Eng'rs*, 404 F. Supp. 457, 460 (D.D.C. 1975)).

402. See *id.* at 695.

403. 476 U.S. 447 (1986).

dentist's diagnosis and recommendation.<sup>404</sup> Insurers often requested the dentist to submit the x-rays used to examine the patient, the necessary insurance claim forms, and any other information concerning the patient's diagnosis and recommended treatment.<sup>405</sup>

In an effort to hinder the implementation of these alternative benefit plans, approximately eighty-five percent of dentists in Indiana formed the Indiana Dental Association (IDA) and refused to submit x-rays, in conjunction with claim forms, to insurers.<sup>406</sup> The IDA was successful and many insurers were unable to obtain compliance with their requests for x-rays.<sup>407</sup> As a result, insurers were forced either to use more expensive means of making alternative benefits determinations, such as visiting the dentists' office, or to completely abandon their efforts.<sup>408</sup> Eventually, out of fear of antitrust liability, a majority of the dentists in IDA agreed to the FTC's cease and desist order.<sup>409</sup>

A number of dentists, who were still unwilling to comply with the insurers' requests and to submit x-rays, formed the Indiana Federation of Dentists (IFD) in order to continue the original plan initiated by the IDA.<sup>410</sup> In an effort to disguise itself from antitrust agencies, the IFD labeled itself a "union"<sup>411</sup> and then issued a rule forbidding members to submit x-rays.<sup>412</sup>

The FTC found, in its own hearing, that IFD's restraint was an unfair method of competition and violated section 5 of the Federal

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404. *Id.* at 449.

405. *Id.*

406. *Id.* at 449-50. An IDA official revealed the dentists' motive in refusing to comply with requests relating to alternative benefits plan determinations:

We are fighting an economic war where the very survival of our profession is at stake . . . . The name of the game is money. The government and labor are determined to reduce the cost of the dental health dollar at the expense of the dentist. There is no way a dental service can be rendered cheaper when the third party has to have its share of the dollar.

*Id.* at 450 n.1. This can be construed as further evidence of the influence of third-party payors.

407. *Id.* at 450.

408. *Id.* at 450.

409. *Id.* at 450-51.

410. *Indiana Fed'n of Dentists*, 476 U.S. at 451.

411. *Id.* Labor unions have certain exemptions from antitrust liability.

412. *Id.*



Trade Commission Act.<sup>413</sup> IFD sought judicial review from the Seventh Circuit,<sup>414</sup> and the FTC appealed to the Supreme Court.<sup>415</sup>

The Court found that the FTC's findings were supported by substantial evidence, that IFD's actions constituted a violation of section 1 of the Sherman Act, and thus also, that IFD's actions violated section 5 of the FTC Act.<sup>416</sup> In reaching this conclusion, the Court again applied the Rule of Reason analysis.<sup>417</sup>

The Court determined that IFD's policy amounted to a horizontal agreement that served to withhold a service that customers desired: the forwarding of x-rays along with claim forms.<sup>418</sup> This refusal to compete impaired the market's ability to advance social welfare by ensuring the provision of desired goods and services.<sup>419</sup> In sum, IFD was not allowed to determine, on behalf of its customers, who were both patients and their insurers, which goods or services they should receive.<sup>420</sup>

Following the decision in *National Society of Professional Engineers v. United States*,<sup>421</sup> the IFD Court stated:

Absent some countervailing procompetitive virtue — such as, for example, the creation of efficiencies in the operation of a market or the provision of goods and services, — such an agreement limiting consumer choice by impeding the 'ordinary give and take of the market place,' cannot be sustained under the Rule of Reason.<sup>422</sup>

The Court stated that the FTC's failure to engage in a detailed market analysis was not fatal to its finding of a violation of the Rule of Reason.<sup>423</sup> Although the purpose of market analysis is to determine whether the activity in question had the potential to produce adverse effects on competition, proof of actual detrimental effects obviated the need for a detailed market analysis.<sup>424</sup>

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413. *Id.*

414. *See Indiana Fed'n of Dentists v. FTC*, 745 F.2d 1124, 1126 (7th Cir. 1984). The Seventh Circuit vacated the cease and desist order on the grounds that it was not supported by substantial evidence. *See id.*

415. *See Indiana Fed'n of Dentists*, 476 U.S. at 453.

416. *Id.* at 465-66.

417. *See id.* at 459.

418. *Id.*

419. *Id.*

420. *Id.*

421. 435 U.S. 679 (1978).

422. *Indiana Fed'n of Dentists*, 476 U.S. at 459 (quoting *National Soc'y of Prof'l Eng'rs*, 435 U.S. at 692) (citations omitted).

423. *Id.* at 460.

424. *See id.* at 460-61 (citing 7 P. Areeda, *Antitrust Law* ¶ 1511 at 429 (1986)).

3. *Image Technical Services, Inc. v. Eastman Kodak Co.*

In *Image Technical Services, Inc. v. Eastman Kodak Co.*,<sup>425</sup> the plaintiff alleged that Kodak restricted access to its photocopier and micrographic parts by refusing to sell these necessary parts to independent service organizations (ISOs).<sup>426</sup> ISOs were limited in their ability to compete in the service market for Kodak machines due to the restriction on parts.<sup>427</sup>

Service and parts for Kodak equipment were not interchangeable with other service and parts, hence the court defined the relevant market as those companies that serviced Kodak machines.<sup>428</sup> The record revealed that Kodak had a ninety-five percent share of the Kodak high volume copier service market and an eighty-eight percent share of the Kodak micrographic service market.<sup>429</sup> When Kodak began implementing restrictions on the availability of its parts, some ISOs withdrew from the Kodak service market or substantially restricted their service since parts were not readily available.<sup>430</sup> As a result, Kodak customers were "locked-in" to obtaining the necessary service and parts from Kodak.<sup>431</sup>

Evidence showed that Kodak practiced price discrimination by selling parts to customers who serviced their own equipment, but refusing to sell parts to customers who hired ISOs.<sup>432</sup> In addition, the cost of switching to a different product was expensive.<sup>433</sup> These two factors combined "locked-in" customers.<sup>434</sup> The Court stated that:

If the cost of switching is high, consumers who already have purchased the equipment, and are thus "locked-in," will tolerate some level of service-price increases before changing equipment brands. Under this scenario, a seller profitably could maintain supracompetitive prices in the aftermarket if the switching costs were high relative to the increase in ser-

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425. 125 F.3d 1195 (9th Cir. 1997).

426. *Id.* at 1201.

427. *Id.*

428. *Id.* at 1203 (citing *Eastman Kodak Co. v. Image Technical Servs. Inc.*, 504 U.S. 451, 482 (1992)).

429. *Id.* at 1212.

430. *Id.*

431. *Id.*, 125 F.3d at 1212. The Ninth Circuit, hearing the case on remand, did not fully discuss the "lock-in" concept, but included a reference to the Supreme Court case that discussed the concept. *See id.*

432. *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 476 (1992).

433. *Id.*

434. *Id.*

vice prices, and the number of locked-in customers were high relative to the number of new purchasers.<sup>435</sup>

The Court concluded that a jury could reasonably infer that Kodak made a conscious choice to gain immediate profits by exerting market power where locked-in customers, high information costs, and discriminatory pricing limited long-term loss.<sup>436</sup>

In addition to acknowledging that customers experienced a "lock-in," the Ninth Circuit also concluded that Kodak's market share in the equipment market further limited consumers' choices.<sup>437</sup> In sum, Kodak refused to deal with its customers in order to control a downstream market.<sup>438</sup>

### VIII. CONCLUSION

"Hospital markets are predominantly local in nature and, by conventional measures often, highly concentrated."<sup>439</sup> In addition, hospitals provide unique services. As one court stated:

For many services provided by acute-care hospitals, there is no competition from other sorts of provider[s]. If you need a kidney transplant, or a mastectomy, or if you have a stroke or a heart attack or a gunshot wound, you will go (or be taken) to an acute-care hospital for inpatient treatment. The fact that for other services you have a choice between inpatient care at such a hospital and outpatient care elsewhere places no check on the prices of the services we have listed, for their prices are not linked to the prices of services that are not substitutes or complements. If you need your hip replaced, you can't decide to have chemotherapy instead because it's available on an outpatient basis at a lower price.<sup>440</sup>

As the judge in *Rockford* emphasized, there are no substitutes for certain services. For many services, the consumer's choice is already limited to either having the necessary treatment or not.

There is no question that health care expenses are high and continuously increasing, but consumers should not have their choices limited because merging hospitals claim efficiencies that are often not justified. In addition, consumers should not be pawns of managed care organizations and third-party payors. The consumers in this in-

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435. *Id.*

436. *Id.* at 477-78.

437. *Image Technical Servs.*, 125 F.3d at 1212.

438. *Id.* at 1211.

439. *Raskin & Zessar*, *supra* note 21, at 21.

440. *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990).

stance are patients with specific health care needs. They should be able to receive the necessary treatment from the doctor or hospital of their choice.

As *Philadelphia National Bank* pointed out, consumers should be at the forefront of the merger analysis.<sup>441</sup> Often, "there is no alternative source outside the realm of general acute care inpatient hospitals to which a patient can turn to obtain such services in response to a small but significant price increase."<sup>442</sup> In addition, consumers generally will not use outpatient services as a substitute for some inpatient services in response to price increases of general acute-care inpatient services.<sup>443</sup>

Choice can still be limited, despite the fact that the FTC and DOJ attempt to ensure that more than one hospital is available in any given geographic area to guarantee consumer choice.<sup>444</sup> While the Agencies have a foundation of case law on which to rely in arguing against a hospital merger that limits consumer choice,<sup>445</sup> some additional improvements can be made.

Hospitals should be held to the efficiencies standard and analysis contained in *Staples*.<sup>446</sup> Hospital efficiency studies should be carefully scrutinized to ensure with some certainty that the efficiencies will be realized and passed on to consumers.

Furthermore, a uniform standard needs to be implemented in order to define the geographic market area. As shown by the case law, the Agencies and the hospitals have several different ways to measure the geographic market.<sup>447</sup> However, uniform standards should ensure that consumers have a viable alternative if the merger is allowed. A hospital located forty or sixty miles away, such as in rural cases, is not necessarily a viable alternative, particularly in the case of an emergency where the patient requires trauma or tertiary care services. This rationale should also apply to reproductive services. Patients should not be forced, due to a merger, to travel extensive distances, thereby increasing costs, to obtain elective health care services.

The rural exception<sup>448</sup> should also be carefully analyzed. In many rural cases, the merger is justified by the numbers.<sup>449</sup> The agencies,

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441. See *supra* note 128 and accompanying text.

442. *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290 (W.D. Mich. 1996).

443. See *id.*

444. See Choslovsky, *supra* note 24, at 309.

445. See *supra* Part V.

446. See *supra* Part V.C.2.c. for a discussion of *FTC v. Staples*.

447. See *supra* Part V. C.1.b.

448. See *supra* Part VI.

449. See *supra* notes 331-34 and accompanying text.

however, must ensure that the merger will not eliminate a service previously provided by the merging hospitals. In addition, the large geographic market areas usually defined in rural cases<sup>450</sup> should be reviewed. While some rural consumers may be willing to travel longer distances to obtain necessary health care services, other rural consumers may be less willing to travel or simply cannot afford to travel.<sup>451</sup> These large geographic markets could present a problem if a rural patient required an extensive stay at an urban hospital. The immediate family may be required to drive back and forth, possibly 120 to 240 miles roundtrip like in the *Ukiah* case,<sup>452</sup> or have to stay at a hotel near the urban hospital.

The Agencies should further ensure that consumers do not get "locked-in" to only one hospital.<sup>453</sup> The combination of merger effects and the strong influence of third-party payors could disadvantage consumers. This powerful combination could eliminate consumer choice.

Proper analysis under the Clayton Act,<sup>454</sup> or possibly the Sherman Act,<sup>455</sup> could ensure that consumers will continue to have a choice regarding their health care needs. If a merger is allowed, the agencies should ensure that the merged institution does not later find it "efficient" to discontinue a service.

In sum, competition ensures consumer choice and protects consumers from paying too much for their health care needs. If the anti-trust laws are not able to protect consumers, then other methods need to be explored, such as procedural reform. Current case law does provide a foundation for a merger challenge, however some aspects still need further analysis and reform. The agencies need to resort back to the original purpose of the Clayton Act and antitrust laws - protection of competition and consumers.

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450. See *supra* notes 346-53 and accompanying text.

451. See *supra* note 355 and accompanying text.

452. See *supra* note 337 and accompanying text.

453. See *supra* notes 442-52 for a discussion of the "lock-in" concept.

454. 15 U.S.C.A. §§ 12-19, 21, 22-27 (West 1997).

455. 15 U.S.C.A. § 1 (West 1997).