Antitrust and Hospital Mergers: A Law and Economics Rationale for Exemption

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Comments

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INTRODUCTION

Few sectors of the economy have been the subject of as many policy initiatives as the health care industry. These initiatives have been designed to make health care more available for people of all incomes; to improve its geographic distribution; to redirect its resources to unmet needs; to make its delivery more comprehensive and economical; and to eliminate its excess capacity which resulted from the prior initiatives. Today many of these initiatives have been abandoned. Forty years of tinkering have left a health care system which is more expensive, more sophisticated in technology and more complex institutionally. It leaves us puzzled about solutions. In 1988 a new initiative began. With acute care hospitals[1] operating with significant excess capacity in beds and services, nonprofit hospital mergers have been challenged as violating antitrust laws. This followed closely on the heels of challenging mergers involving hospitals operated for profit.[2]

The goals of the antitrust laws are to promote competition, economic efficiency[3] and consumer welfare by preventing or punishing activities which tend to create monopolies. Antitrust laws do not

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1. Acute care hospitals provide in-patient medical care to patients for a brief period, generally less than 30 days.

2. *Hospital Corp. of Am. v FTC*, 807 F2d 1381 (7th Cir 1986). This case was the culmination of the Federal Trade Commission's challenge of hospital acquisitions made by the largest for-profit hospital chain in the United States. *Hospital Corp. of Am.*, 807 F2d at 1383-84. This comment focuses on the more recent decisions regarding nonprofit hospital mergers because such hospitals are the dominant mode of organization among acute care hospitals and because the extension of antitrust law to such organizations opens a considerable number of localized hospital decisions to antitrust scrutiny.

3. Efficiency describes the relationship between aggregate benefits and aggregate costs in the use of a particular combination of resources, such as materials, labor, equipment. An efficient use of those resources should produce an aggregate benefit which cannot be increased without increasing the resources. Alternatively, if a specific benefit is desired, an efficient use of the resources would be one which achieves that benefit at the least cost. A. Mitchell Polinsky, *An Introduction to Law and Economics* 7-10 (Little, Brown and Co. 2d ed 1989).

prevent all monopolies, however. Where the development of monopoly power is the result of legitimate business activity and not the result of conspiracy among competitors, mergers which reduce competition, or other prohibited activities, the existence of a monopoly is not a violation of the law.

This comment will examine the application of antitrust laws to hospital mergers within the context of the overall health care policy direction of the past four decades. Some of the policy initiatives of the past have contributed to a hospital market with excess capacity. The structure of the hospital market will be shown to encourage the duplication of services which raise costs. The intended results of mergers between hospitals are to reduce the excess capacity and minimize the duplication of services. Mergers make the hospital market less competitive but more efficient. Thus, the interests of efficiency and of health care cost containment would be better served by a statutory exemption from antitrust laws for hospital mergers.

BACKGROUND

Beginning in the immediate post-World War II period, the construction of hospital facilities was encouraged in 1946 by the Hill-Burton Act[4] through which deficiencies in the availability of hospital beds, especially in rural areas, were to be corrected. Another initiative to make health care, particularly acute in-patient care, more available was the passage in 1965 of Medicare[5] and Medical Assistance.[6] These reimbursement programs were to assist those over the age of 65 and those with low incomes to obtain the health

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4. Hospital Survey & Construction Act (Hill-Burton Act), 42 USC §§ 291-291o-1 (1988). Under this Act, grants and loans were made available for construction and modernization of public and nonprofit hospital facilities. Id.

5. Health Insurance for the Aged Act, 42 USC §§ 1395-1395ccc (1988). Medicare provides hospital benefits described as Part A and medical benefits described as Part B to persons age 65 years and older. Part A is provided without premium payment and covers hospital services, subject to certain deductibles and co-payments. Part B is elective and requires the payment of a monthly premium. Part B covers physician and related services subject to certain deductibles and co-payments. Id.

6. Grants to States for Medical Assistance Programs Act, 42 USC §§ 1396-1396s (1988). Medical Assistance is a program of medical coverage for hospital and physician services funded jointly by federal and state governments. States administer the program under their own rules, but must comply with certain minimum federal requirements. Eligibility is based on income and asset limitations. Generally, only persons living on incomes below the federally defined poverty level are eligible. Often, benefits are not available unless a person is significantly below the poverty level. Id.

care services they needed. The National Health Service Corps[7] was created in 1976 to redistribute an urban physician surplus into rural and inner-city locations, thereby making physician services more available in rural and inner-city locations.

After 20 years of intentionally increasing the resources invested in health care and encouraging increased utilization, concerns were raised about the cost of health care. Policy-makers began to search for new programs to curb or reduce the growth rate. Out of this search came the Comprehensive Health Planning and Public Health Services Amendments of 1966 (hereinafter "CHP"),[8] which brought together health care providers and consumers in a voluntary program to rationalize the development of health care through planning and through review of large capital expenditures.

Accompanying the CHP effort, the Regional Medical Program[9] was established to encourage the development of education, research, training and demonstration programs aimed at heart disease, cancer, strokes and related diseases. Also authorized during this time were experimental health programs to encourage more economical utilization of comprehensive health and mental health services.[10] Another part of this period of policy initiatives was Professional Standards Review Organizations,[11] which were created to establish standards among health care providers which would assure that services paid under Medicare conformed to appropriate professional standards.

Pure voluntarism, as embodied in CHP, was short-lived as a policy to contain the growth and the cost of health care. Continued escalation in health costs suggested that a coalition of providers and consumers was ineffective in restraining the growth and duplication of health care services. Midway through the 1970's, Comprehensive Health Planning agencies, Regional Medical Programs and

7. Health Professions Educational Assistance Act of 1976, 42 USC §§ 254d(a)-254d(i) (1988). The National Health Service Corps allows medical students to enter into agreements with the federal government under which the government pays the costs of a student's medical education and the student agrees to serve for two to four years after completion of school and residency as a physician in an under-served area. Service in such Health Professional Shortage Areas for the agreed upon time means that the physician's medical education expenses are forgiven. Id.

8. Comprehensive Health Planning and Public Health Services Amendments of 1966, 42 USC §§ 243, 245a, 246 (1988).

9. Heart Disease, Cancer & Stroke Amendments of 1965, 42 USC §§ 299(a)-299(j)(1988), repealed by Health Services Amendments of 1985, Pub L No 99-117, § 12d, 99 Stat 495.

10. Social Security Amendments of 1972, 42 USC §§ 1395b-1(a)-1395b-1(b) (1988).

11. Tax Equity & Fiscal Responsibility Act of 1982, 42 USC § 1320c-1 (1988).

experiments in health care delivery were largely replaced by Health Systems Agencies under the National Health Planning and Resources Development Act of 1974.[12] This new policy initiative was intended to "put teeth" into the previously voluntary program which reviewed capital expenditures and new programs of health care providers.

This initiative required new services and capital expenditures by health care providers to have a Certificate of Need (hereinafter "CON") approved by the local Health Systems Agency and by the state's Health Planning and Development Agency. The local and state agencies were to formulate regional and statewide comprehensive health plans which would serve as the basis for granting or denying a CON.[13] When this policy initiative failed to turn around the growth of the health care industry which had been infused with substantial financial resources for 40 years, it was repealed.[14]

After almost 50 years of health policy initiatives which first sought to feed the health care industry and then to starve it, market forces have been turned to as the means which will correct the problems of growth in health care. The replacement of cost-based reimbursement by prospective payment for hospital services to Medicare recipients[15] has been one means of putting market forces into play. When the return sellers can receive for a product or service is reduced, sellers are inclined to provide less. Thus, hospitals responded to prospective payment by attempting to reduce lengths of stay to keep costs within the prospective payments.[16] Under pressure from reduced revenues, hospitals could be expected to find ways to combine in order to reduce costs and increase revenues. In 1984, hospital mergers came under the scrutiny of federal antitrust enforcement.[17]

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12. National Health Planning & Resources Development Act, 42 USC §§ 300k-1-300k-3 (1988), repealed by §701(a), Pub L 99-660, 100 Stat 3799.

13. Id.

14. Repeal of Title XV, Pub L No 99-660, § 701(a), 100 Stat 3799. CON legislation still exists in many states as an artifact of the National Health Planning and Resources Development Act. Federal funding for regional Health Systems Agencies has ended.

15. Medicare Catastrophic Coverage Act of 1988, 42 USC § 1395ww (1988).

16. Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 Law & Contemp Probs 93, 98 (Spring 1988).

17. See *In re Am. Medical Int'l, Inc.*, 104 FTC 1 (1984). American Medical International (hereinafter "AMI"), a for-profit corporation, acquired French Hospital in San Luis Obispo, California, giving AMI control over two of the three hospitals in the city. The Federal Trade Commission challenged the acquisition as violating section 7 of the Clayton Act. Section 7 provides that a corporate merger is illegal if it lessens competition. AMI was ordered to divest French Hospital. Id.

In 1988, the Antitrust Division of the Justice Department initiated antitrust actions to prevent mergers of nonprofit hospitals in Roanoke, Virginia (hereinafter "Roanoke")[18] and in Rockford, Illinois (hereinafter "Rockford").[19] As the first two antitrust actions against nonprofit hospitals, these cases received considerable attention. When the two district courts arrived at different conclusions as to whether such mergers violated antitrust laws[20] and both were affirmed on appeal,[21] the status of the law regarding nonprofit hospital mergers was left unsettled.

The opinions in these cases have generated discussion about the applicability of antitrust law to nonprofit hospital mergers.[22] Commentators have recognized the unique economic characteristics of the health care market which influence the effects of antitrust policy and hospital mergers. While these characteristics are recognized as important to antitrust analysis of hospital mergers, no commentator has suggested that the unique characteristics of the market for acute care hospital services justify an exemption for all such mergers.[23] However, with planning forsaken as a tool for rationalizing health care resources, mergers are the only alternative to bankruptcies to reduce excess capacity and duplication of services. These mergers will not occur in the magnitude required if the Justice Department is scrutinizing mergers on a case-by-case basis. The prospect of antitrust litigation increases the costs and reduces the likelihood of mergers. The analysis presented below suggests that antitrust enforcement works against the policy of containing health care costs. The analysis also suggests that antitrust actions to prevent hospital mergers do not prevent a market failure. They sacrifice efficiency for an ideal of competition, which

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18. *United States v Carilon Health Sys.*, 707 F Supp 840, 841 (WD Va 1989).

19. *United States v Rockford Memorial Corp.*, 717 F Supp 1251, 1252 (ND Ill 1989).

20. *Carilon Health Sys.*, 707 F Supp at 849 (merger did not violate antitrust laws); *Rockford Memorial Corp.*, 717 F Supp at 1292 (merger violated antitrust laws).

21. *United States v Carilon Health Sys.*, 892 F2d 1042 (4th Cir 1989) (unpublished disposition); *United States v Rockford Memorial Corp.*, 898 F2d 1278 (7th Cir 1990), cert denied, ___ US ___, 111 S Ct 295 (1990).

22. Comment, *Roanoke or Rockford: Two Divergent Approaches to Antitrust Enforcement for Not-for-Profit Hospital Mergers*, 28 Duquesne L Rev 561 (1990); Note, *Nonprofit Hospital Mergers and Federal Antitrust Law: The Quest for Compatibility*, 15 Del J Corp L 539 (1990); William G. Kopit and Robert W. McCann, *Toward a Definitive Antitrust Standard for Nonprofit Hospital Mergers*, 13 J of Health Politics, Policy and Law 635 (1988); Erwin A. Blackstone and Joseph P. Fuhr, Jr., *Hospital Mergers and Antitrust: An Economic Analysis*, 14 J of Health Politics, Policy and Law 383 (1989).

23. One analysis, although not focusing on economic issues, has concluded that there are efficiencies generated by mergers which justify a *limited exemption*. Note, 15 Del J Corp L at 550 (cited in note 22).

is inconsistent with the characteristics of the market and hence are bad economic policy and bad legal policy.

LAW AND ECONOMICS ANALYSIS OF HOSPITAL MERGERS

The introduction of economics into legal analysis, while gaining in adherents, is not without serious shortcomings. Substituting economic analysis for legal analysis subverts the common law heritage embodied in stare decisis[24] and confirms the Critical Legal Studies movement's instrumentalist argument that any outcome can be supported and, therefore, the outcomes of legal analysis are indeterminate.[25] Yet, law has an indisputable effect on economic relationships. When law is expanded into a new set of economic relationships, as it has been with hospital mergers, a failure to examine the economic consequences of law denies the integration of law and economics.[26]

In consideration on appeal of the lower court decision enjoining the hospital merger in Rockford, Judge Posner of the Seventh Circuit expressed regret that so little empirical evidence is available regarding the "actual effect of concentration on price in the hospital industry."[27] Nevertheless, he affirmed the district court's decision and stated that "[t]he defendants' immense shares in a reasonably defined market create a presumption of illegality."[28] Both the district court and the court of appeals focused on the share of the market which the new merged entity would possess. Recognizing that the market was already concentrated,[29] the district court found unacceptable the 70% share which the merged hospital would have.[30] The court of appeals shared this concern.[31] The court of appeals performed some analysis of the economics by considering barriers to entry, the existence of excess capacity, the nature of third party payment and their effects on price competition.[32] After acknowledging these factors, however, the court concluded that the government's demonstration that the merger

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24. The principle of stare decisis calls for courts to rely on precedent when applying the same law to substantially the same facts.

25. Bruce A. Ackerman, *Law, Economics, and the Problem of Legal Culture*, 1986 Duke L J 929, 936 (1986).

26. See Ackerman, 1986 Duke L J 929 (cited in note 25).

27. *Rockford Memorial Corp.*, 898 F2d at 1286.

28. Id at 1285.

29. *Rockford Memorial Corp.*, 717 F Supp at 1280.

30. Id at 1281.

31. *Rockford Memorial Corp.*, 898 F2d at 1283.

32. Id.

would create a firm with monopoly power shifted the burden to the hospitals to show that the economics required that the merger be allowed.[33]

Although the merged hospitals in Roanoke would possess a market share of 70%[34] (the same as in Rockford), the district court in Roanoke focused its attention on issues of excess capacity and increased efficiency to be achieved from a merger. Excess capacity in the market area under consideration was about 400 beds based on licensed capacity and 100 beds based on beds staffed and in service.[35] Savings from efficiencies of $40 million over the first five years were recognized.[36] Excess capacity in part of the area under study for the Rockford merger was identified as 384 beds. This excess capacity in Rockford, however, was recognized by the district court to show barriers to entry[37] rather than for consideration of efficiencies.

If law and economics analysis were to change legal outcomes in the application of law to the health care industry, it seems that the Rockford and Roanoke cases would have been a good beginning. Although the Roanoke case began to perform this analysis, Judge Posner, in the Rockford case, ceded that ground to others. It is uncertain how long it will take to produce the evidence which he suggests will be necessary to change the outcomes. In the meantime, precedent has been established which will discourage hospital mergers. The duplication of services and the excess capacity which fuel the increases in health care costs will go unchecked by this latest federal health policy initiative.

In the absence of the studies for which Judge Posner calls, is there a basis in economic analysis to justify antitrust enforcement against hospital mergers or to exempt mergers from such actions? The structure of hospitals has been described in a variety of ways: a competitive model involving utility-maximizing behavior;[38] a physician-hospital cooperative venture;[39] a physician control model;[40] two-firms-in-one (physicians and administration).[41] On

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33. Id at 1285-86. The court's analysis emphasized the potential for collusion after the merger. Id.

34. *Carilon Health Sys.*, 707 F Supp at 848.

35. Id at 842.

36. Id at 845-46.

37. *Rockford Memorial Corp.*, 717 F Supp at 1282.

38. Paul J. Feldstein, *Health Care Economics* 189-90 (John Wiley & Sons, 1979).

39. Mark Pauly and Michael Redisch, *The Not-for-Profit Hospital as a Physician's Cooperative*, 631 Am Economic R 87 (1973).

40. Feldstein, *Health Care Economics* at 192 (cited in note 38).

one matter, all of these analyses agree: the hospital market has pe-
culiarities which make its analysis different from that of many
other products.

The utility-maximizing or traditional economic analysis of hospi-
tals recognizes that

> the hospital will still seek to maximize its profits in the short run through
> its pricing strategy, but it will then attempt to invest that profit in in-
> creased quantity - increased capacity, cost-saving technology, or facilities
> and services that result in an increase in quantity of patients - or in pres-
> tige/quality investments.[42]

This model recognizes that hospitals compete in terms of quality
as well as price and suggests that the market is characterized by
some degree of product differentiation. Product differentiation ex-
ists when a product earns buyer loyalty somewhat unrelated to
price.

The physician-hospital cooperative venture recognizes that a
hospital does not seek simply to maximize quantity of services
sold, but seeks to achieve a level of output sufficient to meet simul-
taneous goals of maximizing "the net income per member of the
physician staff,"[43] and investment in capacity which will provide
enough excess to accommodate physicians' needs for available beds
and support services.[44] In the short-run, this model concludes that
the results will be the same as if the physicians made all of the
decisions. In the long-run, this model recognizes the interests of
administration in maintaining the hospital at a level of capacity
which allows full utilization of physicians. Thus, this model recog-
nizes internal motivation toward excess capacity.

The physician control model assumes that "the decisions under-
taken by the hospital represent the objectives of the staff physi-
cians."[45] Thus, increases in demand for hospital services would be
met by increasing hospital capacity making each physician more
productive rather than by increasing physicians and holding physi-
cian income stable.[46] This model also recognizes the potential for
excess capacity.

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41. Jeffrey E. Harris, *The Internal Organization of Hospitals: Some Economic Im-
plications*, 8 Bell J Economics 467 (1977).

42. Feldstein, *Health Care Economics* at 189 (cited in note 38).

43. Pauly and Redisch, 631 Am Economic R at 88 (cited in note 39).

44. Philip C. Kissam, et al, *Antitrust and Hospital Privileges: Testing the Conven-
tional Wisdom*, 70 Cal L Rev 595, 609 (1982).

45. Feldstein, *Health Care Economics* at 192 (cited in note 38).

46. Id.

The two-firms-in-one model rejects the notion of physician control, whether overt or tacit. Hospital administration and medical staff bring their different motivations into an internal non-zero sum game with an indeterminate outcome.[47] The predictable result of this model is that the hospital is driven to increase in size.[48]

Throughout these models, the consumer seems to have little role in the analysis. The role of the consumer is minimized because of the inelasticity of demand.[49] The inelasticity of demand has been recognized as having a significant effect on the structure of the hospital market.[50] Even Judge Posner recognized in the Rockford case that factors reducing price sensitivity of demand for hospital services make the analysis more difficult.[51]

For all of this analysis of the hospital and the market for its services, commentators have not addressed what these unique economic characteristics may imply for antitrust analysis of hospital mergers on a system-wide basis. Perhaps because of the fact-driven nature of legal analysis in antitrust, commentators have discussed issues in case-by-case terms instead of systemic terms.[52] The benefit of a law and economics analysis should be to step back from the trenches of antitrust litigation to determine whether the systemic problems in the health care industry merit a systemic solution, i.e. an exemption for mergers. An examination of the market for hospital services which addresses its unique characteristics may suggest a systemic solution. Those who have discussed economic issues

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47.   Harris, 8 Bell J Economics at 477 (cited in note 41).

48.   Id at 479.

49.   Inelasticity of demand describes a market in which consumers will not reduce their consumption of a product commensurate with an increase in the price. Demand for the product is insensitive to price changes either because there are no close substitutes or because increases in price do not result in a direct decrease in consumers' income. For example, health insurance paid for by the employer shields consumers from the effect of price increases in health care. The consumers' costs do not change as much as the price increases.

50.   Kopit and McCann, 13 J of Health Politics, Policy and Law at 642 (cited in note 22); Baker, 51 Law & Contemp Probs at 95 (cited in note 16); James F. Ponsoldt, *Immunity Doctrine, Efficiency Promotion, and the Applicability of Federal Antitrust Law to State-Approved Hospital Acquisitions*, 12 J Corp L 37, 70 (1986).

51.   *Rockford Memorial Corp.*, 898 F2d at 1285.

52.   Hospital mergers should be examined individually for anticompetitive purpose or effect. Kopit and McCann, 13 J of Health Politics, Policy and Law at 661 (cited in note 22). Hospital mergers should be subject to a case-by-case analysis and permitted when benefits are greater than costs. Blackstone and Fuhr, 14 J of Health Politics, Policy and Law at 402 (cited in note 22). Antitrust analysis of hospital mergers will be dependent on careful market definition. Baker, 51 Law & Contemp Probs at 164 (cited in note 16). A broad exemption from mergers of nonprofit hospitals is not sought. Note, 15 Del J Corp L at 550 (cited in note 22).

have not looked at the market as one more closely conforming to monopolistic competition rather than to a competitive model.

Monopolistic competition theory was the result of efforts in 1933[53] to reconcile traditional market analysis with the reality of elements of monopoly in many markets. In monopolistic competition, the market consists of a large enough number of firms that each can act with independence while producing a product which is differentiated from the similar products of other firms so that buyers have a preference for one over others and a market into which entry is unrestricted.[54] However, "monopolistic competition may be as rare as perfect competition,"[55] and its application to a particular market may be justified if that market conforms closely to the necessary conditions.

The market for hospital services, except for the most specialized, is local. The number of firms (hospitals) in local markets can vary from one hospital in a rural area to many in a metropolitan area. Nevertheless, whether rural or urban, the hospital market is concentrated.[56] In a market of two hospitals, the hospitals may operate more like an oligopoly,[57] but the differentiation of the product still would allow analysis using the model of monopolistic competition because pricing decisions can be made independently. Thus, the differentiation of product is a key element in determining the applicability of monopolistic competition analysis to hospitals.

Product differentiation exists when "each product is unique and its producer has some degree of monopoly power he can exploit. But usually it is very little, because other producers can market a closely related commodity."[58] Differentiation of product in hospital services is the result of the intermediary role played by the physician in decisions to purchase hospital services. Physicians typically

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53. Two economists, Joan Robinson in England and Edward H. Chamberlin in the United States, simultaneously developed the theory of monopolistic competition (Robinson called it "imperfect competition").

54. Mark Blaug, *Economic Theory in Retrospect* 399 (Richard D. Irwin, Inc., 1968).

55. Blaug, *Economic Theory in Retrospect* at 402 (cited in note 54).

56. Carl J. Schramm and Steven C. Renn, *Hospital Mergers, Market Concentration and the Herfindahl-Hirschman Index*, 33 Emory L J 869, 870-72 (1984). See also Kopit and McCann, 13 J of Health Politics, Policy and Law at 640 (cited in note 22); Baker, 51 Law & Contemp Probs at 151 (cited in note 16).

57. An oligopoly exists where a limited number of firms operate in a single market and the actions of any one firm will affect the activities of the other firms in terms of pricing or output. However, where the products of firms are similar but differentiated, the ability of one firm to affect other firms is limited by buyer loyalty. See Richard H. Leftwich, *The Price System and Resource Allocation* 126-30 (The Dryden Press, 1973).

58. C.E. Ferguson, *Microeconomic Theory* 287 (Richard D. Irwin, Inc., 1969).

have privileges at one or a limited number of hospitals in one mar-
ket. Patients are admitted to the hospital by their physicians.
Thus patients, by choosing a particular physician, are limiting
their choice among hospitals to the ones at which the physician has
admitting privileges.[59] The result is an indirect form of buyer loy-
alty based on the physician's affiliation.

The final requirement for monopolistic competition is that entry
is unrestricted. At first glance, entry into the hospital market
would seem to be restricted by the amount of capital investment
required. However, from an economic perspective, entry is re-
stricted when a new entrant into the market must bear higher
long-run costs of production than firms already in the market.[60]
Thus, capital requirements and licensing requirements would im-
pose no additional burden on the new entrant than they did on
existing hospitals.[61] CON requirements create an artificial barrier
to entry, because they impose costs of waiting and the actual costs
of preparing documentation for the CON review process. The
Court of Appeals in the Rockford case found that CON require-
ments were a barrier to entry.[62] Commentators have described
CON requirements as entry barriers while recognizing that the re-
peal of the National Health Planning and Resources Development
Act and of many state CON laws reduces this barrier.[63] It has been
suggested that in an industry where supply exceeds demand, as in
the hospital market, entry barriers cannot exist because new entry
into the market is irrational.[64] The latter analysis in combination
with the waning strength of CON requirements leads to the con-
clusion that barriers to entry are not a significant problem for the
hospital market. Therefore, the final condition for monopolistic
competition is met.

Since hospitals are subject to analysis using the model of monop-
olistic competition, the question for analysis becomes: will mergers
of hospitals meet or violate the policy of antitrust? If they violate
the policy of antitrust, then the latest federal initiative is sound

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59. "Patients often have little knowledge about their illnesses and how to treat them.
Doctors act as agents for patients, in many cases deciding on the amount of care and the
hospital at which it will be provided, and often simultaneously supplying that care." Baker,
51 Law & Contemp Probs at 95 (cited in note 16).

60. Schramm and Renn, 33 Emory L J at 880 (cited in note 56).

61. Id.

62. *Rockford Memorial Corp.*, 898 F2d at 1285.

63. Blackstone and Fuhr, 14 J of Health Politics, Policy and Law at 400 (cited in
note 22); Baker, 51 Law & Contemp Probs at 153-54 (cited in note 16).

64. Schramm and Renn, 33 Emory L J at 881 (cited in note 56).

policy. If mergers actually serve the policy of antitrust, then the actions of the Justice Department are at cross-purposes with the national interest of containing health care costs. The answer to this question will require: (1) economic analysis of mergers, and (2) examination of antitrust policy, including the efficiencies and failing firm defenses.

The market for an individual hospital under monopolistic competition is demonstrated in the diagram below:

D : Demand
MR: Marginal revenue
AC : Average cost
MC: Marginal cost
P1 : Profit-maximizing price
P2 : Price at efficient production
C1 : Cost of output at profit-maximization
C2 : Cost of output at efficient production
Q1 : Quantity produced at profit-maximization
Q2 : Quantity produced at efficient production
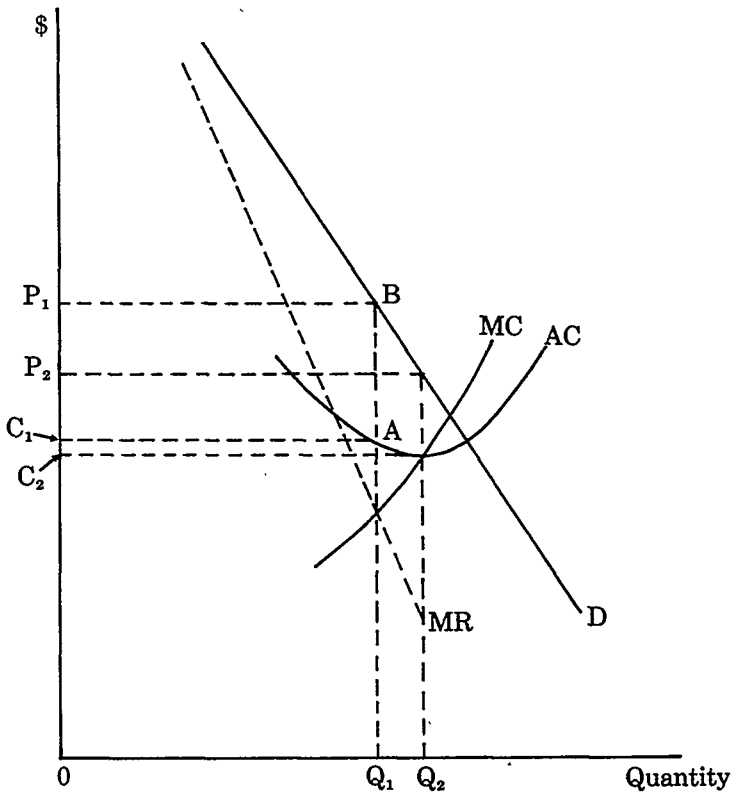
The result of product differentiation is that the demand for the hospital's services is less sensitive to changes in price. Therefore, the demand curve (D) is steep. A large increase in price will result in a smaller reduction in sales. The hospital's revenue from each additional unit of service produced, the marginal revenue (MR), lies below the demand curve and is steeper than the demand curve because an increase in output would force the hospital to sell all of its output at a lower price, thereby reducing total revenues by more than just the revenue lost on the additional units. The average total cost curve (AC) and the marginal cost curves (MC) conform to the standard for any normal firm. The hospital's profit-maximizing output is where marginal cost equals marginal revenue. Below this point, the production of an additional unit generates more revenue than it costs and output would be increased. Above this point, the production of an additional unit costs more than it generates in revenue and output would be decreased.

The hospital will produce Q_1 of services at an average cost of C_1 or a total cost of the area bounded by OC_1AQ_1. If the hospital was free to set its price, it would sell at P_1 for a total revenue of the area bounded by OP_1BQ_1. However, the effect of third party reimbursement programs, such as Medicare's prospective payment and Blue Cross' cost-based reimbursement, limits the ability of hospitals to set prices which will maximize profits. Few patients pay full charges. Thus, the hospital receives less revenue than the full monopoly profits shown in the diagram, but more revenue than its costs.

Another result of monopolistic competition is short-run excess capacity. Each firm can gain from limiting its product to a quantity below what would be produced if the firm operated at its most efficient level of output. The most efficient use of the hospital would occur where marginal cost (MC) equals average cost (AC). This is the most efficient or optimum production under a purely competitive model because at a lower output, the cost of producing the next unit is less and at an output above the point of equality, the cost of producing the next unit is higher. However, for the firm in monopolistic competition, the quantity produced at this scale of operation, Q_2, could only be sold at a lower price, P_2, and the profit would be reduced. Hence, there is no incentive to operate at full capacity.[65]

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65. The implication of monopolistic competition is excess capacity which is the outcome of too many firms compared to the number that would exist in such a market under

In such a market, greater efficiency could be achieved by allowing firms to merge. Two firms of the size shown in the diagram above would be able to achieve some cost reduction by merging. The resulting firm would still have excess capacity because of the nature of the market, but it would operate at lower costs because redundant services could be eliminated profitably. While the savings might not be passed on to consumers by lower prices, it would place less demand on resources for investment in what had been redundant services. If price did not decrease commensurately with costs, the increased revenues could be reinvested in needed services, such as health care for the indigent, or taxed away if the hospital became too profitable.

Monopolistic competition as applied to hospitals correctly predicts the current nature of the market. The hospital market today has excess capacity. Hospitals are encouraged by the market to duplicate the services of their competitors even though the services are underutilized.[66] The extent to which there are unexploited economies of scale is uncertain. Although it appears that the extent of overall economies of scale are small, there may be economies to be achieved in the operation of specialized services.[67] It is such specialized services which often are duplicated at considerable cost. Thus, the outcome of hospital mergers should be the reduction of excess capacity and reduction of cost or, in other words, greater efficiency in the market for hospital services.[68]

The goals of antitrust are to promote competition, economic efficiency and consumer welfare.[69] Judge Posner, in his opinion in the

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perfect competition. Too many firms exist because of the ability to take advantage of product differentiation in the short-run. Each firm has a higher cost because it is too small for optimum efficiency. See Blaug, *Economic Theory* at 400-01 (cited in note 54).

66. Schramm and Renn, 33 Emory L J at 881 (cited in note 56); Ponsoldt, 12 J Corp L at 40 (cited in note 50).

67. Feldstein, *Health Care Economics* at 186 (cited in note 38).

68. See Schramm and Renn, 33 Emory L J at 884-85 (cited in note 56). See also Kopit and McCann, 13 J of Health Politics, Policy and Law at 642 (cited in note 22). Where hospital mergers have occurred, prices have increased no more than in markets where no mergers occurred. Id at 645.

69. Kissam, et al, 70 Cal L Rev at 670 (cited in note 44); Baker, 51 Law & Contemp Probs at 100 (cited in note 16); Andrew G. Berg, *Cost Efficiencies in the Section 7 Calculus: A Review of the Doctrine*, 37 Case W Res 218, 220 (1986). See also *Matsushita Electrical Indus. Co. v Zenith Radio Corp.*, 475 US 574 (1986), and *Monsanto Co. v Spray-Rite Serv. Corp.*, 465 US 752 (1984), for the United States Supreme Court's recognition of efficiency as an antitrust goal. In *Monsanto*, a conspiracy was alleged between a manufacturer and distributors. The Court looked at this alleged anticompetitive activity in terms of its market impact and noted that "[i]n order to assure an *efficient* distribution system, manufacturers and distributors constantly must coordinate their activities to assure that their product will

Rockford case, discussed only the effect of the merger on competition.[70] Similarly, the district court found it necessary to set aside arguments of greater efficiency because the antitrust laws seek to protect competition.[71] Perhaps the failure to address efficiency is rooted in the traditional equating of competition with efficiency.[72] However, this does not help resolve a situation where increased competition decreases efficiency. In such a situation, it would seem that efficiency in terms of better allocation of scarce resources should have priority over increased competition.

Such a priority of efficiency over competition is evidenced in antitrust policy already. An efficiencies defense is allowed against antitrust enforcement. The Federal Trade Commission has recognized that some mergers have the effect of enhancing efficiencies.[73] However, courts have not favored defenses of increased efficiency projected to result from a merger.[74] The efficiencies defense is strictly construed and, thus, rarely allowed.[75]

If efficiency is a goal of antitrust policy and reduced cost is a goal of health policy, when hospital mergers make the industry more efficient, then grounds exist for granting hospital mergers an exemption from antitrust actions. The focus of the Justice Department and the courts on a case-by-case analysis of mergers and any efficiencies defense raises the cost of potential mergers and makes them less likely. The complexity of antitrust litigation has encouraged the courts to establish per se rules of illegality for certain acts which violate the antitrust laws. Some courts have discussed the possibility of a rule of per se legality in predatory pricing cases when prices exceed average total cost.[76] When the structure of a market is such that mergers result in efficiencies, there should be room for a per se rule of legality to encourage such mergers and eliminate the excess capacity.

Another defense available to parties involved in a merger which

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reach the consumer persuasively and efficiently." *Monsanto*, 465 US at 763-64 (emphasis added). Citing *Monsanto*, the Court recognized in *Matsushita* that an alleged predatory pricing conspiracy required more than evidence of below cost pricing, because the impact on the market of such behavior was not harmful. *Matsushita Electrical Indus. Co.*, 475 US at 593-95.

70.   *Rockford Memorial Corp.*, 898 F2d at 1283, 1285.
71.   *Rockford Memorial Corp.*, 717 F Supp at 1291.
72.   Ponsoldt, 12 J Corp L at 72 (cited in note 50).
73.   Berg, 37 Case W Res at 223-27 (cited in note 69).
74.   Id at 232-39.
75.   Baker, 51 Law & Contemp Probs at 160 (cited in note 16).
76.   *Arthur S. Langenderfer, Inc. v S.E. Johnson Co.*, 729 F2d 1050, 1056-57 (6th Cir 1984).

is challenged under the antitrust laws is the failing firm defense. This has been described as "a long-established but ambiguous doctrine which protects certain mergers when one of the merging firms is 'failing.' "[77]

> The failing firm defense is strictly construed to minimize the anticompetitive danger: the firm must be on the verge of insolvency, the acquiring company must be the least anticompetitive purchaser available, and the acquired firm must have made unsuccessful efforts to seek alternative buyers to preserve its assets in the marketplace while reducing the danger to competition.[78]

Although hospitals are failing at an increasing rate,[79] the nature of third party reimbursement is such that a struggling hospital can survive for many years. Although such a defense might be available to merging hospitals, there is good cause to question whether efficiency is best served by waiting until one of the hospitals is near bankruptcy before allowing a merger.

CONCLUSION

After adopting policies which substantially shaped the current hospital market, the federal government tried and abandoned a variety of programs to rationalize the resources being invested in that market. After this failure to contain the costs of health care, the self-regulating function of market forces is being called on to achieve the results which planning and regulation apparently could not. However, the reliance on market forces seems to be based upon a misconception of the market.

Hospitals operate in a market of monopolistic competition which is inherently less efficient than more competitive markets. Perversely, in such a market, efforts to increase competition by preventing the merger and consequent reduction of firms has the effect of encouraging an inefficient market, including investment in duplicative services to preserve market position. Thus, the application of antitrust laws to hospital mergers, whether between for-profit hospitals or nonprofit hospitals, is in conflict with the goals of improved efficiency and reduced health costs.

The prospect that most hospital mergers will be subject to anti-

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77. Schramm and Renn, 33 Emory L J at 882 (cited in note 56).
78. Baker, 51 Law & Contemp Probs at 163 (cited in note 16), citing the 1984 Merger Guidelines of the Department of Justice.
79. Kopit and McCann, 13 J of Health Politics, Policy and Law at 636 (cited in note 22).

trust review and litigation discourages the very activity which
would make the hospital market more efficient. Antitrust review
adds substantially to the transaction costs for such mergers. In-
stead, the policy of the Justice Department and the courts should
be to recognize the unique nature of the hospital market and to
permit all hospital mergers under a general exemption as per se
legal. The only alternative to containing the costs in health care
would be a return to the more intensive regulation and planning
activities which recent administrations have spurned. If the policy
is in fact to allow market forces to work, then mergers should be
allowed because they are the result of the market at work.

Stephen Paul Paschall