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Roger D. Blair

James M. Fesmire

ANTITRUST TREATMENT OF HOSPITAL MERGERS

*Roger D. Blair**

*James M. Fesmire***

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*Professor of Economics, University of Florida. The author appreciates the financial support of the Public Policy Research Center and the College of Business Administration at the University of Florida.

**Professor of Economics, University of Tampa. The author appreciates the financial support of the University of Tampa.

I. INTRODUCTION

Mergers alter industry structure so as to give merged entities increased market power.[1] Unfortunately, the merged entity uses its enhanced market power to raise prices and profits at the expense of consumers.[2] Mergers, however, may create efficiencies that enhance consumer wealth. Since the net effect of mergers on consumer welfare is ambiguous, regulatory authorities will generally challenge any proposed merger which may be anticompetitive.[3] Focusing upon horizontal mergers[4] in the hospital industry, and the unique characteristics of the health care market, this article examines whether hospital mergers should receive special treatment.

Section II explains antitrust policy by examining the case against monopoly, the legislative background, and the standards for horizontal mergers. Section III examines the economics of mergers by describing the effects on both allocative and productive efficiency and the motives for horizontal mergers. Section IV develops the relationship between hospital mergers and efficiency by emphasizing the peculiarities of health care markets and the effect of nonprofit hospitals. Section V analyzes the antitrust treatment of hospital mergers by looking at both judicial and Department of Justice approaches to product and geographic market definition and to their analyses of anticompetitive effects.

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1. For a general discussion of market power in an antitrust context, see Landes & Posner, *Market Power in Antitrust Cases*, 94 HARV. L. REV. 937 (1981).

2. For a provocative analysis, see Stigler, *Monopoly and Oligopoly by Merger*, 40 AM. ECON. REV. 23 (1950).

3. Under § 7A(a) of the Clayton Act, the merging parties must notify the Federal Trade Commission and/or the Antitrust Division of the Department of Justice of their intentions. Clayton Act § 7A(a), 15 U.S.C.A. § 1890 (West 1988). They must also provide information that will permit the reviewer to evaluate the probable competitive consequences of the merger. *Id.* *See* Choate, Higgins & McChesney, Bureaucracy and Politics in FTC Merger Challenges (May 1988) (unpublished manuscript) (analyzing merger enforcement policy at the Federal Trade Commission).

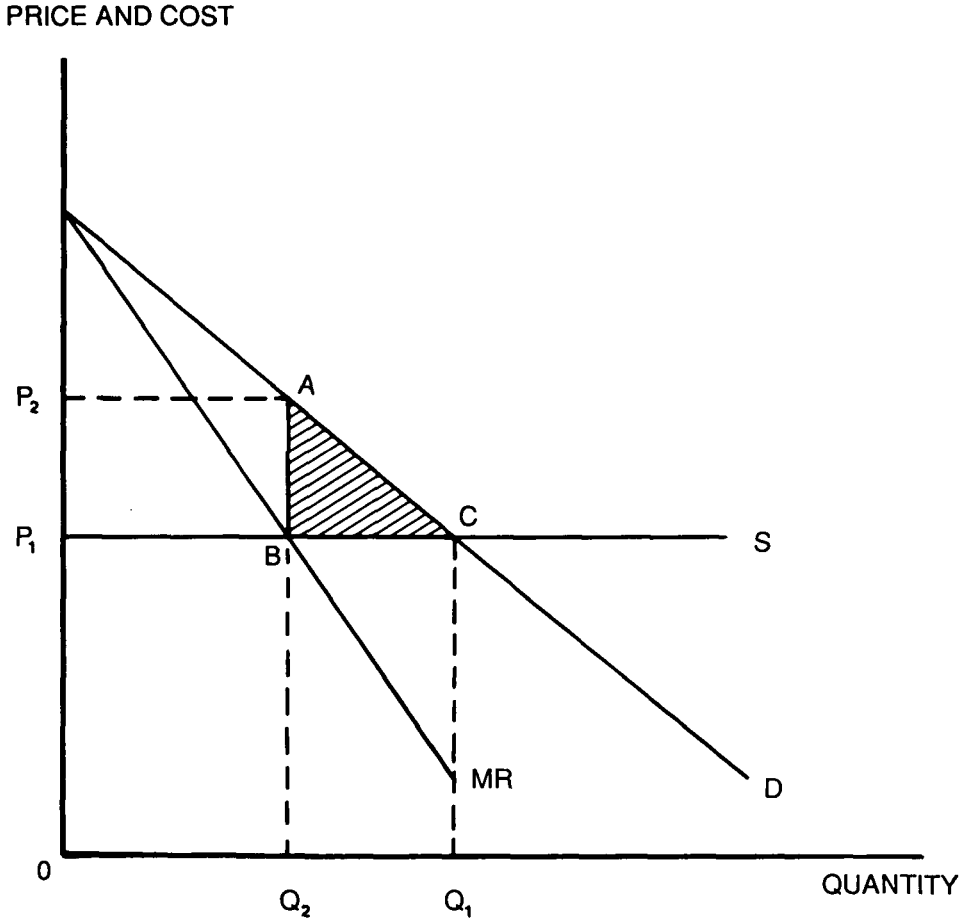
4. A horizontal merger is a merger between two firms that compete with one another in the same line of business. This article discusses mergers of hospitals that provide the same array of services. Thus, this article does not describe a merger between a general acute care hospital and a specialty hospital.

II. ANTITRUST BACKGROUND[5]

A. *The Case Against Monopoly*

Antitrust policy flows directly from the case against monopoly, demonstrated in Figure 1. Consider the price and output of a competitively organized industry. The horizontal[6] line labelled S represents

FIGURE 1



5. For interesting historical accounts, *see generally* W. LETWIN, LAW AND ECONOMIC POLICY IN AMERICA (1965); H. THORELLI, THE FEDERAL ANTITRUST POLICY (1954). For a discussion of revisionist accounts of the economic history of the period, see Scheiber, *Public Economic Policy and the American Legal System: Historical Perspectives*, 1980 WIS. L. REV. 1159.

6. Competitive industry supply is horizontal when all firms in the industry are basically the same, and input prices are unaffected by changes in industry demand. *See* R. BLAIR & L. KENNY, MICROECONOMICS WITH BUSINESS APPLICATIONS 217-23 (1987).

the long-run supply curve, while D represents consumer demand. Competitive equilibrium occurs where supply equals demand, or where S intersects D. Thus, the competitive price and output are P_1 and Q_1, respectively. At this price and output, firms in the industry earn just enough profit to keep their resources employed in this particular industry. The equilibrium demonstrates that any consumer who is willing to pay the cost to society of an additional unit of output can buy that extra unit of output.

Contrast this competitive price and output with the equilibrium price and output under a monopoly. If this industry were under the control of a single firm, the long-run supply curve (S in Figure 1) would represent the marginal and average cost curves for that firm. Instead of having many separate firms under individual ownership and control, a single firm would have many separate plants or production facilities under common control. Under this industry organization, the equilibrium output and price are substantially different.[7] The monopolist will equate its marginal costs to its marginal revenue (MR in Figure 1) to determine the profit-maximizing output, which then determines the profit-maximizing price. In Figure 1, the monopolist's profit-maximizing price and output are P_2 and Q_2, respectively.

Figure 1 reveals that the equilibrium output decreases from the competitive optimum of Q_1 to the monopolistic optimum of Q_2, while price rises from P_1 to P_2. The monopolist earns excess[8] profit of $(P_2\text{-}P_1)\ Q_2$, which is represented by the rectangular area $P_2\ ABP_1$. This excess profit, paid by consumers who continue to buy this product in spite of the higher price, is a transfer from consumers to the producer. Economists do not object to this transfer within society. Instead, their main objection to monopoly stems from the monopolistic misallocation of resources, demonstrated by output Q_2 in Figure 1. When output equals Q_2, the marginal value of the output equals the price, P_2. The marginal value to society of the resources used to produce Q_2, as measured by the marginal cost function, is only P_1. Thus, the monopolist has refused to produce an extra unit of output even though consumers are willing to pay more than the cost to society of an extra unit of output. The triangle ABC represents the welfare cost of the monopolistic restriction of output, which is the social welfare loss.[9]

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7. For a thorough treatment of monopoly, see *id.* at 253-305.

8. The term "excess" is not used pejoratively. These are profits that are greater than those necessary to keep the firm's resources employed in this industry.

9. The social welfare loss due to monopoly can be traced to the pioneering work of Hotelling, *The General Welfare in Relation to Problems of Taxation and of Railway and Utility Rates*, 6 ECONOMETRICA 242 (1938).

B. *Conditions Conducive to Antitrust Legislation*

1. Growth of Combinations

Antitrust laws arose out of the economic and political climate of the late nineteenth century, aided by the economic theory of monopoly. The monopolies of that time both reduced efficiency and transferred wealth from consumers to producers. The consolidation of industry in the late nineteenth century disturbed Congress more than impairment of economic efficiency.[10]

At the end of the Civil War, the U.S. economy was competitively structured. Although few industries were heavily concentrated at that time, the growth of industrial combinations threatened the viability of competition in many sectors. Toward the end of the nineteenth century, increasing numbers of industries, including petroleum, railroads, iron and steel, whiskey, cottonseed oil, oatmeal milling, coal, lumber, ice, beer, meat packing, and tile, organized restraints of trade.[11] Restraints on competition became pervasive.[12]

Firms devised increasingly effective restraints on competition. Initially, they relied on simple price fixing agreements under which all firms agreed to charge the same price.[13] These agreements were usually short-lived because each participant had an incentive to cheat on the agreement. Monopolists replaced unstable price fixing agreements with the more structured pool. Participants pooled their production or sales and then redistributed the profits according to some agreed upon formula.[14] Pooling reduced, but did not eliminate, the incentive to cheat. When competition undermined the pools, monopolists organized trusts. The industrial trust was a cohesive group of firms under central management. Trusts emerged in petroleum, cottonseed oil, linseed oil, sugar, whiskey, and lead.[15] These trusts extended control over the industry in order to obtain monopoly prices and profits.

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10. Lande, *Wealth Transfers as the Original and Primary Concern of Antitrust: The Efficiency Interpretation Challenged*, 34 HASTINGS L.J. 65 (1982).

11. For an extensive history of the development of trade restraints in various American industries in the last quarter of the 19th century, see H. THORELLI, *supra* note 5.

12. For a description of the economic, social and political factors that encouraged the growth of collusive trading practices in the 1870-1880s, see H. THORELLI, *supra* note 5, at 66-72.

13. *Id.* at 77.

14. For an analysis of how pools or joint selling agencies can facilitate cartel activities, *see* Stigler, *The Economic Effects of the Antitrust Laws*, 9 J.L. & ECON. 225 (1966).

15. The Standard Oil Trust served as the model for trusts in other industries. Details of this agreement became public through New York Senate and U.S. House of Representatives trust investigations in 1888. H. Rep. No. 3112, 50th Cong., 1st Sess. (1888) [hereinafter Proceedings in Relation to Trusts]. Cottonseed Oil trusts were subject to litigation in Louisiana and

2. Agrarian Discontent

Following the Civil War, an agricultural depression caused severe discontent among farmers who believed that all non-farm sectors of the economy were conspiring against them.[16] The railroads, facing little competition, charged all that the traffic would bear. The operators of grain elevators, enjoying local monopolies, charged high prices. Insulated from competition by protective tariffs, farm equipment dealers also charged high prices. In taxing the farmers' real property, even the government seemed to conspire against the farmer. While farmers faced high costs and taxes, farm products generally commanded low prices in depressed markets.

The farmers blamed monopolies and trusts as the cause of the low agricultural prices, the high farm equipment prices, and the high, discriminatory railroad and grain elevator charges. Large farm populations formed political pressure groups like the National Grange to promote their interests and obtain state legislation that would protect the farmer.[17] These pressure groups forced the legislators from the agricultural states to address farmers' distrust of monopolies.

3. Behavior of Big Business

Discontent among farmers was coupled with generally adverse public sentiment towards big business because of a steady revelation of offensive business practices.[18] Predatory practices dominated a few large and highly visible industries like the petroleum industry. Standard Oil which used independent refiners to force real independents out of business provided an unsavory role model.[19] Standard Oil en-

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Tennessee. State v. American Cotton Oil Trust, 40 LA. ANN. 8 (1888); Mallory v. Hanaur Oil Works, 86 Tenn. 598 (1888). The National Linseed Oil Trust was organized in 1885, followed in 1887 by the Sugar Trust (the Sugar Refineries Company) and the Whiskey Trust (the Distillers' and Cattle Feeders Company). The Sugar Trust controlled about 70% of the national production. U.S. Industrial Commissions Reports, vol. I, pt. 2, at 109. The Whiskey Trust agreement compiling is reproduced in House Records. H. Rep. No. 4165, 50th Cong., 2d Sess. (1889). The National Land Trust was one of the last trusts formed sometime between 1887-1889. For a brief summary of the development of these trusts, see H. THORELLI, *supra* note 5, at 72-85.

16. *See* THORELLI, *supra* note 5, at 58-62 (explaining the sources of agrarian discontent and the development of the Granger movement to control monopolies).

17. The "Granger laws" were a series of anti-monopoly laws passed to regulate railroads and grain carriers. Illinois was the first state to regulate railroad rates in 1869. Similar acts were passed by other states, including California, Iowa, Michigan, Minnesota, Missouri, Nebraska, Ohio, and Wisconsin. *Id.* at 59 n.19.

18. Congressional reports on trust activities made public many of the details of the large trusts. *See, e.g., supra* note 15.

19. Standard Oil's unsavory trade practices were made public in legislative investigations, *supra* note 15, and widely publicized in I. TARBELL, THE HISTORY OF THE STANDARD OIL COMPANY (1904).

gaged in other unsavory practices which included disparaging its competitors by spreading false rumors about their financial stability and supply reliability, obtaining secret railroad rebates that disadvantaged its competitors, and allegedly corrupting legislators and judges.[20]

4. Public Opinion

Against this backdrop of economic and political abuse, public animosity towards the trusts grew. Hatred and distrust of monopoly has its origins in the Jeffersonian tradition.[21] Monopoly, historically synonymous with unjustified concentration of economic power, was usually associated with some barrier to equal opportunity.[22] In the United States, state statutes prohibiting any grant of monopoly manifested the public distrust. In the final years before passage of the Sherman Act, objections to the trust included allegations that trusts did the following: corrupted public employees and legislators, thereby threatening political democracy; enjoyed the insulation provided by protective tariffs; hurt consumers by charging higher prices; engaged in questionable financial practices, such as watering stock; and caused serious dislocations by suddenly closing plants.[23] The American public, feeling abused by the trusts, sought to legislatively curtail the trusts' power. Any law to prohibit the worst abuses of the most visible trusts would have sufficed. The Sherman Act was the result.

C. *The Sherman Antitrust Act*

The Sherman Act, passed in 1890, is the foundation of current United States antitrust policy. Its main provisions are contained in sections 1 and 2:

> Section 1. Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal.

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20. *See* H. THORELLI, *supra* note 5, at 91-96 (brief history of Standard Oil with references to primary sources supporting allegations of improper conduct).

21. While Thorelli adheres to the Progressive framework of historical analysis that emphasizes the conflict between Hamiltonians and Jeffersonians and the rise of special interests at the expense of public welfare, the "New Legal History," heavily influenced by the legal realism of J. Willard Hurst, has challenged the assumptions underlying the Progressive interpretation. For a collection of readings explaining this new legal history, *see* K. HALL, THE LAW OF BUSINESS AND COMMERCE (1980).

22. H. THORELLI, *supra* note 5, at 227.

23. *Id.* at 108-60.

> Section 2. Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony . . . .[24]

The vague and general prohibition of trade restraints and monopolization constituted little more than a legislative command that the judiciary develop a common law of antitrust. For example, the statute contains no definition of what constitutes a "restraint of trade." This legal term of art, which had no universally recognized meaning in 1890, gained its current meaning through a series of antitrust judicial decisions.[25] The Sherman Act provided a statutory foundation upon which the judiciary could develop a federal common law of trade restraints.[26] As Hovenkamp points out, "the Sherman Act can be regarded as 'enabling' legislation — an invitation to the federal courts to learn how businesses and markets work and formulate a set of rules that will make them work in socially efficient ways."[27]

Commentators expressed immediate dissatisfaction with the Sherman Act, in spite of the fact that the early decisions promoted consumer welfare.[28] The vague and general language of the Sherman Act failed to draw a sharp line between legal and illegal business practices. Critics complained that the Sherman Act exposed business executives to uncertain risks of prosecution.[29] Those distrustful of the judiciary were alarmed at the amount of judicial discretion involved in interpreting such a statute as vaguely worded as the Sherman Act. Congress

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24. 15 U.S.C.A. §§ 1-2 (West 1988).

25. A. NEAL & D. GOYDER, THE ANTITRUST LAWS OF THE U.S.A. 22 (3d ed. 1980).

26. For a recent criticism of the judicial activism that this engendered, *see* Arthur, *Farewell to the Sea of Doubt: Jettisoning the Constitutional Sherman Act*, 74 CALIF. L. REV. 263 (1986); *see also* H. THORELLI, THE FEDERAL ANTITRUST POLICY 228 (1954) (asserting that the Sherman Act was supposed to be a federal codification of the common law of England and the several states). Congress recognized, however, that the common law was not perfectly clear and that it contained some ambiguities, which would become clearer with subsequent decisions.

27. H. HOVENKAMP, ECONOMICS AND FEDERAL ANTITRUST LAW 52 (1985).

28. Initially, the chief impediment to an effective antitrust policy was the negative attitude of the courts. *See, e.g.*, United States v. Knight, 156 U.S. 1 (1894) (the Sherman Act prohibits restraints upon trade and commerce only, not manufacture). This restrictive interpretation was overturned in subsequent Supreme Court rulings. *See, e.g.*, Northern Securities Co. v. United States, 193 U.S. 197 (1904).

29. While the Sixth Circuit Court acknowledged the "manifest danger in the administration of justice according to so shifting, vague and indeterminate a standard," the Supreme Court freely developed its own standard in the ancillary restraint doctrine, enforcing only those covenants in restraint of trade which are ancillary to the main purpose of a lawful contract. United States v. Addyston Pipe & Steel Co., 85 F. 271, 284 (6th Cir. 1898), *aff'd*, 175 U.S. 211 (1899).

did not respond to the demand for greater specificity until after the Supreme Court's decision in *Standard Oil Co. v. United States*.[30] In *Standard Oil*, the Court clearly stated that the Sherman Act had to be enforced according to the "rule of reason."[31] The Court interpreted the broad language of the statute as requiring the judiciary to exercise judgment.[32] Since the Sherman Act prohibited only unreasonable restraints of trade, courts had discretion to determine whether any particular contract unduly restrained free competition.

The rule of reason confirmed the worst fears of many opponents of the Sherman Act who were wary of judicial discretion. Some groups continued to push for absolute prohibitions of certain business practices, while others were more inclined toward unbridled laissez-faire. The final result was compromise legislation, which was supposed to provide some specificity: the Clayton Act.[33]

D. *The Clayton Act*

In 1914, Congress passed the Clayton Act which addressed specific business practices believed to foster monopolies. The Clayton Act includes a proviso that the business practices it addressed were illegal only if their effect was to substantially decrease competition or to create a monopoly. Among other things, the Clayton Act deals with mergers.[34] Economic history teaches us that some of our largest firms like Standard Oil, U.S. Steel, and General Motors were the products of mergers or acquisitions.

Once the market structure in an industry reaches monopoly or near-monopoly status, section 2 of the Sherman Act applies. While section 2 of the Sherman Act attempts to remedy market structure problems, section 7 of the Clayton Act provides some preventive measures.[35] Section 7 forbids any merger which might substantially lessen competition or tend to create a monopoly. As amended by the Celler-Kefauver Act, section 7 of the Clayton Act provides

> [t]hat no person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the

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30. 221 U.S. 1 (1911).

31. *Id.* at 60.

32. *Id.* at 63-64.

33. 15 U.S.C.A. §§ 12-27 (West 1988).

34. Section 2 of the Clayton Act addresses price discrimination in its many forms. Clayton Act § 2, 15 U.S.C.A. § 13 (West 1988). Section 3 deals with exclusionary practices such as tying, exclusive dealing, and territorial restrictions. *Id.* at § 3, 15 U.S.C.A. § 14.

35. *See* Stigler, *Mergers and Preventive Antitrust Policy*, 104 U. PA. L. REV. 176 (1955).

> 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.[36]

The provision is notable for several reasons. First, a plaintiff need only show that a merger *may* have the proscribed effect. Since a plaintiff need not show any actual, adverse competitive impact, section 7 can prevent the market restructuring that is most conducive to collusive behavior or single firm dominance. Second, as the statute now reads, section 7 applies equally to horizontal, vertical, and conglomerate mergers. Third, the proscribed effect on competition must relate to a "line of commerce" in a "section of the country." In other words, a product market and a geographic market must be defined in order to evaluate the competitive impact.

E. *Loophole For Nonprofit Firms*

A loophole exists in the Clayton Act for mergers of nonprofit hospitals.[37] Section 7 of the Clayton Act applies to nonprofit as well as for-profit hospitals for *stock* acquisitions. Parties acquiring assets, however, are subject to the jurisdiction of the Federal Trade Commission (FTC). FTC jurisdiction extends to persons, partnerships, and corporations.[38] The FTC Act defines "corporation" to include any business entity that is "organized to carry on business for its own profit or that of its members."[39] Due to the FTC Act's limited definition of "corporation," the Clayton Act may not cover asset acquisitions involving nonprofit hospitals.

The extent of FTC jurisdiction is not yet defined. In *United States v. Carilion Health System*,[40] the Western District Court in Virginia held that section 7 does not apply to mergers of nonprofit hospitals, while in *United States v. Rockford Memorial Corp.*,[41] an Illinois district

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36. 15 U.S.C.A. § 18.

37. *See* Miles, *Hospital Mergers and the Antitrust Laws: An Overview*, 29 ANTITRUST BULL. 253 (1984); Singer, Application of Federal Antitrust Law To Mergers of Competing Hospitals (Nov. 8, 1985) (materials accompanying remarks presented at 19th New England Antitrust Conference).

38. 15 U.S.C. § 45(a)(2).

39. 15 U.S.C. § 44.

40. 707 F. Supp. 840 (W.D. Va. 1989).

41. 717 F. Supp. 1251 (N.D. Ill. 1989).

court held that section 7 does apply. Both decisions, however, are being appealed. If the Supreme Court endorses the limited definition of "corporation" in the FTC Act, the health care industry would largely escape antitrust scrutiny because the nonprofit hospital is the predominant model of organization in the industry. Consequently, this exemption could apply to a large number of hospital mergers.[42]

F. *Horizontal Merger Standards*

The language of section 7 of the Clayton Act imposes some requirements on the judiciary in developing horizontal merger standards. In determining the legality of a horizontal merger, a court must ascertain whether the merger will substantially decrease competition or tend to create a monopoly in any line of commerce in any section of the country. This analysis requires a clear definition of product market ("line of commerce") and geographic market ("section of the country"). After defining the markets, the court must determine the competitive significance of the merger. Most of the Supreme Court's standards, developed by the Warren Court, reflect a hostile attitude toward horizontal mergers.[43]

1. Product Market Definition

Defining the relevant product market is a difficult problem. Economists usually look at the cross-elasticity of demand to assess the substitutability of two products,[44] but the cross-elasticity of demand is difficult to measure. An analyst must rely upon price correlations and purchase patterns as a practical way of drawing inferences about the cross-elasticity of demand.[45] Courts, however, have not relied on such evidence. Historically, the Supreme Court has adopted whatever product market definition was proposed by the government.

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42. *See* Blair & Fesmire, *Antitrust Treatment of Nonprofit and For-Profit Hospital Mergers*, 7 ADVANCES IN HEALTH ECON. & HEALTH SERV. RESEARCH 221 (1986).

43. *See, e.g.*, United States v. Von's Grocery Co., 384 U.S. 270, 278 (1966) ("It is enough for us that Congress feared that a [nonprofit] market marked at the same time by both a continuous decline in the number of small businesses and a large number of mergers . . . ."); United States v. Philadelphia Nat'l Bank, 374 U.S. 321 (1963) (merger between firms controlling an "undue percentage" of a market and which results in a "significant increase" in concentration is inherently likely to lessen competition); Brown Shoe Co. v. United States, 370 U.S. 294 (1962) (Court adopts "domino theory" in mergers, believing that approval of one merger now might require the Court to approve subsequent mergers that would further concentrate the industry).

44. The cross-elasticity of demand equals the percentage change in the quantity of good X demanded divided by the percentage change in the price of Y. If X and Y are substitutes, the cross-elasticity should be positive and fairly large.

45. For a discussion of this approach, see R. BLAIR & D. KASERMAN, ANTITRUST ECONOMICS 106-10 (1985).

United States v. Continental Can Co. [46] is a particularly egregious example of the Court's failure to exercise independent judgment. Continental Can, a metal can manufacturer, acquired Hazel Atlas, a glass jars manufacturer.[47] Although the lower court recognized that metal and glass containers were separate products,[48] the Court found them to be competing in some uses.[49] Ignoring reasonable interchangeability of use and cross elasticity of demand, the Court ruled that the relevant product market included both metal *and* glass containers.[50] The majority was not "concerned by the suggestion that if the product market is to be defined in these terms it must include plastic, paper, foil and any other materials competing for the same business."[51] This ad hoc reasoning demonstrates that the Court can manipulate the product market definition to obtain any desired result in a merger case.[52]

2. Geographic Market Definition

The analytical tools used to define the relevant product market also can be applied to defining the relevant geographic market. Not surprisingly, however, the Supreme Court has failed to articulate a consistent standard in evaluating geographic markets. For example, in *United States v. Pabst Brewing Co.*,[53] the Court failed to carefully define the market. According to the Court, section 7 of the Clayton Act "requires merely that the Government prove the merger has substantial anticompetitive effect somewhere in the United States."[54] The Court never defined the relevant geographic market in which the government must demonstrate an anticompetitive effect.

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46. 378 U.S. 441 (1964).

47. *Id.* at 443.

48. *Id.* at 448 (citing 217 F. Supp. at 780-81).

49. *Id.* at 449-52.

50. *Id.* at 455. Thus, though the interchangeability may not be so complete, and the cross-elasticity of demand not so immediate as in the case of most intra-industry mergers, there is, over the long run, the kind of customer response to innovation and other competitive stimuli that brings the competition between these two industries within § 7's competition-preserving provisions.

51. *Id.* at 457-58.

52. *See, e.g.*, United States v. Aluminum Co. of Am. (Rome Cable), 377 U.S. 271 (1964) (bare and insulated aluminum conductor constitutes one market for the purposes of § 7 because both are used for conducting electricity and sold to the same customers, but copper and wire constitutes a separate market).

53. 384 U.S. 546 (1966).

54. *Id.* at 549.

3. Establishing Anticompetitive Effect

The Court measures anticompetitive effect in terms of market shares. In *Brown Shoe Co. v. United States*,[55] the Court identified market share as "one of the most important factors to be considered when determining the probable effects . . . on effective competition in the relevant market."[56] In *United States v. Philadelphia National Bank*,[57] the Court expressed its conviction that

> [a] merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects.[58]

Market share theory has several conceptual problems. In theory, market share is only linked to market power at the extremes of perfect competition and monopoly.[59] Moreover, the empirical link between market share and market power is vehemently disputed.[60]

III. THE ECONOMICS OF MERGERS

Antitrust policy regarding hospital mergers should reflect the social and economic goals of antitrust policy. Antitrust law seeks to advance consumer welfare,[61] to equitably distribute economic and political power,[62] to promote small business,[63] to preserve local control over

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55. 370 U.S. 294 (1962).

56. *Id.* at 343.

57. 374 U.S. 321 (1963).

58. *Id.* at 363. This cavalier attitude toward proof of adverse effect was not an isolated instance. In the *Continental Can* decision, the Court observed that "[w]here a merger is of such size as to be inherently suspect, elaborate proof of market structure, market behavior and probable anticompetitive effects may be dispensed with in view of § 7's design to prevent undue concentration." 378 U.S. at 458 (1964).

59. *See* Saving, *Concentration Ratios and the Degree of Monopoly*, 11 INT'L ECON. REV. 139 (1970).

60. *See* Weiss, *The Concentration-Profits Relationship and Antitrust*, in INDUSTRIAL CONCENTRATION: THE NEW LEARNING 184 (H. Goldschmid, H. Mann & J. Weston eds., 1974); Demsetz, *Two Systems of Belief About Monopoly*, in INDUSTRIAL CONCENTRATION: THE NEW LEARNING 164 (H. Goldschmid, H. Mann & J. Weston eds., 1974).

61. Bork, *Legislative Intent and the Policy of the Sherman Act*, 9 J. L. & ECON. 7 (1966).

62. Fox, *The Modernization of Antitrust: A New Equilibrium*, 66 CORNELL L. REV. 1140, 1152-54 (1981); Pitofsky, *The Political Content of Antitrust*, 127 U. PA. L. REV. 1051, 1054 (1979).

63. Blake & Jones, *In Defense of Antitrust*, 65 COLUM. L. REV. 377, 384 (1965).

business,[64] to prevent concentrations of industrial power,[65] and to encourage entrepreneurial ability.[66] The antitrust laws promote economic efficiency[67] by promoting competition and inhibiting monopolistic behavior. Since monopolies tend to restrict output and raise prices to consumers, thereby reducing consumer welfare, a reduction in monopolistic behavior tends to increase efficiency and enhance welfare. While all these goals have merit, advancing consumer welfare is the most important goal of antitrust regulation of hospital mergers.

A. *Allocative vs. Productive Efficiency*

The earlier examination of monopoly[68] focused on allocative inefficiency which results from the monopolistic tendency to restrict output. But a merger that enhances efficiency is beneficial. Figure 2 illustrates the potential conflict between allocative and productive efficiency.[69] Suppose that competing manufacturers of products propose a merger. In Figure 2, D is the demand curve for the product, and AC_1 is the constant average cost and marginal cost curve.[70] Prior to the merger, competition will drive price to P_1, which equals average cost (AC_1), and the competing firms will produce total output equal to the quantity Q_1.[71] If the merger results in a significant increase in market power, then the new, merged firm will be able to raise its price to P_2.[72]

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64. Brown Shoe Co. v. United States, 370 U.S. 294, 315-16 (1962).

65. Comanor, *Conglomerate Mergers: Considerations for Public Policy*, in THE CONGLOMERATE CORPORATION 13-24 (R. Blair & R. Lanzillotti eds. 1981).

66. Blake & Jones, *supra* note 63, at 384.

67. *See generally* P. AREEDA & D. TURNER, ANTITRUST LAW 103-13 (1978); R. BORK, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF 50-71 (1978); R. POSNER ANTITRUST LAW: AN ECONOMIC PERSPECTIVE 8-22 (1976).

68. *See supra* notes 6-10 and accompanying text.

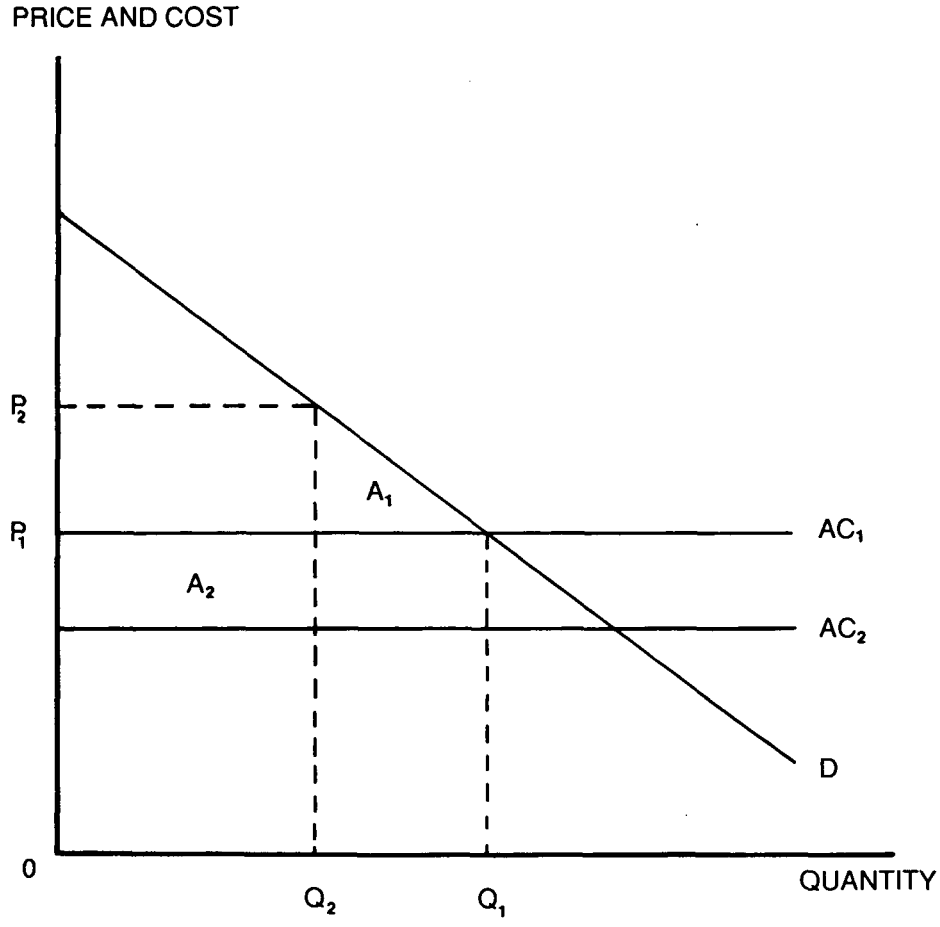
69. *See* Williamson, *Economies as an Antitrust Defense: The Welfare Tradeoffs*, 58 AM. ECON. REV. 18 (1968). The text discussion parallels that of R. BORK, *supra* note 67, at 107-10.

70. If the average cost is constant, then marginal cost (the amount that is added to total cost when an additional unit is produced) must also be constant and equal to average cost. If marginal cost were greater than average cost, then an extra unit of production would add more to total cost than the previous average, and the average would rise. If marginal cost were less than the previous average, then the extra unit would cause average cost to fall. *See supra* note 6, at 142-47.

71. Price equal to average cost results in zero economic profit. Zero economic profit, however, means that the firm is earning a normal profit. Economists, interested in resource allocation, include in total cost all payments required to attract and hold resources for the firm. A normal profit is required to keep the entrepreneur, an important resource, in the business. When price is equal to average cost, then firms are earning what is called a competitive return or a normal profit. *See id.* at 186-187, 217-23.

72. Competitive firms are restricted in their ability to increase price by the existence of many rivals ready to service their customers. Because it eliminates competitors to whom a

FIGURE 2



The proposed merger, then, may have two results that affect consumer welfare: (1) price may go up and output will fall, reducing consumer welfare, and (2) the average cost of production may decrease, thereby enhancing consumer welfare.[73] The net effect on consumers will depend on the relative size of these welfare effects. The triangular area A_1 represents the loss of consumer welfare due to the merged

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firm's customers might turn, a merger may give the firm the ability to raise price with a smaller loss of sales than would be the case in a more competitive atmosphere.

73. These efficiencies would result from economies associated with large scale production, promotion or distribution.

firm's output restriction. The rectangular area A_2 represents the gain to society resulting from the efficiencies in production achieved by the merger. After the merger, the new firm produces only Q_2 units of output, but these units, which previously cost AC_1 each, now only cost AC_2. Consequently, the merger reduces costs by AC_1-AC_2 for each unit produced, resulting in a total cost reduction of $(AC_1\text{-}AC_2)Q_2$ which equals the area A_2.[74] If A_1, the welfare loss associated with the merged firm's reduced output, is greater than A_2, the increase in wealth caused by productive efficiencies, then the merger will reduce consumer welfare. On the other hand, if A_2 is greater than A_1, then the merger will, on balance, increase welfare.[75]

B. *Motives for Mergers*

Why do firms merge? Certainly their goal is not to increase consumer welfare. Firms may have many specific motives for a merger. As profit seekers, firms usually seek to enhance profits. Since profit is equal to the difference between the firm's total revenue (price of the product times the quantity sold) and total cost (average cost of the product times the quantity sold), profits will rise whenever revenues increase, costs decrease, or both. Firms merge either to increase efficiency, thereby lowering costs and raising profits or to increase market power, thereby raising revenues and increasing profits. The consequences for consumer welfare of a proposed merger hinge on which of these motives dominates.

C. *Merger to Oligopoly*

Most mergers will not result in a structural monopoly. Because mergers occur in a formerly competitive environment, noncompetitive pricing may result. Higher prices encourage independent firms to remain independent.[76] Moreover, as market structure approaches

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74. These cost reductions measure the amount of resources that are freed by the efficiency gains — resources that can be used to produce other goods that will benefit society and, thus, increase welfare. In contrast to the deadweight loss measured by areas A_1, area A_2 represents a real saving of resources for society. These resources are free to produce additional goods in other, presumably competitive industries.

75. Lande argues that this analysis is insufficient because it does not consider the transfer of wealth from consumers to producers that results from such a merger. *See* LANDE, *supra* note 10, at 65. Look again at Figure 2. After the merger, consumers must pay P_2 instead of P_1 for the Q_2 units that they purchase. That is, they must pay an additional $(P_2 - P_1)Q_2$. In Lande's view, the prevention of such "unjust" transfers was the primary intent of the antitrust laws.

76. The economic logic is similar to the explanation for cheating in a cartel. *See* Stigler, *supra* note 2.

monopoly, the antitrust authorities are more likely to challenge any given merger.[77] Thus, at worst, merger activity is more apt to result in oligopoly than monopoly.[78] Unfortunately, for purposes of policy analysis, the economic results of oligopolistic behavior are not as certain as those in competitive or monopolistic markets because the presence of just a few firms leads to strategic behavior on the part of individual firms. Each firm's behavior is based, in part, on the anticipated reactions of its rivals. In this kind of environment, the results cannot be known precisely. Nonetheless, collusion and noncompetitive results are much more likely in markets with fewer participants.[79] The smaller the number of firms involved, the easier it is to consummate, implement, and enforce collusive agreements.[80]

Even if firms do not practice overt collusion in a market where strategic behavior is possible, tacit understandings may lead to noncompetitive behavior. Further, these tacit forms of collusion can, in the extreme, lead to monopoly pricing.[81] Tacit agreements present special problems for antitrust enforcement since no formal agreement exists.

IV. HOSPITAL MERGERS AND EFFICIENCY

Mergers may increase market power, which tends to decrease consumer welfare. Mergers may also increase efficiency, which tends to increase consumer welfare. While antitrust authorities are acutely aware of increases in market power due to mergers, they are less aware of the efficiencies that may result from such mergers. This section briefly outlines some of the peculiarities of the health care market.

Nonprofit hospitals receive certain tax advantages not shared by for-profit hospitals. In addition, nonprofit hospitals may enjoy favorable merger treatment. The advantages that nonprofit hospitals enjoy

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77. *See infra* note 116, Justice Dep't Merger Guidelines (June 14, 1984).

78. An oligopoly is an industry dominated by a few large firms.

79. *See* Hay & Kelley, *An Empirical Survey of Price Fixing Conspiracies*, 17 J.L. & ECON. 13 (1974) (for some empirical evidence).

80. *See* R. BLAIR & L. KENNY, MICROECONOMICS FOR MANAGERIAL DECISIONMAKING 330-37 (1982).

81. *See* E. CHAMBERLIN, THE THEORY OF MONOPOLISTIC COMPETITION 30-55 (8th ed. 1962); *see also* Posner, *Oligopoly and the Antitrust Laws*, 21 STAN. L. REV. 1562 (1969); Spence, *Tacit Coordination and Imperfect Information*, 11 CAN. J. ECON. 490 (1978); Turner, *The Definition of Agreement Under the Sherman Act: Conscious Parallelism and Refusals to Deal*, 75 HARV. L. REV. 655 (1962).

over for-profit hospitals may significantly weaken the competitive check that the for-profit hospitals provide. Further, nonprofit hospitals may dissipate these advantages through inefficiency.

A. *The Health Care Market*

The health care market has special problems[82] that stem from uncertainty and lack of market information.[83] Even with today's extensive medical knowledge and complex technologies available for treatment, consumers remain largely ignorant. They have insufficient knowledge of the symptoms, causes, diagnoses, and treatments to adequately evaluate the quality of care provided by their physicians and hospitals. Physicians are ethically bound to provide for the needs of the patient first,[84] but even if physicians act in an ethical manner, lack of information renders consumers unable to make informed decisions. Consumers unable to adequately evaluate the quality of care they receive are unable to make rational decisions among competing providers based on price.

While consumer ignorance inhibits competition in health care, third-party payment for health care further impedes competition.[85] Even if consumers have the necessary information to determine the best price, consumers have no incentive when insurers pay all or a large percentage of the bills. If consumers lack both the ability and the incentive to evaluate medical procedures and to seek out the best price, insurers might take on that role. But it would be costly for insurers to gather full information about the symptoms of patients and arrive at satisfactory diagnoses and treatments that are in accord with those of the physicians. "To the extent that the insurer defers to the physician's 'discretion' and 'judgment,' he forgoes the role of monitor."[86] Reviewing a physician's judgment would be costly indeed, and that cost would be compounded by the fact that competent physicians may not agree

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82. Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416 (1980); Frech, *Competition in Medical Care: Research and Policy*, 5 ADVANCES IN HEALTH ECON. & HEALTH SERV. RES. 1 (1984) (both provide good summaries of these special problems).

83. *See* Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963); *see also* Woolley & Frech, *How Hospitals Compete: A Review of the Literature*, 2 U. FLA. J.L. & PUB. POL'Y 57, 59-60 (1988-89) [hereinafter Woolley].

84. The medical malpractice liability crisis, however, is ample proof that this obligation is not always fulfilled.

85. *See* Frech, *supra* note 82; *see also* Woolley, *supra* note 83, at 60-61 (discusing results of empirical studies regarding effects of third-party payments by health insurers).

86. *See* Clark, *supra* note 82, at 1421.

on the relative merits of different treatments. Inadequate information among consumers and insurers and expert disagreement on the cost-effectiveness of treatments seriously compromise meaningful competition in health care markets.

B. *Nonprofit Hospitals and Efficiency*

If nonprofit hospitals enjoy exemption from section 7 of the Clayton Act, they can merge despite the merger restrictions on for-profit hospitals. This discrepancy in the hospital industry has serious implications for hospital efficiency. First, if some hospitals can merge while others cannot, then those which cannot merge will not benefit from the efficiency inherent in economies of scale. Their costs will be higher than necessary, resulting in loss of consumer welfare. Second, nonprofit hospitals derive cost advantages not from efficiency differences but from certain legal advantages nonprofit firms enjoy. Nonprofit hospitals are accorded favorable tax status at the expense of other parts of the economy. Since nonprofit hospitals do not labor under the profit motive, they dissipate their advantages in ways that amount to a loss of efficiency, thus resulting in consumer welfare losses. Third, nonprofit hospitals may dissipate their gains from economies of scale since the for-profit hospitals provide no competitive check. Finally, even if the law allowed for-profit hospitals to merge, the nonprofit hospitals are still free to dissipate the advantages associated with their nonprofit status.

Professor Clark has documented the disparate treatment accorded to nonprofit hospitals, pointing out that numerous statutes, regulations, and judicial doctrines discriminate against for-profit hospitals.[87] Nonprofit hospitals are exempt from state and local property taxes, and the federal government exempts gifts to nonprofit hospitals from federal income taxes, while gifts to for-profit hospitals are not exempt. Although the government taxes for-profit hospitals for unemployment compensation according to payroll, it taxes nonprofit hospitals only on actual claims, which is usually a lower amount. For-profit hospitals can obtain federal grants and federal loans for the development of health maintenance organizations (HMOs) only if they locate the HMOs in an area that is under-served. In addition, Medicare reimbursements call for "necessary and proper" costs of rendering services, which include a fair return on equity. But this requirement has not been interpreted to include income taxes, and thus the reimbursements result in a lower rate of return when adjusted for taxes.

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87. *Id.*

Clark lists a myriad of other ways in which federal policies discriminate in favor of the nonprofit hospitals.[88]

Nonprofit hospitals, then, enjoy a considerable competitive advantage due to these discriminatory policies. In addition, Clark found that for-profit hospitals are denied cost savings resulting from any economies of scale that exist — and most would agree that they do exist. If nonprofit hospitals enjoy cost advantages because of economies of scale and also because of favorable treatment, one would expect them to provide services at a lower cost.

Yet, in spite of lower occupancy rates, for-profit hospitals have lower costs than nonprofit hospitals. This is apparently attributed to smaller amounts of cost-generating resources and also to shorter lengths of stay in for-profit hospitals for similar procedures. If for-profit hospitals have these cost disadvantages and still have lower costs, one would think that patients receive lower quality services in for-profit hospitals because of less concern for patients and a greater concern for profits. Empirical evidence, however, shows no differences in the quality of care provided by for-profit as compared to nonprofit hospitals. If nonprofit hospitals enjoy cost advantages, but still provide a similar quality of service while experiencing higher actual costs than the for-profit hospitals, then they must be less efficient. The reasons for the relative inefficiency of nonprofit hospitals lie in the very nature of their nonprofit status and the incentives that that status implies.

Clarkson finds that differences in incentives between nonprofit and for-profit hospitals have their roots in differences in property rights invested in owners and managers.[89] These differences in incentives, in turn, lead to differences in efficiency. In the case of for-profit hospitals, the owners or trustees have exclusive rights to all benefits, pecuniary and nonpecuniary, derived from the production of hospital services. They impose on their managers rules and regulations designed to maximize those benefits. Managers are often afforded partial ownership rights in order to insure that they share similar goals with the owners. Managers directly rewarded by increases in profits and capital values have a direct stake in the efficiency with which the for-profit hospital provides services.

The trustees of nonproprietary hospitals, on the other hand, do not have exclusive rights to these pecuniary and nonpecuniary benefits. Since they do not have these rights, they cannot assign them to managers in order to provide them with incentives to maximize the firm's

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88. *Id.*

89. Clarkson, *Some Implications of Property Rights in Hospital Management*, 15 J.L. & ECON. 363 (1972).

wealth. Consequently, managers of nonprofit hospitals have a greatly reduced link between their own welfare and the wealth of the hospital. Accordingly, they have less interest in enhancing efficiency than the for-profit hospital manager and, predictably, managerial slack is greater in nonprofit hospitals. This managerial slack results in less rigorous supervision of employees, hiring on the basis of academic credentials rather than on harder-to-obtain indications of performance ability, a wider variance in input selection among nonprofit hospitals since input selection is more constrained by market forces in the case of for-profit hospitals, a less intense effort to collect bad debts because of less pressure to increase revenues, and less price consciousness in their purchasing efforts.[90]

Managerial slack may dissipate any cost advantages that accrue to the nonprofit hospitals, advantages that for-profit hospitals would seek to extract in the form of current income and increased value of the firm. While enhanced by a system of third party payments and the information problems in health care noted above, the ability of nonprofit hospitals to survive managerial inefficiencies may also lie in the lack of competition from the for-profit hospitals.

V. ANTITRUST TREATMENT OF HOSPITAL MERGERS

The Clayton Act forbids mergers that may substantially lessen competition or tend to create a monopoly.[91] That is, it proscribes mergers that would enhance market power in a significant way.[92] The Clayton Act defines a market as "any line of commerce . . . in any section of the country."[93] This, as noted above, makes it necessary to establish a product market as well as a geographic market in which to assess market power. This section looks first at product market then geographic market as defined by both the courts and the Justice Department. After establishing the relevant market, the regulator must determine whether a proposed merger may substantially lessen competition or tend to create a monopoly.

A. *The Product Market*

The extent of a product market is defined by the degree to which products are substitutes for one another. If good product substitutes exist, then the propensity of a producer's customers to switch to another product limits the producer's ability to raise prices.

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90. *Id.* at 364-67.
91. 15 U.S.C.A. § 18 (West 1988).
92. *See supra* notes 6-9.
93. 15 U.S.C.A. § 18 (West 1988).

The Supreme Court recognized this approach in *Brown Shoe Co.*[94] when it mentioned both the "reasonable interchangeability of use" and the "cross-elasticity of demand" while discussing product markets.[95] Cross-elasticity of demand measures the degree to which the producer is limited in its ability to raise price by the propensity of its customers to switch to other products when faced with price increases.[96] If a small percentage increase in price by a producer results in the defection of a large percentage of its customers to competing products, then the competing products are good substitutes. The existence of competing products inhibits the ability of the producer to raise prices, and for purposes of measuring market power, the product definition should include these products. If, on the other hand, price increases do not bring about significant defections, then the products are not good substitutes and are not in the same product market. While the Court has stated that reasonable interchangeability and cross-elasticity of demand are important measures for determining the product market, it has not relied heavily on such evidence.[97]

Bank merger cases have influenced hospital merger cases because of the similarities between the banking and hospital industries: both are regulated, both are service industries, and both provide a "cluster of services." In *United States v. Philadelphia National Bank, Inc.*, the Supreme Court first introduced the "cluster of services" concept with reference to commercial banking.[98] In *United States v. Marine Bancorporation, Inc.*, the Court reinforced the concept of "commercial banking business."[99]

In *In re American Medical International*, the FTC adopted the "cluster of services approach" in deciding a hospital merger case.[100] American Medical International (AMI) acquired French Hospital and thereby gained control of three of the five hospitals in San Luis Obispo, California and eighty percent of the acute-care beds.[101] Arguing that the product market should include services offered by non-hospital

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94. 370 U.S. 294 (1962).

95. *Id.* at 325.

96. *See supra* note 5 and accompanying text.

97. *See* United States v. Aluminum Co. of Am. (Rome Cable), 377 U.S. 271 (1964).

98. 374 U.S. 321, 356 (1963). Banks provide a variety of services such as checking accounts, loans, and ATMs that are also provided by other financial institutions. These could each be viewed as a separate service, subject to significant competition from savings and loans. But if only commercial banks provide the entire package, the whole "cluster of services," then they are effectively shielded from competition from those that provide only parts of the cluster.

99. 418 U.S. 602 (1974).

100. 104 F.T.C. 1, 177 (1984).

101. *Id.* at 3.

providers, AMI contended that if it raised prices for its services, customers would be free to obtain these services from non-hospital providers. Since reasonable interchangeability existed, AMI asserted that the non-hospital providers should be included in the product market.[102] The FTC stated, however, that the unique "cluster of services" provided by an acute care hospital was analogous to those described in *Philadelphia National Bank* [103] and that reasonable interchangeability did not exist.[104]

The FTC in *American Medical International* concluded that the cluster of services provided by general acute care hospitals is a unique package of services.[105] These services are complementary in providing health care since many patients need an array of services that usually are available together only in a general acute care hospital. In addition, those in the hospital business recognize only other hospitals as competitors.[106]

The court in *Hospital Corporation of America v. Federal Trade Commission* reinforced the cluster of services approach.[107] Hospital Corporation of America (HCA), the largest hospital chain in the United States, took control of several hospitals in the Chattanooga, Tennessee area.[108] Because the administrative law judge applied the "cluster of services" doctrine, the court excluded outpatient facilities or providers in the market definition but included all outpatient services.[109] The FTC noted, however, that inpatient hospital services may be the correct product market.[110] While these inpatient hospital services were not a factor in *Hospital Corporation of America*, they may well influence the shape of product markets in future cases. Two recent district court decisions are in conflict on this point. In *United States v. Rockford Memorial Corp.*,[111] the court defined the market as acute inpatient services, thereby excluding outpatient facilities.[112] In contrast, the district court in *United States v. Carilion Health System*[113]

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102. *Id.* at 192. It is, of course, in the defendants' interest to include as many providers as possible in the product market, thus diluting the defendants' market share.

103. United States v. Philadelphia Nat'l Bank, 374 U.S. 321 (1963).

104. *In re* American Medical Int'l, Inc., 104 F.T.C. 1, 193-94 (1984).

105. *Id.* at 194.

106. *Id.*

107. 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987).

108. *Id.* at 1383.

109. *Id.* at 1384.

110. *Id.* at 1384-85.

111. 717 F. Supp. 1251 (N.D. Ill. 1989).

112. *Id.* at 1259-60.

113. 707 F. Supp. 840 (W.D. Va. 1989).

defined the market to include outpatient facilities.[114] The Supreme Court has yet to resolve the issue of relevant product market definition in hospital merger cases.

B. *Department of Justice Guidelines*

To improve the predictability of its merger enforcement policy,[115] the United States Department of Justice (Department) published new merger guidelines in 1984.[116] The guidelines' approach to determining the product market involves a hypothetical firm that enjoys a monopoly position in each (narrowly-defined) product produced or sold by the merging firms.[117] The Department then asks what would happen if the monopolist imposed a "small but significant and nontransitory" price increase.[118] If the price increase causes so many buyers to shift to substitute products that such a price change is not profitable, the Department will add to the product group the product that is the next best substitute for the merging firm's product.[119] The same inquiry is repeated until a group of products is identified for which a hypothetical monopolist could impose a "small but significant and nontransitory" price increase which results in increased profits.[120] In most cases, the relevant product market will consist of the smallest group of products that satisfies this test. In determining product substitutability, the Department will give particular weight to the following types of evidence: 1) a buyer's perceptions that the goods are substitutes, 2) similarities or differences in price movements over a period of years unexplained by other factors, 3) similarities or differences in customary usage, 4) design, physical composition and other technical characteristics, and 5) evidence of sellers' perceptions that the products are or are not substitutes.[121]

The guidelines' approach may undermine the "cluster of services" approach to product market determination.[122] By examining each service individually and trying to determine its substitutes, the Depart-

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114. *Id.* at 847-48.

115. *See* Blair & Kaserman, *supra* note 45, at 246-49.

116. 1984 U.S. Justice Department Merger Guidelines, Antitrust Trade Reg. Rep., Special Supp. §§ 1-16 (June 14, 1984).

117. *Id.* § 2.

118. *Id.*

119. *Id.*

120. *Id.*

121. Blair & Kaserman, *supra* note 45, at 247.

122. *See* Cruz, *Product and Geographical Market Measures in the Merger of Hospitals*, 91 DICK. L. REV. 497 (1988).

ment invites the hospitals to argue that non-hospital providers should be included in the market definition. But even if courts accept hospital arguments that the guidelines supersede the "cluster" approach, the Department could still argue that the "cluster of services" is a unique product and that the non-hospital services are not a good substitute.[123]

C. *The Geographic Market*

After establishing the product market, the next step is to determine the relevant geographic market. The FTC uses several factors to analyze the geographic market in hospital merger cases.[124] One factor is the immigration and emigration of patients.[125] Starting with the location of the merging hospital, patient origin studies determine the percentage of patients within the hospital's primary and secondary service area who use services offered by providers outside the area. Similarly, the relative importance of patients from outside the primary and secondary service areas is examined. If the percentages of these inflows and outflows are low, then the area is probably the relevant geographic market. If they are high, then the market area should probably be larger.[126] Since one cannot specify precisely what constitutes "low" and "high" in this determination, some arbitrariness is unfortunately inevitable.

Physicians' location is another factor in determining the relevant geographic market. Because of the consumer's lack of information, the physician usually makes, or greatly influences, the decision concerning where to go for hospital services. Consequently, hospitals "compete for physicians in order to increase admissions."[127] Further, since most physicians refer patients to hospitals located near their offices, the area in which physicians are concentrated is an important determinant of the appropriate geographic market.[128] A final factor is the geographic area that the hospital administrators themselves recognize as the relevant one.

The market for acute care hospital services tends to be local in character since both patients and physicians prefer hospitals that are convenient. The judiciary has recognized what may seem intuitively

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123. *Id.* at 521.

124. *Id.* at 521-26 (for an analysis of these factors).

125. *See In re* American Medical Int'l, Inc., 104 F.T.C. 1 (1984); Hospital Corp. of Am. v. Federal Trade Comm'n, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987).

126. Elzinga & Hogarty, *The Problem of Geographical Market Delineation in Antimerger Suits*, 18 ANTITRUST BULL. 45 (1973).

127. *In re* American Medical Int'l, Inc., 104 F.T.C. at 197.

128. *See* Cruz, *supra* note 122, at 524.

obvious: patients go to local hospitals except for highly specialized medical services. For example, in *In re American Medical International*, the city of San Luis Obispo as well as San Luis Obispo County were relevant geographic markets.[129] The court in *American Medicorp v. Humana, Inc.* found that the relevant geographic market was "in and around Bluefield, West Virginia."[130]

The Department of Justice Guidelines seek to identify a geographic area in which a hypothetical firm, as the only present and future producer or seller of the relevant product in the area, could profitably impose a "small but significant and nontransitory" increase in price.[131] The Department begins at the geographic location of each merging firm and considers what would happen if the hypothetical monopolist imposed such a price increase.[132] If so many buyers would switch to products produced in other geographic areas that the hypothetical monopolist would find the price increase unprofitable, the Department will add the location providing the next best substitute products and ask the same hypothetical question again.[133] This process is repeated until the monopolist is able to profitably impose such an increase in price.[134] The smallest market in which this can occur is the relevant geographic market.[135]

In determining geographic substitutability, the Department gives particular weight to the following: shipping patterns of the merging firm and its competitors; evidence that buyers actually consider shifting purchases, especially in response to price changes; differences or similarities in price changes for the product that are not explained by other factors; transportation costs; costs of local distribution; and excess capacity of firms outside the location of the merging firms.[136]

D. *Anticompetitive Effect*

After defining the product and geographic markets, courts determine whether a proposed merger will substantially lessen competition. In *United States v. Columbia Steel Co.*,[137] the Supreme Court deter-

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129. *In re* American Medical Int'l, Inc., 104 F.T.C. at 187.

130. American Medicorp, Inc. v. Humana, Inc., 445 F. Supp. 573, 605 (E.D. Pa. 1977).

131. 1984 U.S. Department of Justice Merger Guidelines, Justice Dep't Merger Guidelines, Antitrust Trade Reg. Rep., Special Supp. at §§ 1-16, 3, 2.31 (June 14, 1984).

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.* § 2.32.

137. 334 U.S. 495 (1948).

mined that the anticompetitive effect of a merger hinges on the market shares involved. Although market shares have been important at least since that landmark 1948 decision, the importance of market shares increased dramatically following the Cellar-Kefauver Amendment to section 7 of the Clayton Act in 1950.[138]

The Court prefaced its *Brown Shoe* decision with a review of the factors instrumental in the passing of the Cellar-Kefauver Amendment.[139] Among those factors was Congress' desire to provide the power to halt a merger trend.[140] Congress also wanted to provide a lower standard of proof than that demanded by the Sherman Act to make it easier for the government to prevail in court.[141] While noting that Congress proposed no tests for defining either the "relevant markets" or "substantially lessened competition," the Court declared that Congress had intended that a merger be viewed functionally in the context of the relevant industry.[142] Finally, the Court noted that the language of section 7 clearly concerns the probabilities of concentration rather than with its certainties.[143]

Although the Court in *Brown Shoe Co.* found that the merger of the manufacturing facilities involved was too insignificant to come under section 7, it found that the merger of the shoe manufacturer with another shoe retailer did come under section 7.[144] Focusing on the market share of the merged firms, which is "one of the most important factors when determining the probable effects . . . on effective competition in the relevant market,"[145] the Court found that a five percent share was important in a fragmented market.[146] Further, it went on to find that a small share takes on greater significance if the retail outlet is a part of a national chain.[147] What transforms a small share into a significant one, however, is not clear.

Although the shoe retailing industry was not concentrated, the Court noted a historical tendency toward concentration in the industry through merger.[148] Admittedly, this merger did not involve huge mar-

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138. 15 U.S.C. § 18 (1950).

139. Brown Shoe Co. v. United States, 370 U.S. 294, 315-23 (1962).

140. *Id.* at 315.

141. *Id.* at 318.

142. *Id.* at 320-22.

143. *Id.* at 323.

144. *Id.* The Court explained that the merger of the fourth largest shoe manufacturer with the largest shoe retailer could result in a large potential market foreclosure and that this vertical merger would be analogous to a tying arrangement.

145. *Id.* at 343.

146. *Id.* at 343-44.

147. *Id.* at 343.

148. *Id.* at 345.

ket shares. Nevertheless, the Court feared a domino effect of having to approve other mergers in the industry if it approved this merger.[149] Consequently, it ruled against Brown Shoe: "[w]e cannot avoid the mandate of Congress that tendencies toward concentration in industry are to be curbed in their incipiency."[150]

The Court also focused on market share in *United States v. Philadelphia National Bank*.[151] The Philadelphia National Bank, second largest commercial bank in the Philadelphia area, merged with the third largest commercial bank of the forty-two commercial banks in the four-county area around Philadelphia.[152] The newly merged firm would have been the largest in the area with a market share of thirty-four percent to thirty-six percent.[153] The Court declined to conduct any economic analysis. Noting that Congress was concerned about a rising tide of concentration in the economy, the Court said,

> This intense congressional concern with the trend toward concentration warrants dispensing, in certain cases, with elaborate proof of market structure, market-behavior, or probable anticompetitive effects. Specifically, we think that a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market, is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing the merger is not likely to have such anticompetitive effects.[154]

Incredibly, the Court felt that this "test is fully consonant with economic theory."[155] Philadelphia National Bank tried to argue that a larger bank in Philadelphia would bring business to the area and stimulate its economic development, but the Court rejected that argument: "[w]e are clear . . . that a merger the effect of which may be substantially to lessen competition is not saved because, on some ul-

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149. *Id.* at 344.

150. *Id.* at 346.

151. United States v. Philadelphia Nat'l Bank, 374 U.S. 321 (1963).

152. *Id.* at 330.

153. *Id.* at 331.

154. *Id.* at 363.

155. *Id.* The Court assumed that "competition is likely to be the greatest when there are many sellers, none of which has any significant market share." *Id.* (citing Comment, *Current Problems of Horizontal Mergers*, 68 YALE L.J. 1627, 1638-39 (1959)).

timate reckoning or social or economic debits and credits, it may be deemed beneficial."[156] So much for social welfare.

E. *Market Analysis in Hospital Merger Cases*

1. Price Competition

Because of the prevalence of third-party payment and cost-based reimbursement, one may argue that consumers are not sensitive to price differences among hospitals.[157] If hospitals do not benefit from price competition, no price competition will exist among them. In the absence of price competition, no market mechanism exists to discipline the hospitals' price and quality of care decisions. Thus, there would be no need for traditional antitrust concerns regarding mergers in concentrated markets. But the courts, in attempting to protect whatever competition exists in the hospital industry, have rejected this logic.

Price competition *does* exist in the hospital industry. In *American Medical International*, the court found that "price competition clearly existed between French [hospital] and Sierra Vista [hospital] with regard to . . . room rates, operating room rates and emergency room rates."[158] For example, French Hospital waived its usual emergency-room fee during non-peak hours.[159] This practice obviously benefits consumers who do not have insurance and those who must make copayments. Less obviously perhaps, reduced claims will benefit everyone with health insurance because lower claims mean lower costs to the insurer which, in turn, will mean lower insurance premiums.[160]

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156. *Id.* at 371. The logic of *Philadelphia Nat'l Bank* was applied in United States v. Aluminum Co. of Am., 377 U.S. 271 (1964), and in United States v. Continental Can Co., 378 U.S. 441 (1964). In both cases, the government presented some market share data, and the Court ruled in its favor without any economic analysis. In *Continental Can*, the Court observed that "[w]here a merger is of such size as to be inherently suspect, elaborate proof of market structure, market behavior and probable anticompetitive effects may be dispensed with in view of § 7's design to prevent undue concentration." 378 U.S. at 458.

157. In fact, AMI made a similar argument. *See* Respondent's Brief on Appeal from Initial Decision at 6-21 and 43-51.

158. *In re* American Medical Int'l, Inc., 104 F.T.C. 1 (1984).

159. *Id.* at 203.

160. Hospital Corp. of Am. v. Federal Trade Comm'n, 807 F.2d 1381 (7th Cir 1986), *cert. denied*, 481 U.S. 1038 (1987). The decision recognized that there had been little price competition among acute care hospitals, but whatever price competition existed should be protected. Moreover, changes in the array of health care consumers (HMOs and PPOs) may serve to increase price competition. Thus, the possibility of price competition should be preserved.

2. Market Concentration

Measures of market concentration — the traditional concentration ratio or the Herfindahl-Hirschman Index — cannot be dispositive in an economic analysis of mergers.[161] Concentration is only one of the relevant factors. It is also necessary to consider the supply offered by actual and potential competitors as well as the share commanded by the merged firm. In the hospital industry, the supply offered by rival hospitals may be quite large since many hospitals have excess capacity (i.e., a low utilization or occupancy rate). Where excess capacity does not exist, however, the supply response may be close to zero since the certificate-of-need (CON) requirements pose an almost insurmountable entry barrier.

Ordinarily, poor economic performance — excessive prices, low quality, poor service — provides an incentive for outsiders to enter or current rivals to expand. In the hospital industry, however, the expansion of supply is controlled by CON determinations. Adding beds in an existing hospital or the construction of a new hospital requires a CON. Without the CON, the state forbids entry. Whenever a hospital requests *de novo* entry or expansion, hearings are held and the existing hospitals can intervene to oppose the new entry. Generally, the new entrant cannot use opportunity for greater profit as a basis for establishing the need for additional capacity. As long as there is sufficient capacity to handle the case load, the state will not permit new entry. In the hospital merger cases, the courts have recognized that CON requirements have posed very high entry barriers.[162]

VI. CONCLUSION

Hospital mergers may pose the same sorts of competitive risks that other mergers pose. To the extent that the market structure becomes less competitive, one may argue that mergers may substantially lessen competition or tend to create a monopoly. When hospital mergers fall short of monopoly, the greatest competitive danger is that the remaining hospitals will collude. Since hospitals have banded together historically to solve joint problems, this danger is quite real. Some hospitals have exchanged wage and price data[163] and entered

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161. *See* Landes & Posner, *supra* note 1.

162. *See also In re* American Medical Int'l, 104 F.T.C. 1 (1984) (market allocation agreement is suspect); *see generally* Gross, *Certificate of Need: Background and Review of Recent Changes in Florida's Law*, 2 U. FLA. J.L. & PUB. POL'Y 183 (1988-89).

163. Exchanges of price data tend to be suspect. *See* United States v. Container Corp. of Am., 393 U.S. 333 (1969); United States v. United States Gypsum Co., 438 U.S. 422 (1978).

into anticompetitive market allocation agreements.[164] Moreover, hospital administrators have often joined forces in opposing CON applications of other hospitals.[165] Thus, it is appropriate for the antitrust authorities to remain vigilant.[166] Hospital competition can be beneficial and should be preserved and protected.

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164. These are also suspect. *See* United States v. Topco Assoc., Inc., 405 U.S. 596 (1972).

165. This behavior is protected by the Noerr-Pennington doctrine. *See* Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127 (1961); United Mine Workers of Am. v. Pennington, 381 U.S. 657 (1965). The doctrine permits joint efforts to petition a government agency.

166. There is some evidence that the Department of Justice has maintained its vigilance. It has challenged two hospital mergers: United States v. Carilion Health Sys., 707 F. Supp. 840 (W.D. Va. 1989), which it lost, and United States v. Rockford Memorial Corp., 717 F. Supp. 1251 (N.D. Ill. 1989), which it won.