The mid-1990s saw an unprecedented wave of hospital mergers in response to the revenue squeeze of lower utilization rates under managed care and reduced reimbursement from government programs, and the costs associated with the greater availability of expensive medical technology.

Against this backdrop, antitrust regulators permitted many hospitals to combine with the hope they would be able to accomplish clinical and cost-saving efficiencies. It was anticipated that any increase in the market power that the merged hospitals would have would be offset by the significant bargaining power of HMOs. In the few mergers they did challenge, antitrust regulators had a difficult time convincing courts that a proposed merger would cause a sufficient lessening of competition to warrant pre-merger intervention.¹

Now concerned about a renewed rise in medical costs, Federal Trade Commission Chairman Timothy J. Muris has recently announced an initiative by the FTC to examine whether previous mergers have accomplished the hoped for efficiencies or have simply enabled hospitals to increase their charges to payors.¹ The FTC has begun this initiative with an investigation of post-merger market conduct involving the now combined Evanston Northwestern Healthcare and Highland Park Hospital in the suburbs of Chicago. The staff has sought documents from the hospitals and from several major health plans that reportedly complained about post-merger price increases.¹ Reportedly, the FTC also is investigating the post-merger effects of the 1997 merger of two acute care hospitals in Poplar Bluff, Missouri,¹ a combination that the FTC had sought to enjoin but was rebuffed by the Eighth Circuit.¹

The FTC has taken the position that it retains the power to examine combinations that were under review even after they were allowed to proceed.⁶ While one can question whether it is good public policy to allow combinations to proceed and then re-examine them after they have occurred, or whether effective remedies are even available at that late date, it is clear that the antitrust agencies are not legally estopped from examining the effects of a merger that they permitted to proceed.

Former FTC Chairman Robert Pitofsky justified using this approach where the anticompetitive effects of a merger were uncertain or novel, and where substantial efficiencies were claimed, because it permitted the parties to proceed with their intended transaction. He noted that an indirect benefit of this enforcement policy was that "parties claiming efficiencies or brushing off the possibility of anticompetitive practices may be induced in the years following the merger to pursue more aggressively the efficiencies or avoid more carefully anticompetitive effects."⁷ Responding to criticism that such a policy placed the FTC in the role of regulator rather than law-enforcer, he stated that, by announcing an intention to re-examine an approved merger at the time it closes its merger investigation, the FTC puts the parties on notice that at some future time – two, three or four years down the road – it intends to revisit the market segment and the transaction to see if the transaction and others like it led to anti-
competitive effects. In the meantime, as always, Commission staff would investigate any complaints that anticompetitive effects have emerged.\(^1\)

Likewise, a collateral effect of the FTC’s announced “subsequent review” of hospital mergers, even belatedly, may be to promote self-restraint by some hospitals in contracting practices and to reinvigorate the search for cost-saving efficiencies.

This article discusses the remedies available to the FTC as it goes forward with this initiative, and suggests issues that will be open to re-examination with respect to these merged hospitals.

The FTC’s Enforcement Arsenal

Section 7 of the Clayton Act prohibits any person from combining with or acquiring the assets of another person if “the effect … may be substantially to lessen competition, or to tend to create a monopoly.”\(^9\) With the pre-merger notification required by the Hart-Scott-Rodino Antitrust Improvements Act of 1976, the antitrust agencies have greater advance information about intended combinations and can seek injunctive relief, under § 7 of the Clayton Act, in advance of the transaction. Although pre-merger enforcement is the more regular practice, the Supreme Court has held that divestiture is a remedy available under § 7 of the Clayton Act to remedy an anticompetitive combination.\(^10\)

In addition, § 5 of the Federal Trade Commission Act empowers the FTC to restrain a party from engaging in “unfair methods of competition.”\(^11\) Practices that do not violate the Sherman and Clayton Acts may nonetheless violate § 5 of the FTC Act.\(^12\) Because of the additional flexibility of § 5 of the FTC Act, the showing that the FTC would be required to make in an administrative proceeding under that statute would be less demanding than the more stringent proof required in a monopolization or attempted monopolization claim under § 2 of the Sherman Act or a claim of an unlawful combination under § 7 of the Clayton Act.

The FTC will also have certain procedural advantages in proceeding under § 5 of the FTC Act. A proceeding under § 5 of the FTC Act is an administrative proceeding in which the formal rules of evidence do not apply.\(^13\) Orders of the FTC are subject to judicial review. However, a finding of a violation will be sustained so long as it is supported by “substantial evidence,” which is not a terribly demanding standard.\(^14\)

The FTC has wide discretion in fashioning a remedy that will bring to an end a trade practice found to be unfair or that is necessary to restore competition. Its remedial powers are not limited to prohibiting a recurrence of the specific conduct found to be offensive. The FTC has a wide array of equitable remedies available to restore competition: structural remedies such as divestiture and dissolution; and conduct remedies that may impose restrictions on business practices. The Commission has used structural remedies in health care markets to order the divestiture of a hospital acquired in violation of § 7 of the Clayton Act,\(^15\) and to impose limitations on the size of physician groups so as to reduce their market power.\(^16\) Commission orders frequently include “fencing-in” remedies, i.e., provisions that impose restrictions on business practices that might otherwise be lawful.\(^17\) In consent orders in the health care industry, the FTC has included provisions that restrict contracting practices, and provisions that would permit payors to terminate, without penalty, contracts entered into during the period the anticompetitive conduct was being practiced.\(^18\) Remedial orders of the FTC are subject to judicial review but an order will be sustained if it bears a “reasonable relation” to the violation and the need to prevent a recurrence of the offending conduct.\(^19\) Violation of an FTC order is punishable by civil monetary penalties of up to $10,000 per day for continuing violations.\(^20\)

Proceeding under § 5 of the FTC Act, the staff of the Commission will have greater flexibility in the cases that it brings and the remedies it can obtain, and be subject to a less demanding standard of proof than an enforcer would be subject to in bringing a conventional antitrust suit in federal court.

The issue remains as to what remedy for anticompetitive effects would be effective to restore competition. Divestiture can be an effective remedy in some, but certainly not all, situations. In many situations, it will no longer be possible to “unscramble the egg” of the combined hospitals because there has been sufficient integration and elimination of duplicative medical and management personnel to make a separation of the hospitals too costly to produce a reduction in hospital rates in the near term.\(^21\) Furthermore, in some situations, a merger was seen as a way of eliminating duplicative costs because one of the hospitals was already an inefficient and weak competitor or because the market was “over-bedded.” In a number of litigated mergers, the hospitals asserted some variation on a “failing company” defense—that is, that one of the hospitals would close or would not be a viable competitor if it were compelled to continue to operate independently.\(^22\)

Restoring the status quo ante, even if possible, will not assure vigorous price competition where one of the hospitals was having difficulty in maintaining its competitive position because of financial weakness, size, limited facilities or servic-
es, or reputation. Forcing the divestiture of a hospital that had not been able to succeed or which could not be viable as a free-standing competitor would not be a productive remedy.

As an alternative, if there has been an abuse of market power by the combined hospital, the FTC may seek to impose contracting restrictions. However, given the FTC’s aversion to being cast in the role of regulator, it is difficult to anticipate what conduct remedies it would be prepared to advocate – particularly in proceedings that are contested rather than resolved by consent order.

The Likely Areas of Interest in Re-examining Hospital Mergers

Many of the same concerns raised in pre-merger investigations of hospital combinations will reappear as subjects of inquiry in revisiting those combinations. This already is evident in the reports of the documents being requested from the earliest hospitals to receive FTC requests for disclosure. One difference, however, is that arguments will be less theoretical, since now there will be empirical data from which to assess actual market effects and cost-saving efficiencies.

Has There Been a “Lessening of Competition”? A combination whose effect “may be to substantially lessen competition” is unlawful under § 7 of the Clayton Act. One of the ways in which a party can establish a prima facie case is to demonstrate that the merged entities will have a significant percentage of the relevant market, enabling them to raise prices above competitive levels. The Horizontal Merger Guidelines, promulgated jointly by the Justice Department and the FTC, measure the concentration of the relevant market before and after the proposed transaction. Antitrust agencies attempt to assess whether the increased concentration of the market through the combination is likely to have an adverse effect on competition.

One of the ways in which competition could be adversely affected is if the merged firm could find it profitable following the transaction unilaterally to raise prices or to suppress output. This analysis entails a theoretical examination of whether the merged firm could adopt such a strategy without existing competitors or new market entrants taking away sufficient business to render that strategy unprofitable. This analysis should not be based upon a “static” view of the market, but should consider how the market would reposition itself if a “hypothetical monopolist” were to impose a “small but significant and nontransitory” increase in price. Inherently, prior to a proposed transaction, this analysis is predictive and theoretical.

In enjoining the proposed merger in United States v. Rockford Memorial Corporation, 898 F.2d 1278 (7th Cir. 1990), Judge Posner expressed frustration in attempting to predict the consequences of proposed hospital mergers in the absence of empirical evidence:

It is regrettable that antitrust cases are decided on the basis of theoretical queries as to what particular market-structure characteristics portend for competition… We should like to see more effort put into studying the actual effect of concentration on prices in the hospital industry as in other industries. If the government is right in these cases, then, other things being equal, hospital prices should be higher in markets with fewer hospitals. This is a testable hypothesis by modern methods of multivariate statistical analysis, and some studies have been conducted correlating prices and concentration in the hospital industry.

898 F.2d at 1286.

In revisiting the post-transaction marketplace, the FTC would be able to assess theoretical arguments with a broad spectrum of data. In a pre-transaction challenge to a merger, enormous effort is spent on defining the relevant product market (e.g., tertiary care, specific services) and geographic market. It was sometimes argued that one or more hospitals in the relevant geographic area had under-recognized capabilities in particular services that would provide a competitive alternative to the merged hospital. Frequently, the antitrust enforcement agencies failed to persuade courts of their theory of market definition. The FTC has taken the position, however, that where it can show after administrative investigation that there were “actual sustained adverse effects on competition,” then it need not engage in elaborate market analysis.

It also frequently has been argued in the 1990s that post-merger hospital pricing would be constrained by the significant and growing purchasing power of managed care plans. Among other things, it was contended that heavily-managed HMOs had sufficient control of their members’ hospital admissions to be able to “steer” their insureds away from hospitals that were charging non-competitive rates and thereby cause a “critical loss” of admissions that would render a monopolistic increase in price ineffective or unprofitable. The validity of that argument depends on there being alternative hospitals in the area for the HMO to use for the affected services. Often in advance of a merger they opposed, HMO representatives would profess that they would sooner absorb a price increase than “steer” patients to other area hospitals.
Revisiting a marketplace following a merger, the FTC will have access to actual admission and discharge data to determine where patients are being drawn from, their geographic distribution, the services they receive and their payors (e.g., Medicare, indemnity, HMO).

The FTC also will be able to obtain testimony and data from HMOs as to the willingness and ability of HMOs to use a “steering” strategy to discipline price increases in a given market. To the extent that there have been changes in prices in comparable markets that have not experienced similar increases, multivariate analysis would be required. Price studies could be done to measure prices and expenditure in hospital rates (where there has been such an increase) to determine, based upon empirical evidence, if there is a causal connection between those increased rates and any reduction in competition resulting from the merger.

A widely publicized September 2002 report by the Center for Studying Health System Change made several key findings:34

- spending on health care increased 10% in 2001,
- there was a 15% average increase in the cost of employer-sponsored health insurance in 2002;
- spending on inpatient and outpatient hospital care increased by 12%;
- spending on outpatient hospital care grew 16.3%, accounting for 37% of the overall health care spending increase; it was the fastest growing component of overall spending, surpassing even prescription drugs;
- spending on inpatient care jumped 7.1% in 2001, accounting for 14% of the overall spending increase, and growing at almost three times the 2000 rate.

The study found that hospital rates increased, but also found these additional facts that complicate the picture:

- hospital payroll costs grew 8.6% in 2001, more than double the 3.7% increase in 2000; and
- there was an increase in utilization of tests and treatments as managed care has grown less restrictive; and

Further complicating the analysis, public agencies have raised concerns that anticompetitive practices – in addition to mergers – have contributed to increases in hospital costs and, ultimately, hospital rates.35 All of this underscores that the FTC cannot rely upon a simplistic post hoc ergo propter hoc argument that, because there has been a hospital merger and a rate increase, the two are therefore causally connected.

Using the greater flexibility in § 5 of the FTC Act, the staff can be expected to attempt to change the playing field for assessing the competitive effects of hospital mergers. There also will be empirical data and evidence of actual contracting experience on which the FTC, and ultimately the courts, can better assess whether a particular merger has lessen competition.

**Have the Anticipated Efficiencies Been Achieved?**

Merging firms often argue that any anticompetitive effects will be offset by the efficiencies that result from the proposed combination. The Horizontal Merger Guidelines recognize that “mergers have the potential to generate significant efficiencies
by permitting a better utilization of existing assets, enabling the combined firm to achieve lower costs ... than either firm could achieve without the proposed transaction.” Part of the rationale for considering efficiencies is that marginal cost reductions may reduce the merged firm’s incentives to raise prices.36 In the Horizontal Merger Guidelines, the antitrust agencies state that they will consider only those “merger-specific” efficiencies — efficiencies that are unlikely to be accomplishable absent a combination — that are verifiable.37 Courts have considered efficiencies as a means to rebut the government’s prima facie case that a merger will lead to increased prices.38

In order to secure state regulatory approval or to obtain state and local support for their transaction, merging hospitals often promoted their combination as being in the public interest. In some instances, merging hospitals pledged to achieve certain cost reductions and apply those savings to public health programs.39 Since there often was an open question as to whether cost-savings would be passed on to consumers, these undertakings by the merging hospitals “guaranteed” a minimum payment irrespective of whether cost-savings actually were accomplished. Because state health officials and local communities often have different policy priorities than antitrust enforcement agencies, the promise of such savings and the enhanced funding of community health programs were effective in galvanizing support for hospital mergers.40

Often, the merging hospitals also have given undertakings with respect to their post-merger contracting practices with payors, and particularly with HMOs. For example, the merging hospitals in Butterworth gave an extensive commitment regarding its post-merger conduct if no injunction issued. The hospitals committed to (1) freeze or control rate increases for seven years; (2) impose a non-discriminatory ceiling on prices charged to managed care plans; (3) target the merged system’s total margin at a five-year rolling average that does not exceed the average of Moody’s and Standard & Poor’s upper quartile total margins for other health systems nationally; (4) triple their annual funding of community based clinics and similar programs; (5) have the post-merger governing board reflect a spectrum of the local community; and (6) implement structural and operational changes, including management and clinical consolidation. 946 F.Supp. at 1304-09. The Court noted that these commitments amounted to $170 million over the first five years, which meant that “all of the merger related efficiencies calculated by the consultants will be transferred to the community through revenue reductions, or additional services to the underserved.” Id. at 1307 n.8. Although the District Court denied the FTC’s motion for a preliminary injunction, the Court made this commitment an order of the Court. Similarly imposing a limit on rate increases, the consent orders obtained by the Pennsylvania Attorney General limited the merged hospitals’ “case-mix adjusted net inpatient revenue per admission” for five years to an amount equal to a formula adjusted for changes in the American Hospital Association’s Hospital Market Basket Index.41

In revisiting merged hospitals after their consolidation, the FTC staff will be able to assess whether undertakings given have been adhered to, and whether anticipated efficiencies have been achieved and whether they have been passed along to mitigate pressures to increase rates. The argument is also made that non-profit hospitals have a community mission and do not behave in the same way as profit-maximizing organizations.42 The FTC will be able to assess whether there is a greater pass-through of cost-savings in non-profit hospitals, and whether that pass-through is used to hold down hospital rates (an objective of the antitrust laws) or is spent on community needs without benefiting payors.

In many instances, it simply may not be possible to realize the full measure of efficiencies that had been anticipated. Many efficiencies studies prepared in the mid-1990s were based upon assumptions about then prevalent market trends it was assumed would continue or accelerate. For example, fearing more heavily restricted managed care, and perceiving opportunities in entering into risk-bearing relationships with managed care companies, some hospitals (including merging hospitals) in the mid-1990s entered into alliances with or created physician practices that would be referral sources and be available for outpatient care. At significant cost, hospitals formed physician-hospital organizations (PHOs) and management service organizations (MSOs). Avoiding duplicative costs in creating the infrastructure to support these vertical arrangements with physicians became a further efficiency that would potentially result from a combination of area hospitals. However, as the market changed, many of these alliances proved to be unprofitable cash drains, and were abandoned either during their start-up years or even before implementation. In any event, economies of scale from combining hospitals’ efforts in these areas did not produce the projected savings.43 As the FTC examines projected efficiencies, it cannot judge them in the cruel light of perfect hindsight.
In revisiting hospital efficiencies, the FTC may find a number of very different situations: (1) situations where hospitals have not been able to achieve claimed efficiencies (a) because they are not really there to be had, or (b) because they have not been implemented; or (2) situations where hospitals have achieved cost-savings but have elected not to pass those savings along in the form of reduced rates — in some instances, because those savings have been invested in improved services or public health programs.

If the FTC involves itself too directly in remedying perceived failures to deliver on efficiencies claims, it will find itself in the role of a rate regulator, a mission that the FTC usually prefers to avoid. Another difficulty in fashioning a remedy based upon realizing greater efficiencies is that the FTC is not equipped to substitute its judgment for that of hospital management and will not want to be seen as usurping that role. Where the FTC is more likely to be successful with a remedy directed at efficiencies is where the hospitals themselves have developed a plan, but have been dilatory or internally resistant to implementing it.

Has There Been a True Merger of the Hospitals?
Hospital combinations assume a variety of organizational structures: some may be outright mergers; others may be combined into multi-hospital systems, with different degrees of retained management autonomy; others may be combined into a loose confederation. When area hospitals combine, it is a challenge for management to balance long-standing institutional pride (and rivalries) with the needs and promise of a combined institution. This challenge is likely to be most acute in combining teaching hospitals that have affiliations with different medical schools.

Antitrust enforcement agencies have had a concern about hospital “virtual” mergers; that is, combinations of hospitals that do not result in the formation of an integrated “single entity.” As they view it, if the combination does not result in a single entity, the coordinated actions of the hospitals can be a “contract, combination or conspiracy” in restraint of trade and potentially a violation of § 1 of the Sherman Act. If the post-transaction combination results in a true single entity, that entity would not be legally capable of conspiring and the combined hospitals would have a joint interest in the pricing and sale of their common product. Antitrust enforcers contend that loose confederations of autonomous hospitals, particularly those that retain separate financial interests and do not share risk, are not a single entity and can violate the antitrust laws through their joint pricing and negotiating with managed care companies, and in jointly refusing to deal with or credential other providers. A loose confederation of hospitals, without meaningful integration and risk sharing, is not greatly different, conceptually, from physician networks that the FTC has challenged on the same grounds — that they restrain pricing without enhancing efficiencies.

In New York v. St. Francis Hospital, two troubled hospitals in Poughkeepsie, New York applied for a certificate of need (CON) to jointly provide diagnostic catheterization, MRI, and mobile lithotripsy services, after state authorities had suggested that they formulate a plan to implement a cardiac catheterization laboratory at only one hospital. The hospitals also applied for, and obtained approval, of a joint venture, Mid-Hudson Medical Center, that would not have “...any physical facility or staff of its own” but instead would be “empowered with shared operational and management authority for new clinical services for each of the sponsoring hospitals...” In their CON application, the hospitals stated that the board of Mid-Hudson would be responsible for “assuring fairness to each hospital through adoption of a ‘fairness formula’ — a doctrine that guarantees each hospital a fair share in the financial losses and gains resulting from alterations in services” and that Mid-Hudson would “…strive to maintain the necessary inpatient and outpatient activity levels at [the two hospitals] (currently 40/60 market-share split respectively) to ensure balanced financial performance.” The “Fairness Formula” allocated revenues based on relative market share, adjusting for certain variable costs and capital investments in establishing a “center of excellence.” The parties could not argue that, by this arrangement, they had become a single entity. They did argue, however, that the nature of their joint venture militated for application of a rule of reason antitrust analysis under which its pro-competitive features and projected efficiencies could be considered to outweigh any restraint on competition between them. Rejecting a “state action” defense, the District Court found the arrangement to be a per se violation of the antitrust laws and granted summary judgment to the New York Attorney General.

Another informative enforcement action involving a “virtual merger” is shown by the Department of Justice, Antitrust Division’s recent enforcement of its consent judgment in United States v. Morton Plant Health System, Inc. There, two hospitals were enjoined from merging but had been specifically permitted to form a partnership to consolidate, jointly operate and sell to the constituent hospitals at cost (1) certain patient care services, and (2) certain administrative services. The consent judgment prohibited concerted action in managed care contracting. The Antitrust Division’s subsequent investi-
gation found prohibited joint activity. To resolve this violation, the hospitals agreed to pay nearly $200,000 for the costs of the investigation and to pay a civil penalty of $300,000 to be used for indigent health care in the local area. They also agreed to be barred from contracting for any services jointly, to permit payors to terminate existing agreements without penalty, to be barred from contracting through a local hospital network, and to divest to one of the two constituent hospitals certain outpatient clinics operated jointly by them.53

There has been a suggestion that redundancies in clinical and medical education areas are the most difficult for a hospital system to eliminate. One can readily see how it is easier to combine laundry or administrative support services in two academic hospitals than it is to designate a single head of a medical service or to eliminate a service or laboratory at one of two prestigious hospitals.54 Yet, it is these economies that may hold significant promise for unrealized cost-savings, and that may have been identified as areas for cost-savings in the hospital’s pre-merger efficiency study but not been acted upon. The FTC may take the position that the failure to complete an integration of the hospitals means that (1) no true merger has been accomplished and that therefore the “merged” hospitals are engaging in an “unfair method of competition” and prohibited joint activity in their contracting with payors, and (2) the hospitals still are susceptible of separation through a divestiture order because “the egg has not really been scrambled.” Likewise, the threat of the drastic remedy of a divestiture in this situation may propel hospitals to overcome institutional inertia and internal rivalry to achieve efficiencies that, though painful, would permit more moderate pricing.

Conclusion

In re-examining hospital mergers, the FTC will have available to it a wealth of empirical data which will make the analysis of competition less theoretical. To establish meaningful proof that hospital mergers have lessened competition, the FTC will need to develop benchmarks that permit an inference that the decreased competition between the now-merged hospitals actually caused increased prices. But, even if that causal connection is shown, the issue will remain as to what remedies realistically can be devised to restore competition or, at least, assure that cost-savings are passed along to consumers. As is often the case, the pressure of an investigation may lead to creative results in the form of consent orders. In any event, the FTC’s threats of investigation will cause hospital boards and administrators to revisit the goals they intended in undertaking the merger.

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Footnotes:


5. Tenet, 186 F.3d 1045 (8th Cir. 1999).


The Hart-Scott-Rodino process has made it both possible and mandatory to review the vast majority of significant mergers in advance … Moreover, history has demonstrated that it can be difficult to obtain effective post-merger relief. For these reasons, the agencies may have tended to de-emphasize scrutiny of consummated transactions. Conditions are somewhat different now, and the Chairman of the Commission has already expressed an interest in some post-transaction reviews. One advantage of post-hoc review, of course, is that it can focus more on history than on predictions. It is likely that caveats [about post-merger review] of the kind expressed in the separate statements here will become more common in the future.

See also PepsiCo, Inc./The Quaker Oats Co., 2001 WL 867038 (FTC Aug. 1, 2001).


8. Id.


13. See, e.g., FTC v. Cement Institute, 333 U.S. 683, 705-06 (1948); Concrete Materials Corp. v. FTC 189 F.2d 359, 362 (7th Cir. 1951).

14. Colonial Stores v. FTC, 450 F.2d 733, 739-40 (5th Cir. 1971). See also Montgomery Ward & Co. v. FTC, 691 F.2d 1322, 1327 (9th Cir. 1982); Borden, Inc. v. FTC, 674 F.2d 498 (6th Cir. 1982).


17. These remedies derive their name from FTC v. National Lead Co., 352 U.S. 419, 431 (1957), in which the Supreme Court confirmed the authority of the FTC to impose remedies that extend beyond the specific conduct found to be unlawful, stating: “[R]espondents must remember that those caught violating the [FTC] Act must expect some fencing in.” (emphasis added).


19. Courts have modified or vacated FTC orders that are overbroad. In Marco Sales Co. v. FTC, 453 F.2d 1 (2d Cir. 1971), the Second Circuit remanded to the FTC a cease and desist order which seemed to arbitrarily prohibit the petitioner from engaging in a business practice permitted to the rest of the industry. But see Porter & Deutsch, Inc. v. FTC, 605 F.2d 294, 307 (7th Cir. 1979) (“The fact that other firms in the market are not similarly burdened does not affect the validity of this order.”)


21. See, e.g., FTC v. Staples, Inc., 970 F.Supp. 1066, 1090 (D.D.C. 1997) (“‘Unscrambling the eggs’ after the fact is not a realistic option” because “it is extremely unlikely … that the merger could be effectively undone and the companies divided if the [FTC] later found that the merger violated the antitrust laws.”).

22. See, e.g., California v. Sutter Health System, 130 F Supp. 2d 1109, 1133-36 (N.D. Cal. 2001) (revised decision), aff’d without published opinion, 217 F.3d 846 (9th Cir. 2000) (“Sutter Health System”); Freeman, 69 F.3d at 272 (factor militating for denial of preliminary injunction was that, given its financial condition, one hospital may not remain in business through an FTC administrative proceeding). C.f. Tenet, 186 F.3d at 1055 (market may not be capable of sustaining two high-quality hospitals).


24. As a condition of permitting a merger, the Pennsylvania Attorney General included limitations upon hospital rate increases as part of a consent order, but this was not an approach favored by the FTC. See note 39 infra and accompanying text. In Buttenworth, the hospitals offered an undertaking that included limitations on rate increases but the FTC persisted (unsuccessfully) nonetheless.


26. Horizontal Merger Guidelines, 4 Trade Reg. Rptr. (CCH) ¶ 13,104.

27. Horizontal Merger Guidelines, § 1.11 (usually an ‘increase of five percent lasting for the foreseeable future’). See also Toys Markets, Inc. v. Quality Markets, Inc., 142 F.3d 90 (2d Cir. 1998); International Distribution Centers v. Walsh Trucking Co., 812 F.2d 786, 792 (2d Cir. 1987) (an inference of monopoly power is drawn only after considering relevant market conditions, in addition to market share, such as “the strength of the competition, the development of the industry, the barriers to entry, the nature of the anticompetitive conduct and the elasticity of consumer demand.”)

Barriers to entry for new hospitals are high; in addition to the enormous costs involved in building a new hospital, there are regulatory requirements which typically include a showing of community need for additional capacity. In view of the fact that many areas are “over-bedded” and that this under-utilization of existing capacity contributed to the market conditions impelling hospital combinations, a court would not likely find that ease of entry mitigates a finding of a dominant market share. See, e.g.,
FTC v University Health, Inc., 938 F.2d 1206, 1211 (11th Cir. 1991).

28. Patient discharge data typically is used as a starting point for delineating the relevant geographic market. Patient origin studies for the merging hospitals determine (1) the percentage of patients residing within the hospital's area who remain in the area for hospital services, and (2) the percentage of patients served by area hospitals who are residents of the area (a version of the Elzinga-Hogarty test). The preliminary market definition encompasses an area where the percentage of these patients' inflows and outflows reach between 75 and 90%. This approach is a widely used tool but, because it is historic and does not take into account consumer reaction to a hypothetical post-merger price increase, it has been criticized as too static a measurement when used alone. See, e.g., Freeman, 69 F.3d at 269; Sutter Health System, 130 F. Supp. 2d at 1120-32; Mercy Health, 902 F. Supp. at 978.


30. See generally Freeman, 69 F.3d at 270 n.14; Sutter Health System, 130 F. Supp. 2d at 1129-30. Cf. Tenet, 186 F.3d at 1054.


The FTC’s re-examination of Poplar Bluff will potentially raise issues of post-merger re-positioning. Ironically underscoring that pre-merger challenges are, at best, predictive, one reason given by the Eighth Circuit for reversing the injunction against the Poplar Bluff merger was that “[t]he reality of the situation in our changing healthcare environment may be that Poplar Bluff cannot support two high-quality hospitals.” Tenet, 186 F.3d at 1055 (emphasis supplied).

About two years after the injunction granted to the FTC was reversed and the merger allowed to proceed, a joint venture of a local physician practice and a hospital 90 miles away in Cape Girardeau, Missouri announced plans to build a new 35-bed hospital in direct competition with the merged hospital. M. Taylor, “Big Brewings in a Small Town,” Modern Healthcare, April 8, 2002, p. 20.

32. R. Pitofsky, “Subsequent Review,” 1995 WL 462251 at * 5 (FTC Aug. 7, 1995)(“It may be difficult several years later to identify cause and effect …. But economic cause and effect is a constant problem in enforcing competition laws.”)

33. By way of example, in its challenge to the Staples/Office Depot merger, the FTC presented studies of pricing in geographic markets where there were one, two and three competitors. See FTC v. Staples, 970 F.Supp. at 1075-78. The FTC’s economic expert testified that the merger would raise prices on average by 9% in markets in which Staples and Office Depot stores overlapped. See J. Baker, “Econometric Analysis in FTC v. Staples” available at www.ftc.gov/speeches/other/stspch.htm.


35. For example, an examination of hospital group purchasing organizations (GPOs) in the spring and summer of this year, suggested that cost-savings were not being realized by conflicts of interest and self-dealing involving manufacturers who both supplied and financed the GPOs. The GPOs long-term exclusive contracts with manufacturers raised questions about whether these organizations were finding the best products at the lowest price. See, e.g., “A Mission to Save Money, A Record of Otherwise,” N.Y. Times, June 7, 2002, C-1. The New York Attorney General has opened an inquiry into the business practices of GPOs. N.Y. Times, September 7, 2002, B-2, c.1.

36. Horizontal Merger Guidelines, § 4. It is argued, however, that there will be an incentive to pass-through of those cost-savings to consumers only if there is still price competition in the post-merger marketplace.

37. The Horizontal Merger Guidelines § 4 give the following guidance as to the types of efficiencies that are likely to be cognizable:

“[E]fficiencies resulting from shifting production among facilities formerly owned separately, which enable the merging firms to reduce the marginal cost of production, are more likely to be susceptible to verification, merger-specific, and substantial, and are less likely to result from anticompetitive reductions in output. Other efficiencies, such as those relating to research and development, are potentially substantial but are generally less susceptible to verification and may be the result of anticompetitive output reductions. Yet others, such as those relating to procurement, management or capital cost are less likely to be merger-specific or substantial, or may not be cognizable for other reasons.”

In a recent divestiture proceeding, FTC complaint counsel took the following position:

“Efficiencies are not cognizable where they would not “be sufficient to reverse the merger’s potential to harm consumers in the relevant market, e.g., by preventing price increases in that market.” Merger Guidelines § 4. Accordingly, efficiencies that reduce only fixed costs are disregarded because they do not lower the variable costs of production, and therefore are
unlikely to benefit consumers. In contrast, efficiencies that reduce the variable cost of production are far more likely to be passed along to consumers.”

Complaint Counsel’s Pre-Trial Proposed Conclusions of Law in MSC.Software Corp., 2002 WL 1425540.
39. In Pennsylvania v. Providence Health System Inc., 1994-1 Trade Cas. (CCH) ¶70,603 (M.D. Pa. 1994), the Pennsylvania Attorney General filed a federal antitrust suit and simultaneously filed a consent judgment with respect to the merger of hospitals in the Williamsport area. The merged hospital system pledged to achieve $40 million in savings in the first five years, of which 60% in the first year and 80% in the next four years were to “be passed on to consumers or other purchasers of health-care services in the form of low-cost or no-cost health-care programs for the community or by reducing prices or limiting actual price increases for existing services,” with an absolute obligation to pay an amount equal to the shortfall in the $40 million if the cost savings were not achieved. In addition, the merged hospital agreed to “attempt, in good faith, to contract with all health plans operating in its service area which offer commercially-reasonable terms on a fully-capitated basis, a percentage of premium reimbursement methodology.” A similar consent judgment was entered in Pennsylvania v. Capital Health Systems Services, M.D. Pa., 4 CV-95-2096 with respect to the merger of hospitals in the Harrisburg area.

The merging hospitals in U.S. v. LIJ, 983 F. Supp. at 148, agreed with the New York State Attorney General that they would pass along $100 million in cost savings over five years, and guaranteed $50 million to serve the economically disadvantaged and elderly members of the community.

Upon the merger of Moses Cone Health System and Wesley Long Community Hospital, which together accounted for 70% of the acute care beds in the Greensboro, North Carolina vicinity, the hospitals funded a $50 million endowment to support women’s health and indigent care programs.

40. In litigated challenges to proposed mergers, courts have attached weight to these public interest commitments as reasons to deny an injunction, even if they did not rise to the level of an “efficiencies” defense. See, e.g., Butterworth, 946 F. Supp. at 1300; U.S. v. LIJ, 983 F. Supp. at 148.
41. See, e.g., Pennsylvania v. Providence Health System, 1994-1 Trade Cas (CCH) at 72, 288-89 (¶¶2.3-12.6).
44. Id.
45. A recent analysis of academic medical center (AMC) mergers reported savings of only 1-2 percent. There is evidence suggesting that efficiencies flow from clinical consolidation in merging hospitals. However, recent market studies of hospital mergers have noted the extreme geographic and political hurdles to getting clinical departments to consolidate.

Burns & Pauly, supra, text accompanying notes 27-29.
46. See, e.g., M. Botti, “Comments on the Antitrust Aspects of Hospital Virtual Mergers,” PLI Health Care M&A 2000, Department of Justice Documents, 1175 PLI/Corp. 205.
50. 94 F. Supp.2d 399 (S.D.N.Y. 2000).
51. The “state action” doctrine immunizes from antitrust liability conduct by state or private parties pursuant to a state regulatory program. To qualify for this immunity, (1) the challenged conduct must be “one clearly articulated and affirmatively expressed as state policy” and (2) “the policy must be ‘actively supervised’ by the state itself.” California Retail Liquor Dealers Assn
v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980) (emphasis supplied). The St. Francis Hospital Court held that the State’s approval of the CON did not amount to the “active supervision” required for antitrust immunity. St. Francis Hospital, 94 F. Supp. 2d at 410-11.

52. The two largest acute care hospitals in northern Pinellas County, Florida – Morton Plant and Mease – announced a merger that the Antitrust Division opposed. The hospitals consented to a judgment by which they were prohibited from merging, but were permitted to form a partnership to jointly operate and sell to the constituent hospitals at cost certain patient care and administrative services. The judgment specifically prohibited executives and members of the partnership from discussing other patient services and managed care contracting. In 1998, the hospitals sought the enforcement agency’s consent to a modification of the consent judgment to permit them to merge because of more recent changes in the local market that made a merger less of a competitive concern than it had been in 1994. That request led to a “subsequent review.”


54. See Rockford, 902 F. Supp. at 988 (“The most serious problem, which was not adequately addressed by the hospitals, is the ability of the DRHS Board to impose on the physicians and other parties the type of changes that will be required in order to achieve the efficiencies outlined in the [experts’ pre-mergers] reports.”).