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# Antitrust in Healthcare

## **FTC's Retrospective Review of Mergers**

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Hospital mergers and acquisitions can pose difficult antitrust issues, including questions of geographic market, product market, barriers to entry, competitive effects, and efficiencies defenses. The antitrust enforcement agencies have monitored hospital mergers for years, fearing that undue concentration of market power in local hospital markets would retard competition and result in higher prices. However, the enforcement agencies are on an almost decade-long losing streak. The agencies have lost cases in California, New York, Missouri, Michigan, Iowa, and elsewhere.

The losing streak included United States v. Long Island Jewish Medical Center, 983 F. Supp. 121, (E.D.N.Y. 1997); FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996), aff'd per curiam, 121 F.3d 708 (6<sup>th</sup> Cir. 1997); United States v. Mercy Health Services and Finley Tri-States Health Group, Inc., 902 F. Supp. 928 (N.D. Iowa 1995), vacated as moot, 107 F.3d 632 (8th Cir. 1997); FTC v. Freeman Hosp., 911 F. Supp. 1213 (W.D. Mo. June 9, 1995), aff'd, 69 F.3d 260 (8th Cir. 1995); FTC v. Hospital Board of Directors of Lee County, 1994-1 Trade Cas. ¶ 70,593 (M.D. Fla.); aff'd, 38 F.3d 1184 (11th Cir. 1994) (state action defense upheld). The California Attorney General also failed in a merger challenge in the Oakland-

Berkeley area in California v. Sutter Health System, 84 F. Supp. 2d 1057 (N.D. Cal. 2000).<sup>1</sup>

In the Long Island case, the Justice Department alleged that the proposed combination of two academic medical institutions would likely lead to higher hospital prices for health care consumers in the Long Island, New York area. The Department further alleged that the merging hospitals competed head to head to be the "flagship" or "anchor" hospital in the networks of hospitals that managed care companies assemble on Long Island. After a trial on the merits, the District Court granted judgment in favor of the defendants and dismissed the complaint. The court found no market for "anchor hospitals," found that for tertiary level services the market was larger than Long Island, and that for primary level hospital services the government had failed to show likely anticompetitive effects.

The FTC dropped its challenge to the hospital merger in Grand Rapids, Michigan, after its efforts to secure a preliminary injunction failed. The federal district court concluded that preventing managed care plans from obtaining price reductions would not harm competition since, in the court's view, these price reductions represent cost shifting to non-managed care

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<sup>1</sup> Successes had been achieved in some earlier cases: American Medical International, Inc., 104 F.T.C. 1 (1984); Hospital Corp. of America, 106 F.T.C. 361 (1985), enforced, 807 F.2d 1381 (7<sup>th</sup> Cir. 1986), cert. denied, 481 U.S. 1038 (1987); United States v. Rockford Mem. Corp., 898 F.2d 1278 (7<sup>th</sup> Cir.), cert. denied, 498 U.S. 920 (1990); but cf. FTC v. University Health, Inc., 938 F3d 1206 ((11<sup>th</sup> Cir. 1991).

patients. FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd*, 1997-2 Trade Cas. P 71,863 (6th Cir. 1997). The court also suggested that the community-oriented composition of the combined system's board of directors made it unlikely that the merged entity would impose harm on consumers through price increases.

In three other cases, the courts considered the government's definition of the geographic market to be too narrow, in part because the courts concluded that managed care plans could induce patients to travel considerable distances to obtain care. United States v. Mercy Health Services, 902 F. Supp. 968 (N.D. Iowa 1995); FTC v. Freeman Hosp., 911 F. Supp. 1213 (W.D. Mo.), *aff'd*, 69 F.3d 260 (8<sup>th</sup> Cir. 1995); Tenet Healthcare Corporation v. FTC, 186 F.3d 1045 (8<sup>th</sup> Cir. 1999), *rev'g*, 17 F. Supp.2d 937 (E.D.Mo. 1998).

In various of these cases, the judges found that the agencies' geographic market definition failed to consider referrals from clinics in fringe areas, the strong emphasis that hospitals place on expanding their service areas, and the willingness and ability of managed care enrollees and plans to make changes in their health care providers for financial reasons. The courts rejected arguments by the government that managed care plans were powerless to prevent imposition of price increases by the merged hospital systems.

For a while it seemed that the agencies were back on their heels and unlikely to tackle troublesome mergers. Even so, there was not a flurry of new hospital mergers. In fact, there has actually been a reduction in hospital merger activity. A few reasons seem to account for this.

First, much of the merger activity a few years ago seemed to be driven by a fear of Columbia HCA's expansion. Nonprofit hospitals seemed to think that by merging or forging joint operating agreements they could fend off entry or expansion of for-profit hospitals that they considered a danger. With the threat of Columbia receding, the merger and joint operating agreement ferment lessened. Also, many of the mergers and joint ventures that were forged over the past few years have unraveled. They may not have produced either the cost savings, efficiencies, or increased leverage that their participants had hoped for. Finally, in some recent cases, state antitrust enforcement scrutiny has contributed to abandonment of plans for combinations. The collapse of the planned affiliation of LifeSpan and Care New England in Rhode Island is an example of this. Also, in New York, the Attorney General acted decisively against a hospital joint operating arrangement or "virtual merger" that he alleged was, in effect, nothing more than a cartel arrangement. The challenge in Poughkeepsie to the combination of St. Francis Hospital and Vassar Brothers Hospital was successful. New York v. St. Francis Hospital, 94 F. Supp. 2d 399 (S.D.N.Y. 2000). The decision leaves open debate on the extent to which systems can

combine, but retain some autonomy, while still being viewed as a “single entity.” Also, the Department of Justice and the State of Florida forced two hospital systems in the Tampa/St. Petersburg area to reform their affiliation, after they had violated an earlier consent order. They had been permitted to merge some of their operations, while keeping others separate. They admitted violating the order, are paying a fine, and have agreed to additional reforms to foster a return of competition between them. U.S. v. Morton Plan Health System, Inc., Civ. A. No. 94-748-CIV-T-23E (M.D. Fla. July 12, 2000) (stipulated enforcement order agreement). In all three cases, health plans had actively urged enforcement officials to press forward with antitrust initiatives.

Now, moreover, health care markets have turned. Strong consumer demand for broad-based managed care networks appears to have given hospitals in general a stronger bargaining position with health plans. “Need to have” hospital systems appear to have leverage over health plans, and reportedly are exploiting that leverage with rapid and significant price increases. The FTC announced, and is now conducting active investigations of some of the consummated hospital mergers. It is looking at a number of mergers that were investigated at the time, but let through, and even at combinations that were unsuccessfully challenged. The litigated merger in Poplar Bluffs, Missouri is one focus. Others are in Wilmington, North Carolina and Evanston, Illinois. One is in California.

These investigations might produce enforcement actions against long-consummated mergers, or may only provide support for cases yet to be brought against some other merger in the future. The Commission staff is seeking to use sophisticated economic analysis of actual hospital pricing to test the competitive effects of these mergers.

These inquiries will help elucidate a number of issues:

- a) Is it appropriate to assess hospital geographic markets with a principal focus on the willingness of consumers to travel for lower cost or better quality care, or should the analysis focus on competition by hospitals in their dealings with managed care plans?;
- b) How does geographic distance and proximity bear on a managed care plan's ability to steer patients to lower cost hospitals within their networks, so as to discipline the higher priced hospitals in their networks?
- c) Will non-profit hospital systems with apparent market power forego price increases that a for profit system with the same level of power would impose?
- d) What is the relevance of a hospital system's non-profit status if the antitrust inquiry is into loss of competition, not into whether in the absence of competition, the surviving firm will abuse its power?
- e) If a non-profit system is permitted to merge to monopoly on the premise that it will use its power beneficently, what protection remains were that hospital system to be sold to a for-profit firm?
- f) Are tertiary and primary level hospital services really in separate product markets?

No complaint or report has yet been issued by the Commission. The FTC staff has issued a letter to the Attorney General of Louisiana regarding the proposed acquisition of Slidell Memorial Hospital by Tenet.

<http://www.ftc.gov/be/v030008.htm> The FTC staff concluded that the acquisition might reduce competition and harm consumers. Tenet owns NorthShore Regional Medical Center, the only other full service hospital in

Slidell. The FTC noted that residents of Slidell have benefited from the competition between Slidell Memorial and NorthShore. The staff emphasized an analytical model focusing on the pressure on managed care plans to have both hospitals in any managed care network, and on limited ability of health plans to engender patients to substitute use of other hospitals. The FTC also stated that specialty hospitals in Slidell are not adequate substitutes and competition from those hospitals would probably not prevent Tenet from increasing prices after the proposed acquisition.

The letter lays out the thinking of the FTC staff, and may set forth the intellectual framework for the Commission's planned initiative on re-invigorated hospital merger enforcement. The study results remain to be completed, to fill in the actual effects analysis.

When an action is brought, we may see a battle royale. One issue may be the relevance of post hoc price effects evidence. If the issue in a Clayton § 7 case is the likely effect of a planned merger, what is the relevance of factual occurrences after the merger happens? Is the relevant test what were the likely effects considered as of the time when the merger happened? Is it indirect evidence of what one might have predicted would happen, were one examining the market as it was when the merger occurred? Can the evidence be introduced directly as evidence of a continuing antitrust violation?

Another wrinkle is the hole in the FTC's jurisdiction for certain charitable organizations in non-merger matters. See 15 U.S.C. § 44 (definition of corporation). If a hospital combination does not involve a merger, consolidation or acquisition of assets, but rather some sort of joint operating agreement, the Commission may lack jurisdiction. There is particular reason, therefore, for an active enforcement role for the Department of Justice as regards hospital combinations.

And finally, I suppose, if the initiative bears fruit, I wonder if the Commission will expand its retrospective merger hunt to other industries, or even other segments of the health care industry.