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Hospital Mergers: The Symptoms of Anticompetitive Consolidation & A Routine Checkup on the Horizontal Merger Guidelines

Stefan Rao Kostas[a1]

In 2021, President Biden issued an executive order that addressed the negative implications of market concentration within the healthcare industry. Specifically, President Biden called for the revision of the Horizontal and Vertical Merger Guidelines to enact antitrust safeguards that limit unchecked hospital mergers and promote competition. This Article delves into the role of the healthcare sector in the U.S. economy and how the current state of hospital mergers limits competition and, thus, the quality of care available to patients. Further, this Article studies U.S. federal regulations, case law, and merger retrospectives to uncover pitfalls within the current Horizontal Merger Guidelines. In conclusion, this Article proposes adding hospital-specific language and more context for merger efficiencies to the guidelines as a remedy for its current anticompetitive consequences.

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INTRODUCTION

The financial condition of the American healthcare industry continues to grow wealthier yet contemporaneously reduces the quality of care that millions receive. This paradox is caused by the increasing monopolization of the healthcare system through hospital mergers and market concentration. According to the Federal Trade Commission ("FTC"), as of 2021, there were no longer any highly competitive health care markets in the country.[1] Hindering competition results in both higher prices and

[1] *See* Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, HEALTH AFFAIRS (Sept. 2017), https://www.healthaffairs.

barriers for alternative options to enter the market. Thus, within the healthcare industry, a lack of competition will likely require patients to pay increased prices for a diminished quality of care.

This Article argues that revised guidelines, with incorporated healthcare-specific language, is the best way to combat future anticompetitive effects of hospital consolidation. By providing distinct guidance to courts, agencies are better positioned to successfully prevent unchecked and unfettered hospital mergers. Specifically, courts need accessible regulations on how to define the geographic market of the hospital mergers under their consideration. Without this direction, courts are left to make impactful decisions solely on an interpretation of the antiquated Horizontal Merger Guidelines. Applying these changes will give courts and agencies the ability to better protect the United States ("U.S.") population's access to quality healthcare at reasonable costs.

This Article proceeds in four parts. Part I discusses the importance of healthcare to the U.S. economy and the essential role that hospitals play in the industry. Building on this background, Part I then considers the benefits of competition in healthcare, the current administration's concerns with unchecked hospital mergers, and relevant literature on the foregoing discussion. Part II analyzes the findings from the FTC's published merger retrospectives and explores the results of agencies in hospital merger litigation. Part III reviews the current Horizontal Merger Guidelines and identifies the limitations of its current approach. Part IV then provides an overview of what has been proposed by literature and recommends a revision of the Horizontal Merger Guidelines to address these shortcomings.

I. THE IMPLICATIONS OF HOSPITAL MERGERS IN THE HEALTHCARE INDUSTRY

Before exploring how the FTC has fared in preventing concentration and blocking hospital mergers, it is important to understand the background of healthcare in the U.S. and its relationship with the nation's economy. This Part discusses healthcare in the U.S., the role of hospitals within the industry, and how hospital mergers adversely impact patients. Additionally, it previews President Biden's 2021 executive order and his call to the agencies to reinvigorate antitrust enforcement.

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org/doi/10.1377/hlthaff.2017.0556; *see also Hospitals & Monopoly*, OPEN MARKETS INST., https://www.openmarketsinstitute.org/learn/hospitals-monopoly (last visited Oct. 7, 2022).

A. What is the Healthcare Sector's Share of the U.S. Economy?

The healthcare sector is vital to the pulse of the U.S. economy.[2] In most developed countries, healthcare consists of more than 10% of the gross domestic product ("GDP").[3] In the U.S., healthcare contributed to 18.2% of GDP in 2021 and is projected to reach 20% by 2028.[4] In conjunction with this proportion, healthcare has maintained its status as the largest U.S. employer for a number of years – employing 20.9 million individuals in 918,433 establishments in 2019.[5] Additionally, this sector accounts for 24% of government spending,[6] with health insurance serving as the largest component of nonwage compensation (26%) and healthcare comprising a large portion of consumer spending (8.1% of consumer expenditures)[7]. Thus, the growth and strategic decisions of the 784,626 players in the healthcare industry have significantly impacted the health of the U.S. economy and, further, its consumers.[8]

The importance of this industry, however, does not stop at its value to the economy, but extends to its effect on the daily life of the nearly 330 million that live in the U.S.[9] Access to healthcare is an important characteristic of a successful, developed country.[10] The Human

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2 Ryan Nunn et al., *A Dozen Facts About the Economics of the U.S. Healthcare System*, BROOKINGS INST. (Mar. 10, 2020), https://www.brookings.edu/research/a-dozen-facts-about-the-economics-of-the-u-s-health-care-system/.

3 Irene Papanicolas et al., *Health Care Spending in the United States and Other High-Income Countries*, THE COMMONWEALTH FUND (Mar. 13, 2018), https://www.commonwealthfund.org/publications/journal-article/2018/mar/health-care-spending-united-states-and-other-high-income.

4 *Forecasted U.S. Nat'l Health Expenditure as Percentage of GDP from 2021 to 2028*, STATISTA (Sept. 8, 2021), https://www.statista.com/statistics/934320/us-health-expenditure-as-percent-of-gdp-forecast/.

5 *2019 Country Business Pattern Now Available*, UNITED STATES CENSUS BUREAU (Apr. 22, 2021), https://www.census.gov/newsroom/press-releases/2021/county-business-patterns.html; *see also* Earlene K. Powell, *Census Bureau's 2018 County Business Patterns Provides Data on Over 1,200 Industries*, UNITED STATES CENSUS BUREAU (Oct. 14, 2020), https://www.census.gov/library/stories/2020/10/health-care-still-largest-united-states-employer.html.

6 *See* Ryan Nunn et al., *supra* note 2.

7 Lekhnath Chalise, *How Have Healthcare Expenditures Changed? Evidence from the Consumer Expenditure Surveys*, U.S. BUREAU OF LABOR STATISTICS: BEYOND THE NUMBERS (Nov. 2020), https://www.bls.gov/opub/btn/volume-9/how-have-healthcare-expenditures-changed-evidence-from-the-consumer-expenditure-surveys.htm.

8 *See* Smiljanic Stasha, *The State of Healthcare Industry – Statistics for 2021*, POLICY ADVICE (Mar. 5, 2022), https://policyadvice.net/insurance/insights/healthcare-statistics/.

9 *U.S. Health Care Coverage and Spending*, CONG. RSCH. SERV. (Apr. 1, 2022), https://sgp.fas.org/crs/misc/IF10830.pdf.

10 *Nutrition Landscape Information System – Human Development Index*, WORLD HEALTH ORG., https://www.who.int/data/nutrition/nlis/info/human-development-index.

Development Index ("HDI"), which ranks countries by human development, lists a "long and healthy life" as one of its three major dimensions for analysis.[11] For this prong, the HDI utilizes life expectancy as the key metric for assessing population health.[12] Over the years, the HDI has accumulated data on the strength of the link between healthcare expenditure and life expectancy.[13] In a study from 1995 through 2014, the HDI identified a trend that a population's life expectancy increases as countries spend more on healthcare.[14] The HDI, however, notes that the U.S. is an "outlier that achieves only a comparatively short life expectancy considering the fact that the country has by far the highest health expenditure of any country in the world."[15]

Currently, the national healthcare expenditure for the U.S. is estimated to reach $6.2 trillion by 2028.[16] The average per person spending on healthcare is $12,530 and far exceeds comparable, developed countries.[17] However, this increased spending does not necessarily equate to better outcomes or patient care. For example, within the Organisation for Economic Cooperation and Development ("OECD"), the U.S. has "among the highest number of hospitalizations from preventable causes and the highest rate of avoidable deaths."[18] Further, twenty-eight OECD countries

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11 *Human Development Index (HDI)*, UNITED NATIONS DEV. PROGRAMME, https://hdr.undp.org/data-center/human-development-index#/indicies/HDI (last visited Oct 7, 2022).

12 *See Human Development Index (HDI)*, INVESTOPEDIA, https://www.investopedia.com/terms/h/human-development-index-hdi.asp (last visited Sept. 6, 2022).

13 *See id*.

14 Pedro Conceição et al., *Human Development Report (2019)*, UNITED NATIONS DEV. PROGRAMME, http://hdr.undp.org/sites/default/files/hdr2019.pdf.

15 Esteban Ortiz-Ospina, *Global Health*, OUR WORLD IN DATA, https://ourworldindata.org/health-meta (last visited Oct. 7, 2022).

16 *See* Ricky Zupp, *US Healthcare Spending to Hit $6.2 Trillion by 2028; Growth Set to Outpace GDP*, S&P GLOBAL (Mar. 24, 2020), https://www.spglobal.com/marketintelligence/en/news-insights/latest-news-headlines/us-healthcare-spending-to-hit-6-2-trillion-by-2028-growth-set-to-outpace-gdp-57739003.

17 *Trends in Health Care Spending*, AMERICAN MED. ASS'N, https://www.ama-assn.org/about/research/trends-health-care-spending; *see also NHE Fact Sheet*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet (last visited Oct. 7, 2022).

18 Melinda K. Abrams & Roosa Tikkanen, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?*, THE COMMONWEALTH FUND (Jan. 30, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019.

have higher life expectancy figures than the U.S., which overall, is a concerning statistic considering none spend as much on healthcare.[19]

Therefore, the healthcare sector's functionality predicates a successful, developed economy and correlates with the quality of life of the country's population.

B. How is the Healthcare System Structured?

The structure of the U.S. healthcare system differs than that of most developed countries.[20] For one, the U.S. does not have a uniform health system or supply universal healthcare to its population.[21] Rather, it is characterized as a privatized system, made up of public and private hospitals, for-profit and nonprofit insurers, and other health care providers.[22] The federal government does, however, provide public funding through its Medicare program for persons 65 and older and maintains other programs for veterans and low-income individuals (e.g., Medicaid and Children's Health Insurance Program).[23] This structure can cause significant problems for certain communities within the U.S. by fostering disparity in access to healthcare.[24] These problems are exemplified by the high costs of care, lack of insurance coverage, and scarcity of physicians and specialists.[25]

C. Hospital Mergers & Anticompetitive Effects

For years, scholars and medical professionals speculated that hospital consolidation would improve the healthcare system and its service of care

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[19] *2020 Annual Report – International Comparison*, UNITED HEALTH FOUND. (Dec. 2020), https://www.americashealthrankings.org/learn/reports/2020-annual-report/international-comparison.

[20] Karen Davis et al., *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, THE COMMONWEALTH FUND (June 16, 2014), https://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror-wall-2014-update-how-us-health-care-system.

[21] Johonniuss Chemweno, *The U.S. Healthcare System is Broken: A National Perspective*, MANAGED HEALTHCARE EXEC. (July 27, 2021), https://www.managedhealthcareexecutive.com/view/the-u-s-healthcare-system-is-broken-a-national-perspective.

[22] Roosa Tikkanen et al., *International Health Care System Profiles: United States*, THE COMMONWEALTH FUND (June 5, 2020), https://www.commonwealthfund.org/international-health-policy-center/countries/united-states.

[23] *See id*.

[24] *See generally* Katrin Hambarsoomian et al., *Disparities in Health Care in Medicare Advantage by Race, Ethnicity, and Sex*, CMS OFFICE OF MINORITY HEALTH (Apr. 2022), https://www.cms.gov/files/document/disparities-health-care-medicare-advantage-race-ethnicity-and-sex.pdf.

[25] Chemweno, *supra* note 21.

to patients.[26] As a result, the U.S. has seen an uptick in hospital consolidation throughout the last two decades with a particular acceleration since 2010.[27] In 2018 – the last year with complete data – "72% of hospitals and more than 90% of hospital beds were affiliated with a [healthcare system]."[28] These figures reflect the rampant mergers and acquisitions occurring within the healthcare industry and signal growing monopolization.[29] In recent years, research groups have started to review hospital mergers and have concluded that this growth in deal volume is confirming these concerns.[30] Both the Harvard Medical and Business Schools examined patient outcomes from approximately 250 hospital mergers between 2009 and 2013.[31] They found that hospital mergers generally increase prices and reduce the quality of care.[32] Specifically, this study uncovered that patient-experience scores deteriorated post-merger, while hospital system performance did not increase proportionate to higher prices.[33]

On balance, the main issue is that increased hospital consolidation is intensifying market concentration. Market concentration, or when fewer firms compete in a given market, can result in less competition and, thus, reduce benefits to consumers and workers.[34] Promoting competition is at the core of American antitrust laws, seeking to yield lower costs, produce better quality services, increase innovation, and enhance wealth equality.[35] Thus, removing the competitive effects from communities that seek

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[26] *See generally* Thomas M. Susman et al., *The Brave New World of Health Care: Hospital Mergers and Joint Ventures in the '90s*, 38 BOSTON BAR J. 3 (1994).

[27] Nancy D. Beaulieu et al., *Changes in Quality of Care after Hospital Mergers and Acquisitions*, NEW ENG. J. MED. (Jan. 2, 2020).

[28] Elsa Pearson, *Hospital Mergers and Acquisitions Are a Bad Deal for Patients. Why Aren't They Being Stopped?*, STAT NEWS (Sept. 2, 2021), https://www.statnews.com/2021/09/02/hospital-mergers-more-oversight-federal-state-officials/.

[29] Greg Rosalky, *The Untamed Rise of Hospital Monopolies*, NPR (July 20, 2021), https://www.npr.org/sections/money/2021/07/20/1017631111/the-untamed-rise-of-hospital-monopolies.

[30] Arthur H. Gale, MD, *Bigger Not Better: Hospital Mergers Increase Costs and Do Not Improve Quality*, MO MED. (Jan.-Feb. 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6170097/#b2-ms112_p0004; *see also* Martin Gaynor, Ph.D. & Robert Town, Ph. D., *The Impact of Hospital Consolidation – Update*, ROBERT WOOD JOHNSON FOUND. (June 1, 2012), file:///C:/Users/srk02/Downloads/rwjf73261.pdf.

[31] Jake Miller, *Hospital Mergers and Quality of Care*, HARVARD MED. SCH. (Jan. 16, 2020), https://hms.harvard.edu/news/hospital-mergers-quality-care.

[32] *See* Beaulieu, *supra* note 27.

[33] *See id*.

[34] Joseph Briggs et al., *Concentration, Competition, and the Antitrust Policy Outlook*, GOLDMAN SACHS (July 18, 2021, 11:47PM), https://www.gspublishing.com/content/research/en/reports/2021.

[35] Maurice E. Stucke, *Is Competition Always Good?*, 1 J. ANTITRUST ENF'T. 162, 165-66 (Feb. 4, 2013).

healthcare can negatively compound for consumers. This Article addresses this main issue and proposes the revisions the FTC needs to prevent both anticompetitive effects and market concentration from riddling hospital systems.

D. President Biden's Executive Order

On July 9, 2021, President Biden issued an executive order on promoting competition in the U.S. economy.[36] President Biden expressed his intent to strengthen antitrust enforcement throughout major industries, with healthcare as one of several priorities.[37] President Biden affirmed his administration's policy of carrying out antitrust laws to "combat the excessive consolidation of industry, the abuses of market power, and the harmful effects of monopoly and monopsony."[38] Notably, President Biden encouraged the FTC and the Department of Justice ("DOJ") to enforce these laws "fairly and vigorously," and to review and revise the Horizontal Merger Guidelines and Vertical Merger Guidelines vis-à-vis hospital mergers.[39] With respect to these mergers, the executive order provides that "unchecked mergers" have led to the "ten largest healthcare systems now control[ling] a quarter of the market," and that "hospitals in consolidated markets charge far higher prices than hospitals in markets with several competitors."[40] Additionally, the order illustrates how unchecked hospital consolidation in certain areas, predominantly rural areas, significantly impacts the population.[41] In solidarity, the FTC Chair Lina Khan and Acting Assistant Attorney General of the DOJ Antitrust Division Richard A. Powers issued a statement confirming that the current guidelines were due for an inspection and revision.[42] Moving forward, Khan and Powers announced that the two agencies were jointly launching a review of the Horizontal Merger Guidelines "with the goal of updating them to reflect a rigorous analytical approach consistent with applicable law."[43]

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[36] Exec. Order No. 14036, 86 FR 36987 (July 14, 2021).

[37] *See id.* § 1.

[38] *See id*.

[39] *See id.* § 5.

[40] *Fact Sheet: Executive Order on Promoting Competition in the American Economy*, THE WHITE HOUSE (July 9, 2021), https://www.whitehouse.gov/briefing-room/statements-releases/2021/07/09/fact-sheet.

[41] *See supra* note 36 at § 1.

[42] Press Release, *Statement of Acting Assistant General Richard A. Powers of the Antitrust Division and FTC Chair Lisa Khan on Competition Executive Order's Call to Consider Revisions to Merger Guidelines* (July 9, 2021), https://www.justice.gov/opa/pr/statement-acting-assistant-attorney-general-richard-powers-antitrust-division-and-ftc-chair.

[43] *See id*.

In the time since this executive order, the FTC and DOJ launched a joint review of guidelines for both Horizontal and Vertical Mergers.[44] Commencing in January of 2022, the FTC and DOJ "held a public comment period for the merger guidelines that sought input from a diverse set of stakeholders from across the nation."[45] Within this period, the agencies released a joint Request for Information on Merger Enforcement ("RFI").[46] The RFI consists of more than 150 questions and encourages industry professionals to provide examples of how mergers have harmed competition and difficulties arising for customers and workers.[47] Closing in late April 2022, the agencies received more than 5,800 comments and conducted a series of listening forums with registered nurses, professors, physicians, pharmacists, and patients to aid in information gathering.[48] The FTC and DOJ are now reviewing the results of the RFI with an aim of furnishing the guidelines by the end of 2022.[49]

As healthcare expenditures increase, experts' concerns grow over whether the U.S. can continue to supply healthcare services that are fiscally responsible yet also support acceptable levels of quality, effectiveness, and equity.[50] Further, as literature suggests, hospital mergers are harming underlying communities and overall competition.[51] Particularly, these mergers are increasing the pricing of healthcare and

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[44] *FTC and DOJ Launch a Joint Review of Guidelines for Both Horizontal and Vertical Mergers, Issuing a Request for Public Comment*, SULLIVAN & CROMWELL LLP: S&C MEMO (Jan. 19, 2022), https://www.sullcrom.com/files/upload/sc-publication-ftc-and-doj-announce-review-of-merger-guidelines.pdf.

[45] Andrew J. Forman, *The Importance of Vigorous Antitrust Enforcement in Health Care*, U.S. DEP'T OF JUST., Keynote Address at the American Bar Association's Antitrust in Healthcare Conference in Washington DC (June 3, 2022), https://www.justice.gov/opa/speech/file/1519516/download.

[46] Press Release, *Justice Department and Federal Trade Commission Seek to Strengthen Enforcement Against Illegal Mergers* (Jan. 18, 2022), https://www.justice.gov/opa/pr/justice-department-and-federal-trade-commission-seek-strengthen-enforcement-against-illegal.

[47] *See supra* note 42.

[48] *See* Eleanor Tyler & Grace Maral Burnett, *Analysis: Thousands Commented on Merger Guidelines. What's Next?*, BLOOMBERG L. (Apr. 28, 2022), https://news.bloomberglaw.com/bloomberg-law-analysis/analysis-thousands-commented-on-merger-guidelines-whats-next; Forman, *supra* note 45.

[49] *US Antitrust Enforcers Take Next Steps to Strengthen Merger Enforcement*, COOLEY (Feb. 1, 2022), https://www.cooley.com/news/insight/2022/2022-02-01-us-antitrust-enforcers-take-next-steps.

[50] William H. Shrank et al., *Health Costs and Financing: Challenges and Strategies for a New Administration*, 40 HEALTH AFFAIRS 235 (2021), https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01560.

[51] *See* Hambarsoomian et al., *supra* note 24; *see also* Michael Hiltzik, *Column: Hospital Mergers Reduce Patient Care and Drive Up Prices, New Data Show*, L.A. TIMES (Jan. 2, 2020), https://www.latimes.com/business/story/2020-01-02/hospital-mergers-reduce-patient-care.

decreasing the quality of care offered to patients.[52] Enforcing Section 7 of the Clayton Act would considerably prevent this concentration.[53] Part II will look at how Section 7 currently regulates hospital mergers and whether agencies have been successful in combatting anticompetitive mergers.

II. LEGAL RESPONSE TO REGULATING HOSPITAL MERGERS

As evidenced by Part I, the healthcare system has a dominant role in the functioning and success of the U.S. economy. For that reason, the anticompetitive implications of hospital mergers can significantly harm the consumers and impact the established healthcare systems. Equally important is the legal treatment of these issues and the precedent set for future antitrust proceedings. This Part discusses the regulations at the federal level, surveys the Merger Retrospective Program of the FTC, and reviews relevant case law. Certain concerns and gaps in the law that emerge from this discussion will be addressed later in Part IV of this Article.

A. U.S. Federal Regulations

In 1890, Congress passed the Sherman Antitrust Act of 1890 ("Sherman Act") as a "comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade."[54] The Sherman Act – the first antitrust law – outlawed "every contract, combination, or conspiracy in restraint of trade," and any "monopolization, attempted monopolization, or conspiracy or combination to monopolize."[55] The vague language in the Sherman Act, however, provided loopholes for massive corporations to engage in predatory pricing, exclusive dealings, and anticompetitive mergers designed to adversely affect competitors.[56] In response, Representative Henry De Lamar Clayton introduced the Clayton Act of 1914 ("Clayton Act") to combat the growing power of monopolies and maintain market competition.[57] With the purpose to clarify and strengthen the Sherman Act,

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[52] *See* Hambarsoomian et al., *supra* note 24.

[53] *See* Bradley C. Weber, *Section 7 of the Clayton Act*, 7 A.B.A. J. LIT. 17 (Fall 2007).

[54] *The Antitrust Laws*, FED. TRADE COMM'N, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws (last visited Sept. 16, 2022).

[55] *See id*.

[56] *The Clayton Antitrust Act*, HISTORY, ART, & ARCHIVES – UNITED STATES HOUSE OF REP., https://history.house.gov/HistoricalHighlight/Detail/15032424979 (last visited Sept. 17, 2022).

[57] *See generally* Jonida Lamaj, *The Evolution of Antitrust Law in USA*, ESJ. 154, 161 (2017).

the Clayton Act introduced regulations prohibiting anticompetitive mergers, predatory and discriminatory pricing, and other products of unethical corporate behavior.[58] Further, the Clayton Act authorized labor unions to engage in activity such as strikes, boycotts, collective bargaining, and compensation disputes.[59] To this day, the FTC and DOJ work jointly to enforce the provisions of the Clayton Act.[60]

This Article deals primarily with Section 7 of the Clayton Act. Initially, Section 7 prohibited the acquisition "by one corporation of the stock of another corporation when such an acquisition would likely result in a substantial lessening of competition between the acquiring and acquired firms."[61] During the 1940s, the FTC investigated mergers in the U.S. economy and posed amendments to address their potential concentrative implications on businesses.[62] Taking these concerns into consideration, Congress amended Section 7 to include mergers by way of the Celler-Kefauver Antimerger Act of 1950.[63] The Supreme Court in *Brown Shoe Co. v. United States* interpreted and described these amendments as Congress's attempt to "plug the loophole" that exempted corporations from Clayton Act enforcement on asset acquisitions. [64] The Court highlighted how the deletion of "acquiring-acquired" language helped expand the scope of Section 7 to cover vertical and conglomerate mergers.[65] Moving forward, the Court concluded that Section 7 would prohibit mergers where the "trend to a lessening of competition in a line of commerce was still in its incipiency,"[66] while the Sherman Act "required proof of extant harm to competition."[67] Therefore, the Court held that Section 7 merger claims should not factor into Sherman Act

[58] *See The Antitrust Laws*, *supra* note 54.

[59] *See* Stephen Frank, *The Myth of the Conflict Between Antitrust Law and Labor Law in the Application of Antitrust Law to Union Activity*, 69, DICK. L. REV., 1, 12 (1964).

[60] *The Enforcers*, FED. TRADE COMM'N, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/enforcers.

[61] A.B.A. SECTION OF ANTITRUST LAW, *Mergers and Acquisitions: Understanding the Antitrust Issues* (3d ed. 2008).

[62] *See* Laura Phillips Sawyer, *US Antitrust Law and Policy in Historical Perspective*, HARVARD BUS. SCH. (2019), https://www.hbs.edu/ris/Publication%2520Files/19-110_e21447ad-d98a-451f-8ef0-ba42209018e6.pdf; *see generally* Deborah A. Valentine, *The Evolution of U.S. Merger Law*, FED. TRADE COMM'N (Aug. 13, 1996), https://www.ftc.gov/public-statements/1996/08/evolution-us-merger-law.

[63] *See generally* Charles J. Steele, *A Decade of the Celler-Kefauver Anti-Merger Act*, 14 VAND. L. REV. 1049 (1961).

[64] Brown Shoe Co. v. United States, 370 U.S. 294, 316 (1962).

[65] *See id*. at 317.

[66] *See id*. at 317-18; *see also* United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 362 (1963); United States v. EI. Du Pont de Nemours & Co., 353 U.S. 586, 589 (1957).

[67] *Summary of Section 7 of the Clayton Act*, AMERICAN ANTITRUST INST. (Oct. 11, 2013), https://www.antitrustinstitute.org/wp-content/uploads/2018/09/Section-7.pdf.

precedent.[68] Additionally, because Section 7 prohibits mergers whose effect "may be substantially to lessen competition, or to tend to create a monopoly," legal analysis under Section 7 is based on "probabilities, not certainties."[69] Thus, this lessening of competition language carries a lower standard of proof than the Sherman Act.[70] In enforcing this standard of proof, the Antitrust Division of the DOJ and the FTC mainly administer Section 7 claims, but state attorneys general and private parties are also authorized by Section 4 or 16 of the Clayton Act.[71]

A Section 7 claim is typically assessed under a three-step "burden-shifting framework."[72] First, the plaintiff must establish a prima facie case that a merger is anticompetitive.[73] A merger will satisfy the "substantial" lessening of competition if a "reasonable probability" that anticompetitive effects will materialize[74] exists, and there is "an appreciable danger of [anticompetitive] consequences in the future."[75] A relevant anticompetitive effect is "higher prices in the affected market."[76] Next, the burden shifts to the defendant to rebut the prima facie case.[77] Here, the defendants must "provide sufficient evidence that the prima facie case inaccurately predicts the transaction's probable effect on competition."[78] It is important to note that the defendant must only make a showing rather than disprove the plaintiff's case.[79] Finally, if the defendant successfully rebuts the prima facie case, "the burden of production shifts back to the

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[68] *See supra* note 64 at 318.

[69] Saint Alphonsus Med. Center-Nampa v. St Luke's Health Sys., 778 F.3d 775, 783 (9th Cir. 2015) (quoting *Brown Shoe*, 370 U.S. 294, at 321).

[70] *See id*.

[71] 15 U.S.C. § 26 ("Any person, firm, corporation, or association shall be entitled to sue for and have injunctive relief . . . against threatened loss or damage by a violation of the antitrust laws"); California v. Am. Stores Co., 495 U.S. 271, 283-84 (1990); *see also Private Antitrust Litigation 2018*, L. BUS. RSCH. LTD 141 (2018), https://www.skadden.com/-/media/files/publications/2017/09/private_antitrust_litigation.pdf.

[72] Ohio v. Am. Express Co., 138 S. Ct. 2274, 2284 (2018).

[73] *See* Olin Corp. v. FTC, 986 F.2d 1295, 1306 (9th Cir. 1993).

[74] FTC v. H.J. Heinz Co., 246 F.3d 708, 713 (D.C. Cir. 2001).

[75] United States v. H&R Block, Inc. 833 F. Supp. 2d 36, 49 (D.D.C. 2011) (quoting Hosp. Corp. of Am. v. FTC, 807 F.2d 1381, 1389 (7th Cir. 1986)).

[76] *H&R Block, Inc.*, 833 F. Supp. 2d at 49.

[77] *Am. Express Co*., 138 S. Ct. at 2284.

[78] United States v. Anthem, Inc., 855 F.3d 345, 349 (D.C. Cir. 2017).

[79] *Section 7 of the Clayton Act: Overview*, PRACTICAL L. ANTITRUST, https://1.next.westlaw.com/Search/Home.html?transitionType=Default&contextData=%28sc.Default%29 (search in search bar for "Section 7 of the Clayton Act: Overview"; then select "Practical Law" under content types on the left side of the screen; select the first result with the correct title) (last visited Oct. 10, 2022).

government and merges with the ultimate burden of persuasion, which is incumbent on the Government at all times."[80]

In the first step of the burden-shifting framework, courts and agencies (often plaintiffs) may also consider the Herfindahl-Hirschman Index ("HHI") to prove a merger is anticompetitive on its face.[81]

i. Herfindahl-Hirschman Index

The HHI enables plaintiffs to analyze the concentration and competition of a market with a simple formula.[82] This index is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers.[83] This calculation can fall in the range of close to zero to 10,000.[84] The DOJ holds that an HHI of less than 1,500 constitutes a competitive marketplace, one of 1,500 to 2,500 is moderately concentrated, and an HHI of 2,500 or greater is a highly concentrated marketplace.[85] Additionally, a merger in a highly concentrated market that increases by more than 200 points raises concerns of anticompetitive effects.[86] The HHI is praised for its simplicity in finding the concentration of a market yet receives criticism for its failure to factor important complexities of various markets.[87]

Additionally, to succeed in a merger challenge under Section 7, the plaintiff must establish the relevant market.[88] A relevant market is a factual

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[80] United States v. Baker Hughes, Inc., 908 F.2d 981, 982-83 (1990); *see also* FTC v. Univ. Health, Inc., 938 F.2d 1206, 1219 (11th Cir. 1991); Kaiser Aluminum & Chem. Corp. v. FTC, 652 F.2d 1324, 1340 (7th Cir. 1981).

[81] Lee Van Voorhis et al., *How Antitrust Agencies Analyze M&A*, PRACTICAL L. ANTITRUST, https://1.next.westlaw.com/Document/I1559f736eef211e28578f7ccc38dcbee/View/FullText.html?originationContext=document&transitionType=DocumentItem&ppcid=6818c48e9c0a40c6a911cac86292cade&contextData=(sc.Search) (search in search bar for "How Antitrust Agencies Analyze M&A" then select "Practical Law" under content types on the left side of the screen; select the first result with the correct title) (last visited Nov. 7, 2022).

[82] *See Herfindahl-Hirschman Index*, U.S. DEP'T OF JUST. (July 31, 2018), https://www.justice.gov/atr/herfindahl-hirschman-index.

[83] *See supra* note 82.

[84] Adam Hayes, *Herfindahl-Hirschman Index (HHI) Definition, Formula, and Example*, INVESTOPEDIA (June 28, 2022), https://www.investopedia.com/terms/h/hhi.asp.

[85] *See id*.

[86] *See id.*

[87] *See generally* Toby Roberts, *When Bigger is Better: A Critique of the Herfindahl-Hirschman Index's Use to Evaluate Merges in Network Industries*, 34 PACE L. REV. 894, 915 (Spring 2014).

[88] United States v. Marine Bancorp., Inc., 418 U.S. 602, 620-22 (1974).

question "dependent upon the special characteristics of the industry involved," and consists of a relevant product and geographic market.[89]

ii. Relevant Product Market

The relevant product market includes products or services that are substitutes for one another or compete against each other.[90] According to the *Brown Shoe Co.* court, "the outer boundaries of a product market are determined by the reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it."[91] In this definition of the relevant product market, courts consider the following factors: industry and public perception, peculiar characteristics of the product, customers' sensitivity to price changes, and attributes of certain customer sets.[92] Additionally, courts use the small but significant and nontransitory increase in price ("SSNIP" or "hypothetical monopolist") test.[93] Here, the test assesses whether a hypothetical monopolist – owning the company producing the relevant product – would receive profit by increasing price by a small but significant amount (typically in the range of 5% to 10%).[94] If the company gains profit from the increase in price, then the products constitute the relevant market.[95] If it is unprofitable, the "agency will add to the product group the product that is the next-best substitute for the merging firm's product."[96] This process repeats until the test identifies a group of profit-producing products for the hypothetical monopolist.[97]

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[89] Twin City Sportservice, Inc. v. Charles O. Finley, 676 F.2d 1291, 1299 (9th Cir. 1982).

[90] *Markets*, FED. TRADE COMM'N, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/mergers/markets.

[91] *Brown Shoe Co.,* 370 U.S. at 325.

[92] *See supra* note 64; *Anthem*, 855 F.3d at 191-92.

[93] John D. Harkrider, *Operationalizing the Hypothetical Monopolist Test*, U.S. DEP'T OF JUST., https://www.justice.gov/atr/operationalizing-hypothetical-monopolist-test.

[94] *See Market Definition Notice Under Review*, LATHAM & WATKINS (July 21, 2021), https://www.lw.com/thoughtLeadership/market-definition-notice-under-review.

[95] Serge X. Moresi et al., *Implementing the Hypothetical Monopolist SSNIP Test with Multi-Product Firms*, THE ANTITRUST SOURCE (Feb. 2008), https://media.crai.com/wp-content/uploads/2020/09/16164305/Implementing-the-Hypothetical-Monopolist-SSNIP-Test-With-Multi-Product-Firms.pdf.

[96] *See* Michael L. Katz & Carl Shapiro, *Critical Loss: Let's Tell the Whole Story*, A.B.A. SECTION OF ANTITRUST L. (Spring 2003).

[97] *See* Harkrider, *supra* note 93.

iii. Relevant Geographic Market

The relevant geographic market is the "area of effective competition where buyers can turn for alternate sources of supply,"[98] or, "the group of sellers or producers who have the actual or potential ability to deprive each other of significant levels of business."[99] Two predominant approaches exist to identify the geographic market: (i) the small-but-significant-and-non-transitory increase-in- price ("SSNIP") test; and (ii) the Elzinga-Hogarty test.[100]

iv. The SSNIP Test

The Horizontal Merger Guidelines' SSNIP test used for product markets similarly defines geographic markets.[101] The agency will impose a small but significant and nontransitory price increase in one location while keeping the terms of sale of the established, relevant product the same in other locations.[102] If this price increase is unprofitable because customers turn to nearby locations, then the agency reevaluates by adding the next-best location for the relevant product.[103] The agency continues this process until it has identified a geographic market where it is profitable for a hypothetical monopolist to impose a SSNIP.[104]

v. The Elzinga-Hogarty Test

In healthcare, the Elzinga-Hogarty[105] test is a two-part test which examines current market behavior by analyzing hospital service areas and patient flow data.[106] First, the test determines the merging hospitals' "service area" or the area from which patients are attracted from.[107] Second, measurements are taken on the flow of patients into and out of the

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98 Morgan, Strand, Wheeler & Biggs v. Radiology, Ltd., 924 F.2d 1484, 1490 (9th Cir. 1991) (citation omitted).

99 Rebel Oil Co. v. Atl. Richfield Co., 51 F.3d 1421, 1434 (9th Cir. 1995) (quoting Thurman Indus., Inc. v. Pay 'N Pak Stores, Inc., 875 F.2d 1369, 1374 (9th Cir. 1989)).

100 *See generally* Dragan Benazić, *Defining the Relevant Market in Function of Managing Competition Policy* (Proceedings of 7th International Conference – Economic Integration, Competition and Cooperation (2009)), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2232748.

101 *Horizontal Merger Guidelines*, U.S. DEP'T OF JUST. (Apr. 8, 1997), https://www.justice.gov/atr/horizontal-merger-guidelines-0.

102 *See id*.

103 *See id*.

104 Harkrider, *supra* note 93.

105 Kenneth Elzinga & Thomas Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 ANTITRUST BULL 45 (1973).

106 United States v. Mercy Health Servs., 902 F. Supp. 968, 978 (N.D. Iowa 1995).

107 FTC v. Freeman Hosp., 911 F. Supp. 1213, 1218-19 (W.D. Mo. 1995).

test market.[108] The "little in from outside" ("LIFO") measurement "calculates the percentage of the patients who reside inside the test market that are admitted to those hospitals located within the test market."[109] The "little out from inside" ("LOFI") measurement "calculates the percentage of the test market's hospitals' patients who reside in the test market."[110] If the test reveals that the LOFI is 100%, then this concludes that all of the admitted hospital patients also reside in the test market. A LIFO and LOFI of 90% predicts a strong sign of a market and a LIFO and LOFI of 75% constitutes a weak sign of a market in the test area.[111] This test was widely used by courts and agencies for decades but has faced criticism in recent years.[112]

Specifically, the downfall of the Elzinga-Hogarty test is its tendency to produce overly broad geographic markets that consist of many competitors.[113] With a large market, the test provides a pool of many hospitals and, thus, a reduced level of concentration.[114] On its face, a merger within the test's outlined market will then fail to constitute a "presumptively anticompetitive" merger as defined in the Horizontal Merger Guidelines[115]; which, in application, will lead to the under enforcement of the antitrust laws to hospital mergers.

With this understanding of Section 7 claims pursuant to the Clayton Act, this Article will now look to the FTC's Merger Retrospective Program. Merger retrospectives analyze mergers, post factum, to determine whether a merger has produced any anticompetitive effects in its respective market.[116] This retrospective investigation allows the FTC to assess the strength of its enforcement actions and develop tools to better predict the effects of future, proposed mergers.[117]

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[108] Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study*, FED. TRADE COMM'N (May 1999), https://www.ftc.gov/reports/competitive-effects-not-profit-hospital-mergers-case-study.

[109] California v. Sutter Health Sys., 130 F.Supp.2d 1109, 1121-22 (N.D. Cal. 2001).

[110] *See id*.

[111] *Sutter Health*, 130 F.Supp.2d at 1121.

[112] Kenneth Elzinga testified on behalf of the FTC that the Elzinga-Hogarty approach is not an appropriate method for delineating the geographic market in hospital mergers. In re Evanston NW Healthcare Corp., 2007 WL 2286195, at *64 (F.T.C. Aug. 6, 2007).

[113] Cory S. Capps, et al., *The Long, Slow Decline of Elzinga-Hogarty and What Comes After*, ANTITRUST CHRONICLE (July 17, 2017), https://www.competitionpolicyinternational.com/the-long-slow-decline-of-elzinga-hogarty-and-what-comes-after/.

[114] *See id.* at 2.

[115] *See id*.; *see also Horizontal Merger Guidelines, supra* note 101.

[116] *Overview of the Merger Retrospective Program in the Bureau of Economics*, FED. TRADE COMM'N, https://www.ftc.gov/policy/studies/merger-retrospective-program/overview.

[117] *See id*.

B. Merger Retrospectives

As mentioned, the Merger Retrospective Program is an effort by the FTC to analyze past mergers and learn from their data to better promote competition in the future.[118] As this Article investigates hospital mergers, this section will review two merger retrospectives from the last decade in the healthcare industry.

i. Sutter Health & Summit Medical Center

In 2008, the FTC conducted a retrospective study of the Sutter-Summit ("Summit Group") hospital merger in the Oakland-Berkeley region of the San Francisco Bay area.[119] In this study, the Commission investigated whether antitrust enforcement would have been proper in the hospital merger and if any anticompetitive effects resulted.[120] Specifically, this retrospective aimed to answer how the hospital's price adjusted after the merger and if the change was but for the transaction.[121] It is important to note that the California Attorney General ("California AG") filed a complaint in federal court to block this transaction and lost, but the FTC never pursued any enforcement.[122]

The relevant transaction occurred when Sutter, a network of non-profit hospitals, acquired the non-profit hospital, Summit, located in Oakland, California.[123] Sutter then merged its Alta Bates hospital with the Summit hospital which was approximately 2.5 miles away.[124] The San Francisco Bay Area contained many hospitals with a range of services but were all a significant distance from Summit.[125]

This merger effectuated hours after the California AG's motion for a preliminary injunction was denied.[126] In the trial, the court defined the market definition to execute its analysis.[127] Both the California AG and Summit Group agreed that acute inpatient care comprised the relevant product market.[128] With the relevant product market agreed upon, the issue arose of what defined the geographic market.[129]

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118 *See id*.
119 Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, BUREAU OF ECON. (Nov. 2008).
120 *See id.* at 1.
121 *See id*.
122 *See id*.
123 *See id*.
124 *See id*.
125 *See id*.
126 *See id*.
127 Tenn, *supra* note 119, at 4.
128 *See id*.
129 *See id*.

At this time, more than twenty hospitals were located in either San Francisco or the East Bay area and a majority offered equivalent services to those of the Summit Group.[130] The California AG argued that the significant commuting times across the San Francisco Bay area created the relevant geographic area as a small region known as the "Inner East Bay."[131] With this geographic market, several hospitals in the metropolitan area were excluded and gave the Summit Group a 50% market share.[132]

At trial, both parties utilized the Elzinga-Hogarty test to either defend or define the relevant geographic market.[133] The judge rejected the California AG's Inner East Bay market – stating that 15% of patients in that area went to hospitals elsewhere, and 15% of patients going to Inner East Bay hospitals resided outside of the proposed market.[134] This decision by the judge supported a wider geographic market that likely implied competition with more hospitals – thus, negating the likelihood for anticompetitive effects.[135]

In review, the merger retrospective calculated the post-merger price change relative to the price change for a control group absent a merger.[136] Drawing from a large pool of data in California, the retrospective used a "two-stage estimation approach that constructed the standard error of the merger effects from the empirical distribution of price changes across the control group."[137] The study looked at how the merger effected both Summit and Sutter's Alta Bates hospitals.[138] The regression analysis revealed that Summit's post-merger price change was among the largest of any equivalent hospital in California.[139] Specifically, based on differing insurers, the Summit price increase qualified between the 95th and 99th percentile of price changes across the hospital groups.[140] Alternatively, Alta Bates's post-merger change was deemed "quite typical," with other comparable hospitals either having a lower or higher increase in price.[141]

On balance, the retrospective concluded that it could not entirely answer its question of whether the Sutter-Summit transaction affected

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[130] *See id*.
[131] *Sutter Health*, 130 F. Supp. 2d at 1121 ("[T]he 'Inner East Bay', encompassing the area between the San Francisco Bay on the west and the Caldecott Tunnel on the east, and running from the Carquinez Strait in the north to Union City in the South").
[132] Tenn, *supra* note 119, at 5.
[133] *See id*.
[134] *See id.* at 6.
[135] *See id*.
[136] *See id*.
[137] Tenn, *see supra* note 119, at 11.
[138] *See id*.
[139] *See id*. at 19.
[140] *See id*.
[141] *See id*.

inpatient hospital prices.[142] On one hand, Summit's prices went up significantly yet, on the other, Sutter's prices did not have a statistically significant change.[143] Thus, this retrospective uncovered the need for a more detailed formula for defining a geographic market that includes the complex factors of the given area.[144]

ii. Phoebe Putney Health System & Palmyra Medical Center

In this merger retrospective, the FTC delved into the merger between the Phoebe Putney Health System ("Phoebe Putney") and Palmyra Medical Center ("Palmyra") in Albany, Georgia.[145] This study sought to identify how local government regulation, specifically antitrust immunity, impacted prices and quality of care.[146]

In 1941, the Georgia Legislature enacted the Hospital Authorities Law "to provide a mechanism for the operation and maintenance of needed health care facilities in the several counties and municipalities of the state."[147] Through the Hospital Authorities Law, local governments were given broad powers to regulate health care in their jurisdictions.[148] This led to the establishment of the Hospital Authority of Albany-Dougherty ("Authority") which regulated Phoebe Putney and its prices.[149] In 1971, Palmyra was built two miles north of Phoebe Putney and demonstrated profitable success for decades.[150] On December 21, 2010, the Authority and Phoebe Putney entered a deal where the Authority would acquire Palmyra for $195 million.[151] The terms of the deal provided that the Authority would become the sole owner of Palmyra and executed a management agreement authorizing Phoebe Putney to run Palmyra.[152]

In April 2011, the FTC voted unanimously to challenge this merger.[153] The FTC embarked on administrative proceedings and filed for a preliminary injunction in federal district court to enjoin the merger until the end of the proceedings.[154] The FTC argued that this merger would create a virtual monopoly for inpatient general acute care hospital services

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142 *See id.* at 22.
143 *See id*.
144 *See* Tenn, *supra* note 119.
145 Christopher Garmon et al., *Healthcare Competition or Regulation: The Unusual Case of Albany, Georgia,* BUREAU OF ECON. (Sept. 2017).
146 *See id.* at 1.
147 FTC v. Phoebe Putney Health Sys., 133 S. Ct. 1003, 1007 (2013).
148 *See* Garmon et al., *supra* note 145, at 4.
149 *See id*.
150 *See id*.
151 *See id*.
152 *See id*.
153 *See id*. at 5.
154 *See id*.

in the respective county and would "eliminate the robust competitive rivalry . . . that has benefited consumers for decades."[155] Specifically, the FTC found that this merger would provide Phoebe Putney with an 86% market share in the six-county area surrounding Albany, Georgia.[156] In response, the Authority, Palmyra, and Phoebe Putney argued that this transaction was protected by Georgia's Hospital Authorities Law and, therefore, was immune from federal antitrust laws under the state-action doctrine.[157] In June of 2011, the district court held for the hospital group by granting the defendant's motion to dismiss and denying the FTC's request for a preliminary injunction.[158] On appeal, the Eleventh Circuit affirmed the lower court's ruling and held that the state-action immunity protected the parties to the transaction.[159] In March of 2012, however, the Solicitor General of the U.S. petitioned the U.S. Supreme Court ("Supreme Court") to review the Eleventh Circuit's holding.[160] The Supreme Court held oral arguments and concluded that state-action immunity did not apply because the Hospital Authority Law did not expressly state an intention to displace competition; thus, remanding the case to the district court.[161] In 2013, the FTC filed motions to prevent further integration of the hospitals and, ultimately, entered into a consent agreement with the Authority and Phoebe Putney in 2015.[162] Under this agreement, the Authority and Phoebe Putney were required to provide notice to the FTC of plans to acquire healthcare providers in the surrounding six-county area for a span of ten years.[163]

This merger retrospective focused on the data sets relating to the change in price and quality associated with the Phoebe Putney/Palmyra merger.[164] For price change, the researchers estimated the difference between the actual post-merger price change and that which would have occurred absent the merger.[165] In calculating the actual post-merger price change, the retrospective utilized the Dafny method.[166] This method incorporates estimates of commercial revenue and discharges from Healthcare Cost Report Information System ("HCRIS") data and adjusts

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[155] Amended Complaint at 2, *Putney Health*. 586 U.S. 216 (2013) (No. 11-civ-58).
[156] Garmon et al., *supra* note 145, at 5.
[157] *See id*.
[158] *See id*.
[159] *See* Garmon et al., *supra* note 145, at 6.
[160] *See id*.
[161] *See id*.
[162] *See id*.
[163] *See id*.
[164] *See* Garmon et al., *supra* note 145, at 9.
[165] *See id.* at 10.
[166] *See* Leemore S. Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*, 52 J. L. ECON. 523, 531 (2009).

to reflect the hospital's average patient severity (i.e., case-mix index).[167] For the price change absent the merger, the retrospective used a synthetic control method where a "synthetic control hospital" is established as a weighted average of non-merging hospitals in Georgia so that the synthetic control illustrates Phoebe Putney/Palmyra before the merger in regards to price and price predictors.[168]

For post-merger quality, the retrospective used quality metrics from the Centers for Medicare & Medicaid Services ("CMS") Hospital Compare portal and the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") Survey.[169] Specifically, the retrospective extracted mortality and readmission rates and patient satisfaction scores.[170] Mortality rates reflected Hospital Compare's 30-day all cause, risk-adjusted mortality rates for heart attacks, heart failures, and cases of pneumonia. Readmission rates reflected when patients had to return to the hospital after initial treatment for such ailments.[171] Lastly, patient satisfaction data reflected responses to a question to rate the hospital overall where patients pick a number between 0 and 10 – with 10 being the highest satisfaction.[172]

Overall, the methods revealed a statistically significant post-merger increase in price and a significant decline in quality.[173] Specifically, the price change spiked 43% immediately after the merger (2011) and then lowered to an average post-merger price increase of 15% (2012-14).[174] On the other hand, the data qualified Phoebe Putney/Palmyra as a low-quality hospital on most measures and suggested that the merger reduced its quality compared to equivalent hospitals in Georgia.[175]

In sum, this retrospective highlighted the risks that are associated with hospital mergers and, especially, what occurs when competition is reduced.[176] As a result, the price increased for consumers and their quality of care declined below reasonable standards.[177] As Phoebe Putney received an 86% market share after the merger, this data presents a

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[167] *See* Garmon et al., *supra* note 145, at 11.
[168] *See id.* at 11-12.
[169] *See id*. at 13.
[170] *See id*. ("We focus on the metrics described above because these are the only metrics that were defined identically in the pre- and post-merger periods.")
[171] *See* Garmon et al., *supra* note 145, at 13.
[172] *See id*.
[173] *See id.* at 16.
[174] *See id.* at 16-17.
[175] *See* Garmon et al., *supra* note 145, at 19.
[176] *See id.* at 20.
[177] *See id.* at 16.

concerning situation where consumers must pay more money for poorer quality care pursuant to existing antitrust law.[178]

This section provided insight into the merger retrospective process and the ability to learn lessons from past mergers. In these two specific studies, a general finding was that the hospital merger increased prices for consumers within the market.[179] Even further, in Phoebe Putney/Palmyra, data provided that the merger reduced the quality of care available to patients.[180] These studies show the importance of successful antitrust enforcement because, if applied, an injunction could have protected the respective markets from increased prices and reduced care.[181] The geographic market was discussed in both retrospectives and indicates its significance in evaluating whether a proposed merger will carry anticompetitive effects or not.

In this next section, this Article will look at relevant case law that occurred before and after the publications by the Merger Retrospective Program.

C. Case Law

i. Saint Alphonsus Medical Center-Nampa, Inc. v. St. Luke's Health System, Ltd. (2012)

This Ninth Circuit case stems from a 2012 merger of two healthcare providers in Nampa, Idaho where the court upheld its divestiture.[182] St. Luke's Health System, an Idaho-based not-for-profit, purchased the Saltzer Medical Group – Idaho's largest independent physician practice.[183] Within the city of Nampa, Saint Alphonsus Health System ("St. Alphonsus") operated the only hospital.[184] Additionally, Saltzer served as the largest adult primary care ("PCP") provider in Nampa with sixteen, followed by St. Alphonsus' nine and St. Luke's eight.[185] The FTC and the State of Idaho filed a complaint, alleging that the merger violated Section

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[178] *See id.* at 5.
[179] *See id*; *see also* Tenn, *supra* note 119, at 19.
[180] *See id.* at 19.
[181] *Preliminary Injunctions in FTC and DOJ Merger Challenges*, PRACTICAL L. ANTITRUST, https://1.next.westlaw.com/Document/Ib0bf94d092a211e498db8b09b4f043e0/View/FullText.html?transitionType=Default&contextData=(sc.Default)&firstPage=true&oWSessionId=0ca8be6784174bc89adcb3980ea0f8d3&isplcus=true&fromAnonymous=true&bhcp=1 (search in search bar for "Preliminary Injunctions in FTC and DOJ Merger Challenges"; then select "Practical Law" under content types on the left side of the screen; select the first result with the correct title) (last visited Nov. 8 2022).
[182] *Saint Alphonsus*, 778 F.3d at 781.
[183] *See id.* at 781.
[184] *See id*.
[185] *See id*.

7 by incurring anticompetitive effects in the adult PCP market.[186] The District Court held that the merger would indeed create anticompetitive effects by way of establishing a "huge market share" and ordered for divestiture.[187]

On appeal, the Ninth Circuit reviewed the case *de novo* and utilized the burden-shifting framework analysis.[188] While both parties agreed to the relevant product market as adult PCPs, the Ninth Circuit focused on establishing the relevant geographic market.[189] Here, the Ninth Circuit affirmed the lower court's incorporation of the hypothetical monopolist test (i.e., SSNIP); specifically, citing the lower court's finding that Nampa residents "strongly prefer access to local PCPs" and that "commercial health plans would need to include Nampa PCPs in their networks to offer a competitive product."[190] With the geographic market set, the court next turned to whether anticompetitive effects were likely.[191] The FTC used the HHI to show a figure of 6,219 in the Nampa PCP market – thus, rising much higher than the requisite 2,500 or above for highly concentrated markets.[192] Additionally, the Ninth Circuit affirmed the lower court's finding that St. Luke's would likely use its power post-merger to negotiate higher reimbursements from insurance companies.[193] Taken together, the Ninth Circuit held that the FTC established a prima facie case.[194]

Next, the Ninth Circuit reviewed the defendant's assertion of merger efficiencies as its rebuttal to the claim.[195] Here, the court primed the reader by pointing out that the Supreme Court has never expressly approved an efficiencies defense to a Section 7 claim.[196] As for its defense, St. Luke's asserted that the merger would allow it to move toward integrated care and risk-based reimbursement.[197] First, the Ninth Circuit rejected St. Luke's claim that it would better serve patients on the basis that it was simply insufficient to carry the burden.[198] The Ninth Circuit held that the purpose of the Clayton Act was to promote competition and better serving patients

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[186] *Saint Alphonsus*, 778 F.3d at 782.
[187] *See id*.
[188] *See id*.
[189] *See id.* at 783.
[190] *See id.* at 784–85.
[191] *See id.* at 785.
[192] *See id.* at 786.
[193] *See id*.
[194] *See id.* at 788.
[195] *See id.* at 791.
[196] *Saint Alphonsus,* 778 F.3d at 778.
[197] *See* FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 351 n.10 (3d Cir. 2016) ("In risk-based contracting, healthcare providers bear some financial risk and share in the financial upside based on the quality and value of the services they provide.").
[198] *Saint Alphonsus*, 778 F.3d at 791.

neither increased competition nor decreased prices.[199] Second, the Ninth Circuit affirmed the lower court's finding that the reimbursement rates for PCP services, post-merger, were likely to increase rather than decrease.[200] Therefore, St. Luke's failed to carry its burden and demonstrate that the merger efficiencies would positively change competition in the Nampa area.[201] Lastly, the Ninth Circuit weighed the equities and found that a divestiture aligned with the best interest of the public and the goals of antitrust enforcement.[202]

Hence, *Saint Alphonsus* supports the notion that courts are unsure on the weight that merger efficiencies should hold. Courts work through the burden-shifting framework and can move to the rebuttal prong with ease. Establishing a prima facie case requires the definition of the market and a likelihood of anticompetitive effects. Moving forward, it will be interesting to monitor any precedent that arises to fine tune the Supreme Court's view of what creates a strong merger efficiency argument.

ii. FTC v. Penn State Hershey Medical (2017)

In this case, the Circuit Court affirmed a motion for a preliminary injunction of a proposed merger.[203] The FTC opposed the proposed merger of Penn State Hershey Medical Center ("Hershey") and Pinnacle Health System ("Pinnacle") (collectively, as "Hospitals").[204] At the time, these were the two largest hospitals in the Harrisburg, Pennsylvania area and the FTC argued it violated Section 7 because it was likely to substantially lessen competition.[205]

As background, Hershey is the primary teaching hospital of the Penn State College of Medicine.[206] It is renowned as a leading academic medical center.[207] Pinnacle is a health system consisting of three hospital campuses – two in Harrisburg and one in Mechanicsburg.[208] Pinnacle's facilities focus on cost-effective primary and secondary care services with a limited range of services in complex care.[209] In June 2014, the two parties signed

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199 *See id*.
200 *See id*.
201 *See id.* at 792.
202 *See* United States v. EI. Du Pont de Nemours & Co., 366 U.S. 316, 330 (1961) (noting that most litigated Clayton Act section 7 cases "decreed divestiture as a matter of course").
203 *See Penn State*, 838 F.3d at 327.
204 *See id.* at 333.
205 *See id*.
206 *See id.* at 334.
207 *See generally Clinical Research*, PENN STATE COLL. OF MED., https://med.psu.edu/clinical-research (last visited Sept. 15, 2022).
208 *See Penn State*, 838 F.3d at 334.
209 *See id*.

a letter of intent and notified the FTC of their proposed merger.[210] On review, the FTC filed a complaint and sought a preliminary injunction for the merger due to its likely anticompetitive effects.[211] Specifically, the FTC argued that this merger would grant the combined hospitals 76% of the market in Harrisburg.[212]

The District Court denied the FTC's request for preliminary injunction and cited the FTC's failure to meet its burden to properly define the relevant geographic market.[213] The FTC then appealed, and the U.S. Court of Appeals (Third Circuit) ("Circuit Court") reviewed the case *de novo*.[214]

The Circuit Court applied the burden-shifting framework to assess this case.[215] To establish whether the FTC had a prima facie case, the Circuit Court first defined the market, focusing on the geographic market as the product market was undisputed.[216] For the geographic market, the Circuit Court discussed the lower court's improper use of the Elzinga-Hogarty test.[217] Specifically, the Circuit Court described the outdated method as one resulting in overbroad markets with respect to hospitals, as supported by empirical research.[218] Therefore, the Circuit Court turned to the hypothetical monopolist test and wrestled with whether the FTC was required to show that insurance companies would accept a price increase rather than excluding the merged Hershey/Pinnacle entity from their networks.[219] The Circuit Court held, rather, that the FTC only had to show that the insurance companies would accept a price increase instead of excluding all the hospitals in the Harrisburg area – which the court found the FTC did.[220] Next, the Circuit Court reviewed if the FTC additionally proved the likeliness of the merger's anticompetitive effects to establish the prima facie claim.[221] In the lower court, the FTC provided its HHI calculation that showed the post-merger HHI was 5,894 – more than twice that of a highly concentrated market.[222] Therefore, the Circuit Court found

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210 *See id*.
211 *See id*.
212 *See id.* at 335.
213 *See Penn State*, 838 F.3d, at 339.
214 *See id*. at 335.
215 *See id*. at 337.
216 *See id.* at 338 ("The District Court found, and the parties stipulated, that the relevant product market is general acute care ("GAC") services sold to commercial payors.").
217 *See id.* at 339.
218 *See id.* at 340.
219 *See id.* at 339.
220 *See id.* at 346.
221 Saint Alphonsus Med. Ctr. v. St. Luke's Health Sys., 778 F.3d 775, 785 (9th Cir. 2015) ("Once the relevant geographic market is determined, a prima facie case is established if the plaintiff proves that the merger will probably lead to anticompetitive effects in that market").
222 *Penn State*, 838 F.3d, at 347.

that the HHI and the calculation of Hershey/Pinnacle's 76% market share sufficiently established a prima facie case.[223]

Next, the Circuit Court analyzed whether the Hospitals rebutted the prima facie case through establishing either: (i) that the combination would not result in anticompetitive effects; or (ii) that extraordinary efficiencies[224] resulting from the merger would offset any anticompetitive effects of the merger.[225] For the efficiencies, the Hospitals argued that the merger would produce procompetitive effects by relieving Hershey's capacity constraints, and also enable Hershey to allocate more money to patients by avoiding the construction of a $277 million bed tower.[226] Further, the Hospitals argued the merger would allow them to engage in more risk-based contracting.[227] The Circuit Court, however, concluded that the Hospitals' efficiencies were incognizable and insufficient to rebut the presumption of anti-competitiveness.[228] In terms of anticompetitive effects, the Circuit Court found that the Hospitals could not defend the fact that the transaction would likely increase post-merger prices.[229] The Circuit Court gave credence to the insurers' testimony that without Hershey and Pinnacle "there would be no network."[230]

Lastly, although the FTC established a presumption in favor of a preliminary injunction, the Circuit Court weighed the equities to decide whether enjoining the merger was in the public interest.[231] This decision rested on whether the harm that the Hospitals would suffer, if the merger was delayed, would harm the public more than if the injunction was not issued.[232] Here, without a specific rubric for equities, the Circuit Court decided on using the effective enforcement of the antitrust laws as the principal equity.[233] In this reasoning, the Circuit Court found that the public would not receive any harm from the delay of the merger and,

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[223] *See id*.

[224] *See* DOJ, *supra* note 101, at 31 ("The Agencies will not challenge a merger if cognizable efficiencies are of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market.").

[225] *Penn State*, 838 F.3d at 347.

[226] *See id*.

[227] *See id*.

[228] *See id*. at 348 ("In order to be cognizable, the efficiencies must, first, offset the anticompetitive concerns in highly concentrated markets [; s]econd, the efficiencies must be 'merger specific[;]' . . . [and t]hird, the efficiencies 'must be verifiable, not speculative." (citation omitted)); *see also Saint Alphonsus*, 778 F.3d at 790.

[229] *See id*. at 352.

[230] *See id*.

[231] FTC v. H.J. Heinz Co., 246 F.3d 708, 726 (D.C. Cir. 2001).

[232] *Penn State*, 838 F.3d at 352; see also FTC v. Univ. Health, Inc., 938 F.2d 1206, 1225 (11th Cir. 1991).

[233] *Univ. Health*, 938 F.2d at 1225 ("The principal equity weighing in favor of issuance of the injunction is the public's interest in effective enforcement of the antitrust laws.").

rather, would benefit from the FTC's investigation into the potential anticompetitive nature of the merger.[234] Thus, the Circuit Court reversed the lower court and approved the motion for preliminary injunction.[235]

Moving forward, the Circuit Court's holding clarified the FTC's approach to defining the geographic market yet created some areas of uncertainty.[236] Specifically, it affirmed the use of the hypothetical monopolist test and disposed of the Elzinga-Hogarty test.[237] On the other hand, however, it raised questions concerning the efficiencies defense, adoption of it, and validation of the burden of proof.[238] Without a clear adoption of the efficiencies defense, market participants lack guidance on the likely success of asserting merger efficiencies in the future. This ambiguity, however, may grant more leverage to agencies in blocking future mergers.

iii. FTC v. Thomas Jefferson University (2020)

Recently, the U.S. District Court for the Eastern District of Pennsylvania denied the FTC's preliminary injunction against a proposed merger.[239] This marked the first time after a long run of successfully challenging hospital mergers for the FTC.[240] In this case, the court held that the relevant geographic market must be assessed "through the lens of the insurers."[241] Therefore, now requiring the FTC to "prove that the insurers would not avoid a price increase in any one of the [FTC's] proposed markets by looking to hospitals outside those markets."[242]

The FTC aimed to block the merger between two healthcare providers in the greater Philadelphia area, Thomas Jefferson Health ("Jefferson") and Albert Einstein Healthcare Network ("Einstein").[243] In December 2020, the Eastern District of Pennsylvania rejected the FTC's request for a preliminary injunction to pause the transaction while it conducted an in-

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234 *Penn State*, 838 F.3d at 352.

235 *See id*. at 353-54.

236 *Antitrust Law – Hospital Mergers – Third Circuit Clarifies Geographic Market Definition and Raises Bar for Efficiencies Defense – FTC v. Penn State Hershey Medical Center*, 838 F.3d 327 (3d. Cir. 2016)., 130 HARV. L. REV. 1736, 1740 (2017).

237 *Penn State*, 838 F.3d at 340.

238 *See id*.

239 FTC v. Thomas Jefferson Univ., 505 F. Supp.3d 522 (E.D. Pa. 2020).

240 *See* Bryan Koenig, *FTC Abandons Challenge to $599M Philly Hospital Deal*, LAW360 (Mar. 1, 2021, 5:53 PM), https://www.law360.com/articles/1359554.

241 *Thomas Jefferson*, 505 F. Supp.3d at 528.

242 *See id*.

243 Norman Armstrong, Jr. et al., *FTC Drops Philadelphia-area Hospital Merger Challenge*, JD SUPRA (Mar. 5, 2021), https://www.jdsupra.com/legalnews/ftc-drops-philadelphia-area-hospital-5305179/#_edn3.

house administrative trial to permanently stop the deal.[244] The FTC alleged this merger would enable the new Philadelphia system to control 70% of the market for inpatient rehabilitation services for patients recovering from acute conditions such as strokes, spinal cord injuries, and traumatic brain injuries.[245] Jefferson argued that the region's four largest commercial insurers (i.e., United, Aetna, Cigna, and Independence Blue Cross) could combat this by simply excluding Jefferson from their network and not suffer any negative consequences.[246] Additionally, Einstein argued that Einstein Medical Center Philadelphia ("EMCP"), the hospital that accounted for 70% of its revenues, is a "safety net hospital."[247] Einstein referred to EMCP as a safety net hospital because it has one of the highest percentages of government-insured inpatients (87%) among large hospitals in the U.S.[248] With Medicare reimbursement rates and medical assistance coverage failing to cover patient care costs, the potential merger parties viewed this transaction as a way to uplift financial struggles and balance power throughout hospitals and insurers.[249] The FTC calculated three different geographic markets using an analysis of patient diversion ratios and argued that Jefferson and Einstein would have to be in each market (in the hypothetical monopolist test); thus, forcing insurers to suffer an increase in rates.[250] Additionally, the FTC argued these higher rates would flow to health plan members vis-à-vis higher insurance premiums.[251] The expert representing Jefferson and Einstein contended that patient diversion ratios did not matter as much as the large insurer's negotiation power and ability to enact health plans that excluded Jefferson and Einstein.[252]

On review, the Eastern District found that the FTC did not carry its burden of defining the geographic market to establish a prima facie case.[253]

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[244] *Thomas Jefferson*, 505 F. Supp.3d at 544.

[245] Jeff Lagasse, *FTC and Pennsylvania Challenge Proposed Merger of Two Philly Hospital Systems*, HEALTHCARE FINANCE (Mar. 2, 2020), https://www.healthcarefinancenews.com/news/ftc-and-pennsylvania-challenge-proposed-merger-two-philly-hospital-systems.

[246] Herbert F. Allen et al., *FTC Loses Bid to Block Philadelphia Hospital Merger in Extraordinarily Busy Year of Hospital Merger Enforcement*, NAT'L L. REV. (Jan. 7, 2021), https://www.natlawreview.com/article/ftc-loses-bid-to-block-philadelphia-hospital-merger-extraordinarily-busy-year.

[247] *Thomas Jefferson*, 505 F. Supp. 3d at 530.

[248] *See id.*

[249] *See id.*; *see generally* Vincent Arora, MD, MAPP, et al., *The Challenge of Understanding Health Care Costs and Charges*, 17 AMA J. ETHICS 1046 (2015).

[250] *Thomas Jefferson*, 505 F. Supp. 3d at 554-55.

[251] *See id.* at 540 (citing FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 342 (3d Cir. 2016)).

[252] *See id.* at 539-40.

[253] *See id.* at 548.

The court held that the FTC's alleged geographic markets did not "correspond to the commercial realities of the industry at issue."[254] Also, the Eastern District held that no evidence existed that patient preferences aligned with insurer preferences when creating a network.[255] Yet, most importantly, the Eastern District held that the FTC did not show whether "enough insurers, in the face of a [SSNIP], would avoid the price increase by looking to hospitals outside the proposed geographic market . . . ."[256]

The FTC then appealed to the Third Circuit and filed a motion for an injunction pending appeal.[257] The Third Circuit, however, denied this motion and the FTC voted 4-0 to voluntarily dismiss the Third Circuit appeal.[258]

The Eastern District's decision and the ultimate voluntary dismissal by the FTC raises many discussion points.[259] First, the recency of this decision shows that the FTC is not invincible in healthcare injunction cases just by drawing a geographic market and applying a hypothetical monopolist test.[260] Rather, courts likely need to see a detailed geographic market through the lens of the insurer that can predict whether certain healthcare plans can or cannot exclude hospitals and still receive profit.[261] Second, the notion that the FTC removed itself from this case and did not see it through the end shows that it may have predicted a loss.[262] Here, the FTC potentially viewed this appeal process as a waste of resources or did not believe enough guidance existed on how to succeed in the trial.[263] Moving forward, this case illustrates the need for more concrete language

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[254] *See id.* at 528.
[255] *See id*. at 541.
[256] *See id.* at 543 (quoting *Penn State*, 838 F.3d at 342).
[257] *See id.* at 544.
[258] *See Thomas Jefferson University, In the Matter of*, FED. TRADE COMM'N, https://www.ftc.gov/enforcement/cases-proceedings/181-0128/thomas-jefferson-university-matter; *see also* Pete Taylor et al., *FTC Drops Its Appeal of Jefferson/Einstein Hospital Merger*, AMERICAN HEALTH L. ASS'N (Mar. 24, 2021), https://www.american healthlaw.org/content-library/publications/bulletins/ecf6e4ad-3b1b-4e16-b3ee-918a40ffb9d2/FTC-Drops-Its-Appeal-of-Jefferson-Einstein-Hospita.
[259] *See supra* note 239.
[260] David Maas & Douglas E. Litvack, *FTC's Hospital Win Streak Ends*, DAVIS WRIGHT TREMAINE LLP (Mar. 3, 2021), https://www.dwt.com/insights/2021/03/ftc-hospital-merger-defeat.
[261] Ashley M. Fischer, *Seventh Circuit Hands FTC Another Geographic Market Definition Victory in Chicago Hospital Merger Case*, MCDERMOTT WILL & EMERY (Nov. 2, 2016), https://www.mwe.com/insights/geographic-market-definition-hospital-merger/.
[262] Maas & Litvack, *see supra* note 260.
[263] *See generally id*.

on defining geographic markets within the horizontal merger guidelines and, especially, within the healthcare space.[264]

In sum, Part II provided an overview of the enforcement authority pursuant to Section 7, the lessons learned from FTC's merger retrospectives, and the way courts have ruled in recent hospital merger cases. In Part III, this Article will expand on the existing gaps in the horizontal merger guidelines and discuss shortcomings in the current approach.

III. SHORTCOMINGS OF THE CURRENT APPROACH AND THE HORIZONTAL MERGER GUIDELINES

Part II began with an introduction of the relevant federal law regarding antitrust enforcement and, more specifically, anticompetitive mergers. It outlined the three steps constituting the burden-shifting framework, and the tests employed to define the relevant product and geographic market and gauge market concentration. Using this background, Part II then assessed three different merger retrospectives published by the FTC and the characteristics and implications of each unchecked, hospital merger. This survey of past mergers showed the likelihood of increased prices and reduced quality of care for consumers within the respective market. Next, Part II analyzed three cases spanning the past decade within the healthcare space and determined how the FTC fared in enforcing regulation on proposed anticompetitive mergers. Navigating through these different cases culminated in a finding of patterns with courts yet raised questions and uncertainty about the future success of the FTC in regulating hospital mergers.

Part III will assess the findings from Part II and discuss the shortcomings of the current approach.

A. *Defining the Candidate Market*

In the retrospectives and cases, the definition of the relevant product market did not present a major concern or point of contention. The definition of the relevant geographic market, however, continued to arise as a major issue. Over the years, courts and experts have moved away from the Elzinga-Hogarty test and now typically only employ the hypothetical monopolist test for the geographic market.[265] Within the Horizontal Merger Guidelines, the hypothetical monopolist test is the predominant

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[264] *See Thomas Jefferson*, 505 F. Supp. 3d at 548; *see also* Thomas R. McCarthy, M.D. & Scott J. Thomas M.D., *Geographic Market Issues in Hospital Mergers*, NERA ECON. CONSULTING, https://www.nera.com/content/dam/nera/publications/archive1/3698.pdf.

[265] *See* Capps et al., *supra* note 113.

test used by agencies.[266] These guidelines, however, do not provide any instruction on how to devise a candidate market for which the court can conduct the hypothetical test on.

As the recent cases suggest, this test is starting to sail through murkier waters within the court systems and in the healthcare space. Particularly, with dynamic healthcare systems, issues arise in the relationships of healthcare providers, insurers, and customers. Providers must negotiate with insurers to set prices for services to patients who are covered by the insurers' healthcare plans.[267] Insurers must decide whether partnering with a healthcare system will attract more or less customers purchasing their medical plan.[268] Additionally, confusion is starting to build on whether patients or insurers are the true consumers of the hospitals' services – an important distinction that identifies the party that would suffer most from post-merger anticompetitive effects.[269] The general trend of courts to dismiss Elzinga-Hogarty tests provides some insight on this question, as the Elzinga-Hogarty method focused on the patient's, not the insurer's, choice in entering or leaving a market.[270] This dismissal provokes the question if the courts are signaling that insurers rather than patients are the bona fide consumers of the hospitals' services.[271]

A Seventh Circuit case provided insight on this question and posited that hospital care competition is a two-stage approach.[272] The first stage of competition occurs between insurers and hospitals as they negotiate whether the hospitals will fall in the insurer's plan and, if so, the prices of provided services.[273] After these terms are negotiated, the second stage of competition occurs between the hospitals and the patients.[274] In this stage, hospitals will then compete with one another to attract patients on

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266 *See* DOJ, *supra* note 101.

267 *See* Kenneth W. Field et al., *The Flaws in Using the Hypothetical Monopolist Test from the "Payor Perspective" in Health Care Merger Cases*, 17 ANTITRUST SOURCE, (Aug. 2017), at 1,2. https://www.americanbar.org/content/dam/aba/publishing/antitrust_source /aug17_field_8_2f.authcheckdam.pdf.

268 Samantha Liss, *Pandemic Propels Health Systems to Mull Insurer Acquisitions, Partnerships*, HEALTHCARE DIVE (Jan. 13, 2021), https://www.healthcaredive.com/news/ pandemic-propels-health-systems-to-mull-insurer-acquisitions-partnerships/593228/.

269 *Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets: Hearing Before the House Comm. on the Judiciary*, 116th Cong. 10 (2019) (statement of Professor Martin Gaynor).

270 *See* Capps et al., *supra* note 113, at 4.

271 *See generally How Healthcare Mergers Affect Health Insurance Plans*, GUNN MOWERY (Mar. 20, 2019), https://www.gunnmowery.com/news/how-healthcare-mergers-affect-health-insurance-plans/.

272 FTC v. Advoc. Health Care Network, 841 F.3d 460, 465 (7th Cir. 2016).

273 *See id*.

274 *See id*.

intangibles such as location, quality, and reputation.[275] As a result, the Seventh Circuit opined that insurers are impacted more so than insured patients.[276] As insurers consider both hospital prices and patient preferences, insured patients only examine the latter.[277] The Seventh Circuit's perspective is similar to the circumstances in *Thomas Jefferson*, and raises the question of whether the Horizontal Merger Guidelines' failure to address this two-stage competition process may have implications in antitrust law.[278]

Currently, when the FTC files a motion for preliminary injunction, its economists must use the facts and circumstances surrounding the case to construct a geographic market method.[279] The premise with the hypothetical monopolist test is that "[t]he analyst proposes a candidate market, simulates a monopolization of that market, then adjusts the candidate market and reruns the simulation as necessary."[280] The guidelines, however, do not provide how to construct the candidate market and how to determine whether a monopolist of hospitals in that area could profitably increase price by a SSNIP.[281] Therefore, absent a conclusive scope, court's enforcement of these guidelines lay in their discretion and interpretation.[282]

Subsequent to President Biden's executive order and the active deal volume of hospital mergers,[283] now is likely the opportune time to include healthcare-specific language in the revised Horizontal Merger Guidelines. The substance of this language, however, is an unprecedented decision as the DOJ and FTC have avoided industry-specific guidance.

Part IV will provide perspectives from current academic literature that address Part III's shortcomings and will conclude with an analysis of a potential solution.

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[275] *See id*; *see also* Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L. J. 671, 678–682 (2000).

[276] *Advoc. Health*, 841 F.3d 460 at 471.

[277] *See id*.

[278] *See generally supra* note 239.

[279] *See* FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 351 n.10 (3d Cir. 2016)

[280] *See id.* at 473.

[281] *See Brown Shoe*, 370 U.S. at 336–37.

[282] Hillary Greene, *Guideline Institutionalization: The Role of Merger Guidelines in Antitrust Discourse*, 48 WM. & MARY L. REV. 771, 779 (2006).

[283] In Quarter 3 alone, 7 transactions were executed involving 20 hospitals with a total transacted revenue of $5.2 billion. In 2020, hospital-related deals totaled 83. *M&A Quarterly Activity Report: Q3 2021*, KAUFMAN HALL, (Oct. 6, 2021), https://www.kaufmanhall.com/insights/research-report/ma-quarterly-activity-report-q3-2021.

IV. PROPOSALS TO AMEND THE HORIZONTAL MERGER GUIDELINES

Part III illustrated the need for clearer guidance for hospital mergers within the Horizontal Merger Guidelines. As the current approach leaves candidate markets up to the discretion of courts, Part IV offers a discussion on what revisions can look like moving forward. Specifically, touching on the importance of having healthcare-specific language or tests in the guidelines. Further, Part IV will predict likely criticism of the potential revisions and address how to mitigate this criticism.

A. Paradigm Shift of Geographic Market Definition in 2010 Guidelines

In review of academic literature on the subject, some authors propose that the 2010 revision to the Horizontal Merger Guidelines presented a paradigm shift.[284] In a retrospective analysis of the six revisions to the guidelines, one article discusses the 2010 version's attempt to "measure directly the economic consequences of horizontal mergers rather than inferring the consequences from implied changes in market structure."[285] This literature cites to the change in the steps of a merger analysis where the 2010 version places market definition as subordinate to the competitive effects of a merger.[286] Therefore, this strategic placing of competitive effects before market definitions may allude to the agency's priority of answering whether a merger substantially lessens competition.[287] This change is supported by the guidelines' language that "the Agencies' analysis need not start with market definition, [considering] the tools used by the Agencies to assess competitive effects do not rely on or require market definition."[288] Further, the literature argues that the approach to geographic market definition differs significantly based on where one starts.[289] The starting point refers to either defining the geographic market by supplier or customer location.[290]

With hospital mergers, it is likely that applying patients, insurers, and healthcare providers to the aforementioned view of the guidelines may create more questions. Similar to the concern posed of whether insurers or patients are the real customer, where is the proper place to start in the

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[284] Kenneth G. Elzinga et al., *Geographic Market Definition in the Merger Guidelines: A Retrospective Analysis*, 53 REV. IND. ORG. 453, 467 (2018).
[285] *See id*.
[286] *See id*.
[287] *See id*.
[288] *See* DOJ, *supra* note 101, at 7.
[289] *See* Elzinga et al., *supra* note 284 at 462.
[290] *See id*.

geographic market analysis of a hospital merger? For example, if the process originates with a supplier location, which party will consist of the supplier. One could argue that the hospital is the supplier as it provides the service to the patient. One could also argue that the insurer facilitates this supply. On the other hand, starting with the customer location provokes whether the insurer or the patient is truly receiving the service. Here, the patient does receive care from the hospital, but the insurer also receives either payment or reimbursement for the individual under its health plan. Altogether, these hypotheticals demonstrate the lack of unambiguous guidance for this subject and the flexibility courts have in deciding antitrust proceedings.

B. Clarifying the Geographic Market & Merger Efficiency Definitions in Revised Guidelines

Furthermore, it is apparent that the guidelines' revision is an opportunity to offer meaningful direction for the court's interpretation of geographic markets. The most appropriate method to address this issue is to include a healthcare-specific section in the guidelines. Although the agencies have steered away from this in the past, it is important to look to the future and assess which mergers will comprise a significant proportion of all mergers. Hospital mergers are increasing and becoming more attractive to the parties involved.[291] As more consolidation occurs, the population of the U.S. will suffer from the following side effects of hospital mergers: price increases and reduced quality of care.[292] An efficient way to combat these anticompetitive effects is through equipping antitrust enforcers with clear language on how to define geographic markets. The hospital merger section of the guidelines can make a difference by determining whether patients or insurers are the consumers in this industry. Additionally, this industry-specific section can taper the overly broad geographic market definition so that the hypothetical monopolist test can result in exact, reliable findings.[293] As mergers in this industry are common, supplying a framework for a hospital-specific geographic market will allow courts to navigate these trials fairly and efficiently.

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[291] *See* Jacqueline LaPointe, *How Hospital Merger and Acquisition Activity is Changing Healthcare*, REVCYCLE INTELLIGENCE (July 20, 2018), https://revcycleintelligence.com/features/how-hospital-merger-and-acquisition-activity-is-changing-healthcare.

[292] *See* Beaulieu, *supra* note 27.

[293] *See generally* David G. Mangum et al., *Importing the Merger Guidelines into Judicial Determinations of Relevant Antitrust Markets: Potential Benefits and Limitations*, PARSONS BEHLE & LATIMER, https://parsonsbehle.com/insights/importing-the-merger-guidelines-into-judicial-determinations-of-relevant-antitrust-markets-potential-benefits-and-limitations.

Additionally, the DOJ and FTC should consider including language concerning merger efficiencies for hospital transactions. Throughout the cases and retrospectives, the court's hesitance to rely on merger efficiencies created uncertainty for all involved parties.[294] Courts implied that because merger efficiencies never factored heavily in the past, they would not hold a strong influence moving forward.[295] This pattern likely gives antitrust enforcers leverage and prevents hospital systems from fully explaining motives for consolidating with other healthcare groups. Therefore, providing merger efficiency language can help all parties to a merger challenge by specifying what factors are considered in the decision.

On balance, these two changes – including hospital-specific language and outlining merger efficiencies in the guidelines – can strengthen the assessment of anticompetitive hospital mergers and fill gaps in case law and retrospectives.

C. Potential Criticism of Hospital-Specific Language

As with most proposed revisions, introducing hospital-specific language to the Horizontal Merger Guidelines will likely attract criticism. For example, opponents may argue that including a geographic market definition for one industry will require doing so for all other major industries. These opponents may even pose that the government is either punishing or protecting the health industry by including a section for hospital mergers. In response to this potential criticism, the agencies would have to make the decision to either include other major industries in the guidelines or create a separate governing handbook for each industry. In choosing what constitutes another "major" industry, the agencies will likely run into issues and backlash. The only option, therefore, would be to create guidelines for mergers in industries that contribute to the nation's merger transaction volume each year. Although this path may seem laborious, it is a solution that conforms to the current administration's antitrust enforcement policy and protects consumers in an industry that saves lives.

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[294] Herbert J. Hovenkamp, *Appraising Merger Efficiencies*, 24 GEO. MASON L. REV. 703, 706 (2017), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=2764&context=faculty_scholarship.

[295] *The Merger Guidelines and the Integration of Efficiencies into Antitrust Review of Horizontal Mergers*, THE UNITED STATES DEPARTMENT OF JUSTICE ARCHIVES, https://www.justice.gov/archives/atr/merger-guidelines-and-integration-efficiencies-antitrust-review-horizontal-mergers.

Another criticism is that courts are not legally bound by the Horizontal Merger Guidelines.[296] The guidelines are, rather, only guidance documents that set forth policy recommendations for courts to incorporate into their analysis of merger challenges.[297] Courts overseeing merger disputes may use these guidelines as persuasive authority yet can deviate from such policy at their discretion and interpretation.[298] A counter to this criticism, however, is the power and influence that sharply defined merger guidelines can have on a court's treatment of merger challenges. Hospital-specific language can provide clarity to courts and help create a framework for the FTC, DOJ, and all involved parties to predict their potential for success on forthcoming merger challenges.[299] Revised Horizontal Merger Guidelines can create an equal playing field by furnishing courts with a blueprint for hospital merger litigation, regardless of its nonbinding nature.

CONCLUSION

The current Horizontal Merger Guidelines enable unchecked hospital mergers to continue producing anticompetitive effects in the U.S. healthcare industry. Without the necessary revisions to the definitions of geographic markets and market efficiencies, hospitals will continue to work within the gaps that the courts cannot fill. Considering President Biden's call for vigorous antitrust enforcement, now is the time for the FTC and DOJ to seriously contemplate including language that is specific to hospital mergers and merger efficiencies in the guidelines. Notably, this consideration will not only fulfill the agencies' duty to comport with

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[296] *See, e.g.*, Chicago Bridge & Iron Co. v. FTC, 534 F.3d 410, 431 n.11 (5th Cir. 2008) ("Merger Guidelines are often used as persuasive authority when deciding if a particular acquisition violates anti-trust laws."); United States v. Kinder, 64 F.3d 757, 771 & n.22 (2d Cir. 1995) ("Although it is widely acknowledged that the Merger Guidelines do not bind the judiciary in determining whether to sanction a corporate merger or acquisition for anticompetitive effect . . . courts commonly cite them as a benchmark of legality."); Cal. v. Sutter Health Sys., 130 F. Supp. 2d 1109, 1120, 1128–32 (N.D. Cal. 2001) ("Although the Merger Guidelines are not binding, courts have often adopted the standards set forth in the Merger Guidelines in analyzing antitrust issues").

[297] Richard J. Pierce, Jr., *Important Changes at the Intersection of Antitrust and Administrative Law*, THE REGULATORY REVIEW (Mar. 21 2022), https://www.theregreview.org/2022/03/21/pierce-important-changes-at-the-intersection-antitrust-administrative-law/.

[298] *See id*.

[299] *See* Alicia J. Batts et al., *FTC and DOJ Seek Comment on Revisions to Merger Guidelines*, FAEGRE DRINKER (Jan. 31, 2022), https://www.faegredrinker.com/en/insights/publications/2022/1/ftc-and-doj-seek-comment-on-revisions-to-merger-guidelines.

federal antitrust law, but it may also improve the quality of life and care for millions of Americans.