

The FTC's Hospital Merger Program: Coming A Cropper?

By Guest Blogger: Professor [Thomas L. Greaney](#)

Federal antitrust oversight of hospital consolidation has come upon hard times. Over the last two months the Federal Trade Commission suffered three notable setbacks in challenges to hospital mergers. Federal district courts in [Pennsylvania](#) and [Illinois](#) have refused to issue preliminary injunctions in cases in which the agency claimed the combined market shares of the merging parties were in excess of 64 and 50 percent respectively. Both cases turned largely on disputes over defining the always-elusive “relevant geographic market” in which merging hospitals compete. In the third case, [the FTC elected](#) to voluntarily dismiss its administrative complaint alleging that a West Virginia hospital merger would result in the combined entity having a market share in excess of 75 percent. The reason for the dismissal was the adoption by West Virginia of SB 597, a law creating a state health care authority to regulate “cooperative agreements” (including mergers) between hospitals and the decision of that body to approve the combination of the two hospitals previously challenged by the FTC.

Both district courts found that the FTC had failed to prove the local geographic markets alleged in its complaints. In the Illinois case, the FTC claimed that the anticompetitive effect of the merger of Advocate Health Care and NorthShore University Health System would be felt in the “North Shore Area” of Chicago, which includes northern Cook County and southern Lake County. The district court’s opinion focused almost entirely on the methodology employed by the FTC’s expert witness, finding error in his failure to include “destination hospitals” that draw a substantial number of patients from the North Shore area and evidence that at least one hospital excluded from the alleged market was the second or third choice of patients residing in that area.

In the Pennsylvania case, the district court rejected as “unreasonably narrow” the FTC’s alleged geographic market which consisted of an area “roughly equivalent” to the Harrisburg Metropolitan Statistical Area. Applying an analytic framework based

on patient travel patterns, the court stressed evidence of in-migration of patients who live outside the alleged market to obtain acute care hospital services. The court also alluded to, but did not rely upon, “several important equitable considerations.” It cited claimed efficiencies associated with the merger, growing pressures for hospitals to undertake risk-based contracting, and other changes in health care organization and regulation. The court also observed that it found “no small irony [when] the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances such as the Hospitals intend here.”

Not surprisingly, the FTC is appealing both decisions. [Studies show](#) that hospital market concentration—much fostered by anticompetitive mergers—has caused steep increases in health care costs. The issue of the dimensions of the relevant geographic market has been the focal point of many antitrust decisions in hospital merger cases. Antitrust agencies lost a series of cases in the 1990s in which courts applied tests based on patient travel statistics that produced large geographic markets. [Subsequent economic studies](#) revealed the flaws in the analytic methodology relied upon and the results in these cases. More recent cases in which the government has prevailed have employed [more sophisticated analytic tools](#) and have [stressed evidence of changes in bargaining leverage](#) as key to understanding the scope of markets and the effects of mergers. In this regard, the decision in the Pennsylvania case seems particularly vulnerable on appeal. [Persuasive economic analysis](#) indicates that the district court judge misunderstood the import of patient flow statistics and ignored important evidence on the central question for geographic market analysis—i.e., identifying which other hospitals constrain the ability of the merging hospitals to exercise market power when bargaining with payers. In this connection, both district courts can also be faulted for ignoring the testimony of payers regarding the enhanced bargaining leverage resulting from the mergers. Thus the two cases present an opportunity for the Third and Seventh Circuits to clarify once and for all the appropriate analytic path for defining hospital markets.

In the third case, the FTC challenged the merger of Cabell Huntington Hospital and St. Mary’s Medical Center, alleging that that the combined entity would account for more than 75% of the market for general acute care inpatient services, as well as a

high share of the market for outpatient surgical services in Cabell, Wayne, and Lincoln, counties in West Virginia and Lawrence County, Ohio. The West Virginia legislature promptly responded with SB 597, a statute that exempts health institutions from federal antitrust scrutiny upon approval by a state regulatory board, the West Virginia Health Care Authority (WVHCA) and established mechanisms for that agency to monitor merged entity's performance. The [FTC had vigorously opposed](#) passage of SB597, contending that the measure was unnecessary and would encourage private health care providers to engage in "blatantly anti-competitive conduct." Nonetheless, apparently sufficiently concerned that the new law checked the necessary boxes required for state action immunity, the FTC dismissed its complaint. Its statement reiterated its belief that such laws "are likely to harm communities through higher healthcare prices and lower healthcare quality." But, it warned, not all state statutes will bar federal antitrust review of mergers, and it would continue to closely scrutinize mergers in the future.

In determining whether state action immunity protects mergers and other affiliations based on state certificate of public advantage laws (COPAs) and other statutes similar to West Virginia's, the key issue is likely to be whether there is adequate "active supervision" by the state. Although the Supreme Court gave modest guidance on the issue in its decision in [North Carolina Dental Board v. FTC](#), and the FTC has issued [guidance](#) with respect to state boards controlled by market participants, the parameters of the rule remain unclear. Nonetheless, because it stopped the FTC in its tracks, West Virginia's statute may become a template for other states seeking to immunize mergers and other cooperative arrangements. That a number of "red" states have shown a willingness to adopt COPAs and other statutes that substitute regulatory regimes to control hospital price and quality and other states have enacted such laws to protect [a single merger or collaborative agreement](#) speaks to the special interest consideration that may underlie legislators' enthusiasm for such measures.

In the worst of scenarios, these recent developments may prove catastrophic for antitrust enforcement in health care. Many arrangements found illegal as restraints of trade or monopolistic conduct require analysis of the relevant geographic market. Erroneous precedent in this area may therefore encourage anticompetitive conduct as well as incentivize mergers that create market power. Likewise, the nation's

experience with legislation that imposes regulatory controls over competitive conditions does not auger well for the success of COPAs and the like. While [legislation targeting and controlling entities with market power](#) may well be appropriate, the wholesale abandonment of the competitive paradigm in health care would be ill advised. Looked at through a Panglossian lens, however, perhaps these developments will afford courts and legislatures the opportunity to think more carefully about competition in health care markets.