Assessing Hospital Mergers and Rivalry in An Era of Health Care Reform

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The hospital industry is confronting major systemic changes prompted by government policy directives and non-regulatory economic forces. Many if not most hospitals also face substantial pressures on their ability to deliver high-quality health care services in a cost-effective manner. In response to demands from consumers, employers, commercial insurers, and government, hospitals place a high priority not only on controlling health care delivery costs, but also on improving access and enhancing the quality of patient care and experience.

Many hospitals view the expansion of scale and opportunity to eliminate costs through mergers as a solution to at least some of their economic challenges. They read the Patient Protection and Affordable Care Act (PPACA) health reform law not only for its incentives and penalties tied to quality, but also for an acceptance (some might say promotion) of the principle that scale and realignment through consolidation or significant integration can enable providers to cut costs, improve quality, and benefit patients.

As they evaluate mergers in a post-PPACA environment, however, hospitals are under no illusions that the law accompanied a repeal of the Clayton and Sherman Acts. The message is out that the Federal Trade Commission and many state attorneys general are actively “on the beat” to intervene to stop mergers that they believe will create market power and harm consumers in violation of antitrust laws—no matter what inferences one might draw from the PPACA about the benefits of integration.

The PPACA does not change the relevance of Section 7 of the Clayton Act to hospital mergers, but health care reform, as codified in the PPACA and as it is taking hold independently in the marketplace, is having a substantial effect on the realities of hospital economics and competition. Critical to an assessment of a hospital merger’s likely effects on competition, therefore, is an understanding of the characteristics and drivers of hospital rivalry in this era of systemic change. It is not a “one-size-fits-all” analysis because hospitals compete locally and local competitive factors often differ substantially from one market to the next. The key to effective merger analysis is to identify the specific competitive factors and impact of reform on the proposed merger in the relevant geographic area where it takes place.

This article highlights many of the changes that are occurring in hospital markets and the implications that these developments may have for competitive analysis of hospital mergers. Many changes stem from legislative and regulatory mandates and others from provider and payor responses to new economic conditions in health care delivery and financing. The result is a significant realignment in hospital market structures, largely in response to shifts in outpatient care, inpatient excess capacity, and pressures to manage population health in more integrated, cost-efficient, and quality-enhancing arrangements. This article addresses these changes in the context of developments at the Federal Trade Commission, particularly in its analytical approach to core antitrust concepts, including market definition and competitive effects in hospital mergers, and concludes with recommendations for parties that appear before the FTC to defend prospective hospital mergers.

Reform and Realignment

It is incumbent on merging hospitals defending their transaction before an antitrust agency to demonstrate why market power is not the goal or expectation underlying their merger plans and why it is unlikely to result from the merger. Health care reform and provider realignment are important to hospital merger analysis because they help explain why so many hospitals are looking to consolidate into larger systems for reasons wholly unrelated to a quest for market power. Hospitals should be prepared to explain to agency staff how these factors apply in their own geographic markets and to their specific transaction. Indeed, parties should explain how competition absent the merger will suffer because one or both of them will be unable to adapt to the mandates of health reform due to shortcomings in capital and economies of scale.

Any discussion linking health care reform and mergers must recognize that the phrase “health care reform” broadly captures many different categories of changes in our health care system. Many critical changes are spurred directly by the PPACA, including reduced Medicare reimbursements and new payment models including value-based reimbursement; new coverage for the previously uninsured; expansion of

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Medicaid coverage; new insurance exchanges; penalties for avoidable readmissions and hospital-acquired conditions; a multitude of new rules for insurers and providers, such as electronic health record requirements and a multiplicity of other mandates; and provisions about organizational forms—some of which are favored (such as Accountable Care Organizations, or ACOs) and some of which are disfavored (e.g., physician-owned hospitals). Many other drivers of change exist besides the PPACA: for example, state laws or regulations that alter the modes for the delivery of care, private sector responses in anticipation and reaction to new laws, and economic, demographic, and patient care pressures that have evolved independently from health reform statutes and regulations. Although the ultimate impact of these changes taken together remains to be seen, health care reform’s influence is already extensive. Significant changes in health care systems and realignment away from old market structures are well underway among both providers and payors.

Central to forces shaping realignment of health care delivery and payment systems are efforts to achieve what is referred to as the “Triple Aim:” (1) enhancing the experience and quality of patient care; (2) improving the health of populations; and (3) reducing the rate of increase in costs per person. The Triple Aim drives realignment by shifting the focus away from individual inpatient care episodes and their associated unit costs. In their place, the Triple Aim applies a longer-term focus on a broader population of residents in an area, their health, efficient and appropriate care delivery and utilization, and the total costs of delivering care. This involves a transition from care in “silos” (i.e., single-provider settings) to integrated delivery that unites physicians and inpatient, outpatient and ancillary service providers—a transition to a system to achieve better outcomes.

Provider Realignment and Responses to Reform
Managing population health portends significant changes in health care cost, payment, and structure. Health care is moving away from markets comprising unaligned and fragmented entities toward ones united by “integrators,” such as large health care systems, multi-specialty physician groups, insurer-led models, or fully integrated organizations like Kaiser. More fully integrated systems could involve either contractual arrangements with independent ownership or common ownership through horizontal or vertical mergers among providers and/or insurers. The integration of care delivery may prompt significant changes in many local markets—including more horizontal and vertical transactions and affiliations among hospitals, physicians, and/or insurers than in prior years. One reason to expect significant future restructuring of this type is the large proportion of inpatient care facilities across the country that are standalone hospitals. Many of these are smaller hospitals, suggesting that patient care in many communities is fragmented at the hospital level and ripe for change.

Indeed, fragmentation and the impetus for further realignment coincides with three structural changes affecting providers that have already significantly revised the landscape for competition in many markets: (1) a shift to outpatient care; (2) excess inpatient capacity; and (3) new business models.

Shift to Outpatient Care. Many more health care services are delivered today in outpatient facilities than were delivered in the 1990s. This increase stems in large part from technologies that permit less invasive procedures and shorter stays. The trends are striking. Outpatient care now accounts for 60 percent of patient care, up from 10 percent in the 1990s. Also, outpatient care has shifted substantially from the hospital setting to freestanding facilities, which increased dramatically between 2005 and 2010. In the 1990s, outpatient facilities owned or controlled by hospitals accounted for about 90 percent of all outpatient services; today, along with the dramatically higher volumes of outpatient services, about half of all outpatient services are delivered by entities other than hospitals. Meanwhile, over the same period since the 1990s, inpatient admissions declined annually even as inpatient care became increasingly complex, higher-acuity, and more specialized.

Excess Inpatient Capacity. The shift in care from an inpatient to outpatient setting contributes to misaligned health care resources in many communities, including excess inpatient capacity. Many U.S. major metropolitan areas have excess bed capacity, in particular hospitals located in cities in the East, Southeast, and Midwest that have experienced significant unemployment, loss of industries, and population decline in recent years. As demand declines for inpatient services, the result can be lower average inpatient occupancy rates at an individual hospital or lower-than-effective volumes for specific services. Existing inpatient hospital capacity in most communities is distributed across a number of independent community hospitals—built before the last decade to meet expected demand—that offer a wide range of general acute care services.

The effects of health care resource misalignment are not limited to excess capacity. Many areas also have an insufficient number of outpatient facilities or primary care physicians (PCPs) that make it difficult to accomplish new models of care that encourage higher utilization of PCPs and lower-cost sources of care than inpatient services (or emergency rooms). Shortages could slow efforts to “bend the cost curve” (i.e., slow the rate of increases in costs) and improve patient access to care at the right location—each of which is a driving force behind newer business models for insurers and providers seeking to sustain and enhance the quality of care while reducing the rate of increase in medical costs.

New Business Models. Over the last decade, some hospitals and health insurers have taken steps consistent with Triple Aim goals to improve and manage patient care and to manage health and cost in a more integrated fashion. These steps have already led to fundamental changes in health care delivery system structures, of which ACOs are but one
model. Integrated delivery systems involving various business models have emerged to coordinate patient care across physicians, hospitals, and insurers and to more fully integrate health care operations.25

This reorganization and integration has resulted in the expansion of multi-hospital systems that include both tertiary facilities and community hospitals, with consolidation of some highest-acuity services into more specialized and centralized units, whether within the hospital or in a few locations to serve the entire system.26 In a trend that is reminiscent of the dramatic expansion in outpatient care through lower-cost and smaller-scale facilities, it is increasingly common for hospitals to use affiliated or employed physician outreach into farther regions to expand their inpatient service areas, with the effect of increasing the outmigration of patients from farther regions to those hospitals for tertiary and other services.27

**Payor Innovation and Responses to Reform**

The payor side is also responding to health care reform and economic pressures, especially with regard to increased pressure for cost-effective networks and products and improved transparency and accountability for consumers in their health care choices. Payor responses cover a wide range of developments, the most relevant of which for antitrust analyses are significant new network products and increased consumer cost-sharing and incentive mechanisms.

**Tiered and Narrow Provider Networks.** Excess hospital inpatient bed capacity, employer concern over accelerating health care costs, and a desire by health insurers and employers to engage consumers to understand the cost differences among their provider choices have aligned to create a more fertile environment for insurers to market lower-cost “tiered network” and “narrow network” benefit designs as well as a broad range of consumer initiatives often referred to as “consumer-driven health plans.”28 Tiered networks, for example, offer health plan enrollees discounted co-payment and other price terms for choosing the lower-priced, in-network providers (in a specific tier) from a larger set of in-network hospitals. Narrow networks contain a more limited set of in-network provider options. Providers in narrow networks accept lower price terms in exchange for the higher volumes that come from having fewer in-network competitors.29

An increasing proportion of commercial insurers successfully offer new network products with consumer choice and incentives for utilization of lower cost providers, and these products are becoming popular with employers and consumers.30

**Tools to Inform Consumers About Price and Quality Among Providers.** An important trend accompanying new network products and benefit designs that attempt to create incentives for consumers is the provision of clear information about the costs of care to consumers that will inform their choices when selecting among providers. The literature suggests that consumers are increasingly responding to health plan incentives, such as lower co-pays, to select high-quality but less costly providers, including those located at farther distances and requiring some additional travel time or inconvenience.31 At the same time, issues remain about the transparency and clarity of the available information as efforts continue to improve the systems.32

Much of the hospital realignment still to occur will be in the form of mergers and acquisitions subject to antitrust scrutiny by the antitrust agencies. Hence, understanding recent developments in hospital merger cases at the FTC provides insight into the types of mergers that generate government concern and close scrutiny.

**FTC Analytical Developments**

Well over 300 transactions involving over 550 acquired hospitals occurred between 2007 and 2012, with almost half that number occurring in 2011 and 2012 alone.33 Many involve acquisitions of a single hospital, which suggests that much of the recent consolidation has been between single hospitals that formed new systems or between a single hospital and a pre-existing system.34 About half of the transactions involved an overlap in the same geographic area, and the majority occurred in areas with several competitors.35 About 5,000 community hospital organizations remain, and the majority of large cities have numerous independent hospital competitors.36

Of those 300-plus hospital mergers since 2007, the vast majority did not trigger an extensive antitrust investigation, much less a legal challenge. This presumably means that the mergers did not threaten anticompetitive effects and commercial insurers did not express significant concern to the government. Former Federal Trade Commission Chairman Jon Leibowitz said last year:

> Let me pause here lest you get the impression that we never see a hospital merger we like. These are rough numbers, but according to public sources, 2007 to 2011 witnessed approximately 333 hospital mergers nationwide. About one third of those, approximately 111, were reported to the FTC under Hart-Scott-Rodino. Of those, approximately one tenth triggered Second Requests. We challenged only four in court—less than two percent of all hospital mergers over the last five years.37

With respect to the hundred or so Hart-Scott-Rodino reported hospital mergers that went unchallenged and the large number closed without Second Requests, however, the FTC has published almost no statements that shed light on any of the mergers’ market characteristics or the Agency’s reasons for its decisions.38 As a consequence, the public can only try to draw inferences from external information and published remarks by FTC officials. Some inferences are that the majority of transactions involved a single hospital, many of which were smaller hospitals, and that most of the transactions occurred in areas with remaining multiple rivals.39 Still, small hospitals do not get a free pass—last year, the FTC challenged Reading Health System’s proposed acquisition of...
fifteen-bed Surgical Institute of Reading. 40

In recent merger challenges, however, the FTC explained certain analytical methods on which it based its conclusions, particularly with respect to market definition and competitive effects. These include important developments for hospitals preparing to defend their transaction before the Agency.

Product Markets Other than “GAC.” Since at least the 1980s, the FTC and the Department of Justice have defined the relevant product market in hospital merger cases as the bundle of “general acute-care inpatient services” (GAC). 41 In its recent ProMedica 42 and Reading Health 43 cases, however, the FTC “unbundled” certain services and defined different product markets around them, a development that may require hospitals to undertake additional analyses to prepare for potential market definition approaches by FTC staff during its investigations. In ProMedica, the FTC alleged two product markets: GAC (exclusive of tertiary services) and, separately, obstetrics. 44 It alleged that four hospitals competed in the GAC cluster market, but only three of those hospitals competed in obstetrics. 45 Explaining its method for finding a separate, “unbundled” product market consisting of obstetrics, the FTC held that “OB services are offered under different competitive conditions than those applicable to the other services included in the GAC inpatient hospital services cluster market: one of the four Lucas County hospital providers . . . does not offer OB services.” 46

Similarly, in Reading Health, the FTC alleged four product markets: inpatient orthopedic services and three discrete outpatient service lines. 47 Although the parties overlapped with respect to all those services, the overlaps comprised just a small subset of the full range of services provided by the acquirer (Reading Hospital) and fewer than all the services provided by the seller (Surgical Institute). 48 According to the FTC, the services bundled inside each of the four markets had the same number of competitors and a common set of competitive conditions. 49 But the competitors identified as “significant” in the four markets were not the same: the FTC alleged that one hospital (St. Joseph) situated in the same three-hospital city (Reading, PA) as the merging parties was a “significant” competitor in only three of the four product markets. 50

Geographic Market Definition and Identification of Competitors. Geographic market definition involves the identification of suppliers and their locations that provide an effective competitive constraint on the price of the relevant product. 51 Determination of which hospitals compete in the relevant geographic market and valid measurement of the competitive constraint they impose are fundamental to an accurate assessment of competitive effects in hospital merger cases. That exercise focuses on whether the merging parties are close competitors for a sufficiently large set of patients and are constrained by so few sufficiently close alternatives that the competition lost by the merger will significantly reduce payors’ ability to negotiate competitive rates. 52

The criteria to determine whether particular hospitals are close substitutes can be complex and identifiable only through a fact-intensive inquiry. The FTC’s methods have involved a range of criteria that stem from a mix of geographic market definition principles (which hospitals to include in the market) and competitive effects principles (which hospitals are close substitutes without an express definition of the market). 53 The FTC seems first to examine how closely substitutable the merging hospitals are and then to examine which individual non-merging rivals impose a sufficiently strong competitive constraint to be regarded as significant participants in the relevant geographic market.

In Reading Health, the FTC identified significant competitors and defined the relevant geographic market according to the acquirer’s primary service area (PSA). 54 It estimated the parties’ and competitors’ shares within each of the analog product markets in a geographic region that corresponded to the PSA and that encompassed all of the acquirer’s inpatient services (i.e., including non-overlapping services that were outside the alleged product markets). 55 The FTC conducted this competitor-identification and share-estimate process four times (one for each of the alleged product markets)—each time using the same set of zip codes that comprised the PSA—while deriving shares based on the number of inpatient admissions (or outpatient visits) attributed to each hospital (or outpatient facility) that drew patients from the PSA.

The FTC counted a market participant as a “significant” competitor if its share met a certain threshold 56 and described the transaction’s competitive effects in terms of the number of significant competitors that would remain post-merger. 57 The FTC appears to have distinguished significant competitors from other market participants based largely on their current shares in the PSA, rather than on proximity to the merging parties or to PSA residents or any other attributes or capacity measures (e.g., number of beds). 58 For example, as noted, the FTC characterized as “not significant” in the alleged “ear, nose and throat surgical services” market a hospital in Reading located just a few miles from the merging parties that had a 2 percent current share of those particular outpatient service volumes in the acquirer’s PSA. 59

In ProMedica, the FTC did not specify a market based on the acquirer’s PSA but instead focused on a localized area of competition—Lucas County, Ohio. 60 Complaint counsel’s economic expert also offered a “willingness to pay” (WTP) discrete choice statistical model to evaluate how substitutable the merging hospitals (and each merging hospital and other rivals) were as participants in health plan provider networks. 61 Under this approach, the higher the estimated “diversion ratio” between the merging hospitals, the closer they are said to be substitutes. 62 When hospitals are close substitutes, it is more likely that a payor can offer a marketable provider network with one of the hospitals and does not necessarily need both. 63 Rival hospitals are likely to be regarded as significant competitors in the relevant market under this framework where there is considerable estimated diversion to them if
the merging hospitals were not available as in-network providers.\textsuperscript{64}

The PSA as a geographic market concept and WTP model as statistical tool to assess competition within a geographic market rely on historical inpatient data or insurer claims data. Both approaches are “static” and measure the significance of competition based on current shares instead of dynamic measures that account expressly for the response of rivals or consumers to changes in prices. As a consequence, each may underestimate the significance of competitors, especially in markets that are undergoing substantial change and where a hospital’s current share is not indicative of its capacity or competitiveness. Historical shares also do not take into account repositioning or expansion by hospitals (e.g., the opening of a new orthopedic surgical service capability by a hospital outside the geographic market to attract patients from within the geographic market), which may be especially relevant for consideration in markets that are undergoing substantial change.

**Preparation for Government Review**

Emerging from the foregoing are various steps involving factual development or data analysis that will help hospitals and their antitrust teams prepare for agency antitrust review.

- Understand and articulate how reform and re-alignment affect your market specifically.
- Organize reform/re-alignment points into a Horizontal Merger Guidelines framework.

To the extent your merger rationale has a foundation in health reform concepts—e.g., to obtain scale for cost-effective population health management and better medical outcomes—explain it in terms of the local market factors that substantiate your reasoning and the tangible ways the merger will accomplish these things.\textsuperscript{65} Also be specific about community impact if the merger does not happen, in terms of reduced access, limits on quality, and higher costs. Broad generalizations about adapting to the impact health reform will have on the U.S. health care system will probably not go very far in showing staff why your particular merger will effectuate real benefits and not substantially lessen competition in the relevant market.

- Seek payor support.
  It is common knowledge that the FTC seeks payors’ views on whether a hospital merger is likely to create pricing power. It is therefore a good idea for the hospitals to inform payors about the merger’s cost-reducing, quality-enhancing potential and seek their support. Hospitals also should determine whether local payors (a) market a tiered or limited network product that compensates consumers with lower prices in exchange for fewer in-network provider choices\textsuperscript{66} or (b) utilize tools that inform consumers about relative prices and potential cost savings in their provider choices. Each practice enables consumers to choose in-network providers that will save them money, even if it means driving a little farther for the care.

- Be ready to explain the procompetitive rationale for the merger.
  “So why are you doing this deal?” Agency staff will want to know why you are merging. If you cannot respond with conviction, facts, and ordinary-course documents, then staff may question your motivations.\textsuperscript{67}

- Be ready to respond to staff skepticism about your efficiency claims.
  The Horizontal Merger Guidelines state that efficiency claims should be merger-specific, cognizable, and substantiated, and FTC staff is vigorous in putting such claims to these tests. Hospitals should anticipate this and scrutinize their efficiency claims—just like FTC staff will—and try to plug any holes you find. For example, a merger may enhance recruitment of specialist physicians who are drawn to a merged system that offers a high combined volume of services in that specialty. If that benefit applies, then be prepared to show that current physician staffing in that specialty at one of the hospitals is insufficient to sustain quality at a competitive level, that you have tried and failed to recruit quality doctors, and that the merger will make recruitment better.

Merging hospitals also may plan to integrate a particular service line in one facility to save cost and improve quality. Staff will ask how this will not create a major inconvenience for patients who live near the hospital where the clinical service will be removed. Hospitals should be ready with the answer, e.g., that any extra travel time is minimal and in any event outweighed by cost and quality benefits that enhance patient experience.

- Prepare to defend the merger’s effects not just in a GAC market but also in individual inpatient, outpatient or physician service (or vertical) markets.
  A merger may raise no concerns in a traditional GAC product market but fail FTC screens if assessed in a narrow alleged market comprising a subset of clinical services. Parties would be smart to identify any overlaps at the service-line level where their combined share substantially exceeds their GAC share. If any exist, then apply a Merger Guidelines analysis to those narrow potential markets and adopt the other practices noted above and below, i.e., prepare to defend the merger in that context. The FTC is increasingly attentive to hospital

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merger effects on services beyond inpatient. It recently alleged harm from health system mergers in markets for primary care physician services (in OSF Healthcare68) and certain outpatient procedures (in Reading Health System69), filed a legal challenge to a hospital’s acquisition of a physician group.70

• Assess whether hospitals at farther distances are becoming important competitive constraints to the merging parties.

The FTC is likely to evaluate competitive effects, at least in part, by using economic models in which patient travel times are an important factor in its assessment of which hospitals are competitive alternatives to the merging parties. Statistical model predictions based on historical data perhaps may be refuted by evidence that more distant hospitals are repositioning and expanding in ways that make them significantly more competitive in attracting patients and referrals, or that consumers are increasingly willing to travel further distances to save on insurance co-payments, premiums or deductibles.

• Know your payor contracts.

Agencies are increasingly concerned about provider contracts that include exclusivity provisions, most-favored-nation clauses, references to rivals, or other clauses that could be open to scrutiny for their potential limitations on competitor entry and expansion or on tiered or limited payor networks that offer options for consumers to choose providers based on price differences. Hospitals in merger transactions should know whether such provisions are contained in their own payor contracts and, if so, should be prepared to explain their business rationale, the competitive justifications for them, and why their existence will not lead to anticompetitive effects from the merger.

Conclusion

The provision of health care services in the United States is undergoing transformational changes. Some changes are systemic, arising from responses to cost pressures and misalignment tied to shifts away from inpatient to outpatient care and other market factors. Other changes reflect provider and payor responses to PPACA and other statutory and regulatory mandates that alter optimal modes for the delivery of care, including payment incentive and penalty provisions targeted to achieving goals of lower costs and higher quality. For hospitals, integration into larger health systems may be necessary to compete effectively because efficiency, scale, and access to capital are fundamental to meeting demands for improved population health management as well as health reform’s quality metrics and mandates to control the total cost of care.

But horizontal hospital mergers also are subject to intense antitrust scrutiny. Merger review is inherently forward looking and intent on discerning the impact of a particular transaction in a particular context. However, the dynamics of health care reform mean that the future with the merger and the future with the “status quo” may be difficult to discern but is critical to specifically demonstrate to the antitrust law enforcers to the extent possible.

To show that a merger will advance health reform’s cost and quality goals and not result in market power, parties must explain the realities of reform-era competition in their particular local market and show through concrete facts and sound economic analysis the reasons why the merger will not lessen that competition. They should strive to demonstrate the implications for competition and the economics of the particular market if the transaction were not to occur. To accomplish this, hospitals must understand how the FTC, based on its recent cases, applies market definition, competitive effects analysis, efficiencies analysis, and the other Horizontal Merger Guidelines concepts specifically to hospital mergers. In this way, hospitals will be in a far better position to show that their merger will foster, not limit, hospital competition, and to demonstrate that the market will be more competitive and effective in providing quality and efficient healthcare after the merger, especially as the market continues its transformation under health care reform. ■

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4 See, e.g., New York State Department of Health, New York State Medicaid Redesign Team (MRT) Waiver Amendment: Achieving the Triple Aim 4 (2012), available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf. A major area of change under the PPACA involves state Medicaid programs, which are impacted significantly by the PPACA; states’ reforms to significant budgetary issues associated with Medicaid adopted in response to the Act; and finally by states’ efforts to improve healthcare delivery systems (access, quality, and costs) associated with Medicaid. See, e.g., U.S. Gov’t Accountability Office, GAO-10-821, Medicaid Expansion: States’ Implementation of the Patient Protection and Affordable Care Act (2012), available at http://www.gao.gov/assets/600/593210.pdf.
5 For example, insurers are introducing innovative new benefit designs and network products in response to pressure from employers to provide greater transparency in the relative costs of care at different providers and to enable (and incentivize) consumers to take costs into consideration in their choice of health care provider. See discussion supra p. 65.
6 Among the most significant of these factors is a general decline in inpatient admissions in many communities. Am. Hospital Ass’n, Chartbook: Trends Affecting Hospitals and Health Systems tbl. 3.1 (2013) [hereinafter AHA Chartbook], available at http://www.aha.org/research/reports/tw/chartbook/2013/table3-1.pdf. This decline is due, in part, to shifts to outpatient care as a result of significant changes in employment or insurance


8 Berwick et al., supra note 7, at 762.


10 See Berwick, supra note 7, at 763–64 (noting that the integrator has the ability to take a defined population and coordinate services to address care, health, and costs).


13 See Hospital Statistics by State, AM. HOSP. DIRECTORY, http://www.ahd.com/state_statistics.html (last accessed May 20, 2013) [hereinafter AM. HOSP. DIRECTORY]. An examination of the data shows that many hospitals have fewer than 150 beds. Id.

14 These technologies include new surgical techniques (e.g., laparoscopic procedures), new types of anesthesia, and devices that enable certain procedures, such as hernia repair, gallbladder removal, tonsillectomies, and many other procedures done primarily on an outpatient rather than inpatient basis. Incisions are less invasive, recovery is quicker, and patient stays are substantially shorter. See U.S. DEPT. OF HEALTH & HUMAN SERV., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, AHRQ PUBLICATION NO. 07-0007, AMBULATORY SURGERY IN US HOSPITALS 26–40 (2007), available at http://archive.ahrq.gov/data/hcup/factbk9/factbk9.pdf.


16 See id.

17 See id. The number of Medicare-credited Ambulatory Surgery Centers (ASCs) grew by 1,000 between 2005 and 2010 to total 5,316. See AHA CHARTBOOK, supra note 6, at tbl.2.1, available at http://www.aha.org/research/reports/tw/chartbook/2013/table2-1.pdf.

18 Inpatient admissions declined from 2004–2010 at a rate of 1 percent, along with inpatient occupancy. Volume of hospital outpatient services averaged 4 percent or greater increase in same period. MEDICARE PAYMENT ADVISORY COMMITTEE, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 47 (2013).

19 Significant excess capacity can result in higher operating costs per patient; reduction or elimination of excess capacity may be difficult to achieve absent mergers or consolidation. See, e.g., Kathleen Carey, Stochastic Demand for Hospitals and Optimizing “Excess” Bed Capacity, 14 J. REG. ECON. 165 (1998); Esther Gal-Orr, Excessive Investment in Hospital Capacities, 3 J. ECON. & MGMT. STRATEGY 53 (1994).

20 Average bed capacity is about 2.5 beds per thousand people, with very substantial variation across regions, even with adjustments for various patient population characteristics. Cities in Midwestern and eastern states in particular have higher bed capacity per thousand. See David C. Goodman et al., DARTMOUTH INST. FOR HEALTH POLICY & CLINICAL PRACTICES, HOSPITAL AND PHYSICIAN CAPACITY UPDATE: A BRIEF REPORT FROM THE DARTMOUTH ATLAS OF HEALTH CARE 2–3 (2009).


25 See SHIH, supra note 24, at 4–8 (discussing studies of 15 different integrated delivery systems, some physician-led, some insurer-led, and some health-system-led (and combinations thereof)).


27 See Emily R. Carrier et al., Hospitals’ Geographic Expansion in Quest of Well-Insured Patients: Will the Outcome Be Better Care, More Cost, or Both?, 31 HEALTH AFF. 827 (2012) (reporting on interviews in 12 communities and finding that many large hospitals are broadening service areas through physician practices and other means).

28 For a general discussion of the trends towards consumer-driven health plans, see Amelia M. Haviland et al., Growth of Consumer-Directed Health Plans to One-Half of All Employer-Sponsored Insurance Could Save $57 Billion Annually, 31 HEALTH AFF. 1009 (2012).

29 A tiered network product typically includes two or three tiers of providers, and a consumer is free to choose among the hospitals in the network, but pays a higher co-pay, deductible, or other out-of-pocket payment for a hospital in a higher cost tier. A narrow network functions in a similar form, except the network of hospitals includes a specific set of hospitals from which the consumer can choose. See NAT’L GOVERNORS ASS’N, STRATEGIES FOR CURBING HEALTH INSURANCE COSTS FOR STATE EMPLOYEES: BENEFIT DESIGN, WELLNESS PROGRAMS, AND DATA MINING 5 (2012), available at http://www.nga.org/files/live/sites/NGA/files/pdf/1210StrategiesForCuringHealthInsuranceCosts.pdf.


See MASS. REPORT, supra note 30, at 15 n.45.


See id.

See id. at 8.

Based on an examination of census population statistics and hospitals and their bed capacity by MSA, the most populous cities tend to be unconcentrated using MSA and bed capacity as measures for geography and share, respectively. See Am. Hosp. Ass’n, AHA Hospital Statistics (2013); U.S. Census Bureau, Population Div., Metropolitan and Micropolitan Statistical Areas, http://www.census.gov/popest/data/metro/total/2011/ (last accessed May 20, 2013).


FTC Bureau of Economics staff published papers analyzing price effects from certain consummated mergers as part of a hospital merger retrospective of the years preceding 2007. See Deborah Haas-Wilson & Christopher Garmon, Hospital Mergers and Competitive Effects: Two Prospective Analyses, 18 Int’l J. Econ. Bus. 17 (2011).


Complaint, Reading Health Sys., FTC File No. 121-0155 (Nov. 16, 2012), available at http://www.ftc.gov/os/adprob/d9335/121116readingsurgicalcmtp.pdf. The authors served, respectively, as counsel to the Surgical Institute of Reading, and economic consultant to both merging hospitals.

See, e.g., United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 138 (E.D.N.Y. 1997) (collecting cases through 1997); The authors served, respectively, as counsel to the merging hospitals, and economic expert witness called at trial by the merging hospitals. See also Complaint, in re OSF Healthcare Sys., FTC File No. 111-0102 (Nov. 18, 2011), available at http://www.ftc.gov/os/adprob/d9349/111118Rockfordcmtp.pdf. Mr. Brennan served as counsel to defendant Rockford Health System.


Complaint, Reading Health System, supra note 40.


Opinion of the Commission, in re ProMedica Health Sys., supra note 44.

Complaint, Reading Health System, supra note 40 (allleging four markets: inpatient orthopedic/spine surgical services; outpatient orthopedic/spine services; outpatient ENT surgical services; and outpatient general surgical services).

The FTC’s press release accompanying its complaint points out that the 737-bed Reading Hospital broadly provides “inpatient general acute care, tertiary services and outpatient care,” whereas the 15-bed Surgical Institute provides a more limited “range of inpatient and outpatient surgical services.” See Press Release, Fed. Trade Comm’n, FTC and Pennsylvania Attorney General Challenge Reading Health System’s Proposed Acquisition of Surgical Institute of Reading (Nov. 16, 2012), available at http://www.ftc.gov/opa/2012/11/reading.stmt. Within Reading Hospital’s overall cluster of inpatient general acute care services and Surgical Institute’s “range” of inpatient service offerings, only one inpatient service line was an alleged relevant product market in the complaint: “inpatient orthopedic/spine surgical services.” Id.

Complaint at 10–12, Reading Health System, supra note 40.

See Complaint at 10–12.

See id.


See Am. Bar Ass’n, supra note 51, at 31–74; Haas-Wilson & Garmon, supra note 38, at 17, 21.

Complaint at 12, Reading Health System, supra note 40. The complaint alleges that the acquiring hospital defined its PSA as “the set of zip codes from which [it] draws approximately 85 percent of its patients.” Id.

Id.

For example, in inpatient orthopedic/spine surgical services, hospitals with shares below 4 percent in the PSA appear to have been included in the relevant geographic market for purposes of calculation of shares and HHIs but were not counted as “significant” competitors. Id. at 13–14.

See, e.g., id. at 16.

See, e.g., id. at 12.

Id. at 15.


Opinion of the Commission at 49, ProMedica Health System, supra note 60.

Farrell et al., supra note 52, at 275–77.

WTP models derive estimates of a hospital’s value to a health plan provider network and evaluate a merger’s competitive significance based on estimated diversion and on the change in the network’s value if offered without the merged parties. A diversion ratio for Hospital A to Hospital B is calculated by estimating the fraction of patients that would shift to Hospital A under the assumption they are “leaving” Hospital A. The model attempts to estimate the hospitals to which patients would likely shift were Hospital A not included in a health plan network. WTP models require specific assumptions that, in at least some case, may not adequately reflect a market’s competitive realities. For a summary of how these models have been used at FTC, see Farrell et al., supra note 52. For a discussion and assessment of the ramifications of these assumptions, see Bryan Heating et al., Comment on Farrell, Balan, Brand and Wendling (2011), Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets (June 19, 2012) (unpublished manuscript), available at http://ssrn.com/abstract=2051028.


The health care literature increasingly reflects empirical studies of gains
from integration and new health care delivery models. See SHIH, supra note 21, at 4–8; see also David Dranove & Richard Lindrooth, Hospital Consolidation and Costs: Another Look at the Evidence, 22 J. Health Econ. 983 (2003) (discussing empirical estimates of cost savings from mergers and systems).

Tiered and narrow network contracting expands the mechanisms for payors to obtain competitive contracts and to make use of alternative suppliers and can result in positive changes in consumer behavior. For a discussion of implications see supra notes 28–30. See also Katherine Ho, Insurer-Provider Networks in the Medical Care Market, 99 Am. Econ. Rev. 393 (2009).


Complaint, Reading Health Sys., FTC File No. 121-0155 (Nov. 16, 2012), available at http://www.ftc.gov/os/adjpro/d9353/121116readingsurgicalcmpt.pdf. In assessing a merger’s effect on outpatient service competition, it would be prudent to identify ambulatory surgical centers and other freestanding facilities, in addition to other hospital outpatient facilities, and to develop information about their entry, expansion, service lines, attending physicians, and inclusion in payor networks.