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NOTE

MONOPOLECTOMY: AN ANTITRUST ANALYSIS OF HEALTHCARE FACILITIES MERGERS UNDER THE FTC'S 2023 MERGER GUIDELINES

George Balchunas

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George Balchunas[*]

I. INTRODUCTION

At an airport, a concert venue, or a sporting event, one is not surprised when a sandwich and a beer cost twenty-five dollars together. At such locations, one anticipates monopoly pricing and prepares accordingly. Healthcare markets in the United States—product markets with more than a few saliently different characteristics than the airport beer market—nonetheless resemble the airport with respect to prices. Per capita health consumption expenditures in the United States comparatively eclipse the per capita health consumption expenditures of other wealthy countries.[1] The mean large, developed country spends about half of what the United States spends per person on healthcare.[2] Naturally, under these circumstances, healthcare costs have consumed a great deal of political attention. The focus of most of this political attention has been on the cost of insurance and

[*] Need author's information.

[1] Emma Wager, Matthew McGough, Shameek Rakshit, Krutika Amin & Cynthia Cox, *How does health spending in the U.S. compare to other countries?*, PETERSON-KFF HEALTH SYSTEM TRACKER (Jan. 23, 2024), https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#GDP%20per%20capita%20and%20health%20consumption%20spending%20per%20capita,%202021%20(U.S.%20dollars,%20PPP%20adjusted).

[2] *Id.*

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prescription drugs on the democratic side,[3] and the cost of compliance with government regulation on the republican side.[4] Yet in the breakdown of total healthcare spending, the largest percentage of expenditures are not directed towards insurance profits, nor to prescription drugs, nor to government administration, nor to government health activities, but to hospital care.[5] In 2021, total expenditure on net insurance costs, prescription drugs, government public health activities, and government administration in the United States added up to $842.8 billion, less than two-thirds of total expenditures on hospital care: $1.3239 trillion.[6] The cost of hospital care thus deserves as much attention as these other significant policy concerns.

Healthcare services markets display a trend toward concentration in recent decades.[7] 1,887 hospital mergers have been announced in the United States between 1998 and 2021.[8] In one regional market—really, in several regional markets—the University of Pittsburgh Medical Center (UPMC) acquired twenty-eight hospitals between 1996 and 2019.[9] UPMC's consolidating tendency has not slowed down into the present: in June of 2023, UPMC signed a non-binding letter of intent to affiliate with the Washington Health System, which consists of two hospitals.[10]

Meanwhile, in December of 2023, the two federal agencies empowered to enforce federal antitrust law, the Federal Trade Commission (FTC) and

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[3] *See, e.g.*, Press Release, White House Briefing Room, FACT SHEET: President Biden Takes New Steps to Lower Prescription Drug and Health Care Costs, Expand Access to Health Care, and Protect Consumers (Mar. 6, 2024) (https://www.whitehouse.gov/briefing-room/statements-releases/2024/03/06/fact-sheet-president-biden-takes-new-steps-to-lower-prescription-drug-and-health-care-costs-expand-access-to-health-care-and-protect-consumers/).

[4] *See, e.g.*, Council of Economic Advisors, *Deregulating Health Insurance Markets: Value to Market Participants*, GOVINFO (Feb. 2019), https://www.govinfo.gov/content/pkg/GOVPUB-PREX6-PURL-gpo117182/pdf/GOVPUB-PREX6-PURL-gpo117182.pdf.

[5] *Trends in health care spending*, AM. MED. ASS'N (Mar. 20, 2023), https://www.ama-assn.org/about/research/trends-health-care-spending.

[6] *Id.*

[7] Hoag Levins, *Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality*, UNIV. OF PA. (Jan. 19, 2023), https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/.

[8] *Id.*

[9] Dave Muoio, *Pennsylvania community health system pursuing affiliation with UPMC*, FIERCE HEALTHCARE (June 21, 2023), https://www.fiercehealthcare.com/providers/penn-community-health-system-pursuing-affiliation-upmc.

[10] *Id.*

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the Department of Justice (DOJ), released new merger guidelines[11] that signal a more aggressive approach to Section 7 of the Clayton Antitrust Act in seeking injunctions against corporate mergers. The new guidelines above all signal a stronger presumption of illegality with respect to mergers and thus require less concrete evidence of a merger's future individualized detrimental impacts on consumer welfare than previous guidelines for FTC or DOJ's antitrust division to prosecute such mergers. Whether these guidelines will acquire cachet in the courts and change the state of antitrust law as we know it is an open question.

Similarly, in February of 2023, the Department of Justice retracted Clinton-era policy statements creating an "antitrust safety zone" for hospital mergers.[12]

This Note will consider how the changes in FTC and DOJ policy signaled by the 2023 guidelines bear upon the healthcare services market. Though ultimately it is not likely that the shift in the agencies' policies will be perfectly reflected in judicial decisions, healthcare administrators and their legal counsel concerned with the expense of litigation can consult this Note to understand how the FTC and DOJ will analyze mergers in their industry under the new guidelines.

II. CHANGES FROM PREVIOUS GUIDELINES

The central distinguishing feature of the FTC's 2023 Guidelines is a stronger presumption that mergers which appreciably increase concentration within a given market are anticompetitive compared to previous merger guidelines.

Section 7 of the Clayton Act is the source of legislative authority by which the FTC and DOJ are empowered to institute suits for injunctions which prevent anticompetitive mergers.[13] Section 7 provides:

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[11] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

[12] Press Release, Department of Justice, Justice Department Outdated Enforcement Policy Statements (Feb. 3, 2023) (https://www.justice.gov/opa/pr/justice-department-withdraws-outdated-enforcement-policy-statements).

[13] 15 U.S.C. § 18

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> No person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person engaged also in commerce or in any activity affecting commerce, where in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be *substantially to lessen competition* [emphasis added], or to tend to create a monopoly.[14]

The indefiniteness of the phrase "substantially to lessen competition" grants the FTC and DOJ and, ultimately, the courts of the United States, significant interpretive discretion. In 2010, the FTC and DOJ's guidelines for horizontal mergers summarized how they would interpret that phrase by stating that mergers should "not be permitted to . . . enhance . . . market power" and that "[a] merger enhances market power if it is likely to encourage one or more firms to raise price, reduce output, diminish innovation, or otherwise harm customers."[15] Those guidelines further elaborate that measuring market shares and market concentration are not "end[s] in [themselves]," but are "only useful to the extent [they] [illuminate] the merger's likely competitive effects."[16] The 2023 guidelines, in contrast, present their governing philosophy through a quotation from a 1963 Supreme Court opinion stating:

> A merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market, is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects.[17]

This difference in philosophy represents a different set of values adopted into the interpretation of Section 7 of the Clayton Act. The 2010 guidelines do not explicitly define competition, but in enforcing Section 7's prohibition against mergers which "may substantially lessen competition" speak of seeking to "identify and challenge competitively harmful mergers while

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[14] *Id.*

[15] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 2 (Aug. 19 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf.

[16] *Id.* at 7

[17] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES 5 (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf. (quoting United States v. Phila. Nat'l Bank, 374 U.S. 321, 363 (1963).

avoiding unnecessary interference with mergers that are either competitively beneficial or neutral."[18] In this identification of "competitive harmfulness," "beneficence," or "neutrality," the 2010 guidelines roughly adopt the view of neoclassical economic theory: that a merger's impact on competition is a function of balancing the positive economic impacts of efficiencies (increases in output and decreases in price) that a merger is likely to generate against the harms of monopoly pricing (decreases in output and increases in price).[19]

By contrast, the 2023 guidelines provide an explicit definition of competition:

> Competition is a *process* [emphasis added] of rivalry that incentivizes businesses to offer lower prices, improve wages and working conditions, enhance quality and resiliency, innovate, and expand choice, among many other benefits. Mergers that substantially lessen competition or tend to create a monopoly increase, extend, or entrench market power and deprive the public of these benefits.[20]

While this definition references results similar to those identified in the 2010 guidelines (and it should be clarified that the 2010 guidelines speak of other competitive outcomes apart from price and output quantity), it identifies competition with the *process* of rivalry which incentivizes these outcomes, rather than the outcomes themselves. Thus, when the guidelines go on to say of efficiencies that "merging parties must demonstrate through credible evidence that, within a short period of time, the benefits will prevent the risk of a substantial lessening of competition in the relevant [market,]"[21] the competition spoken of should not be assumed to consist in what the 2010 guidelines called "competitive effects";[22] instead, to qualify as a pro-competitive efficiency under these guidelines, a merger must create efficiencies which amplify the process of competition. For example, if a merger were to create a firm whose efficiencies were likely to directly benefit consumers in some way, but substantially increased the concentration of a market and for one reason or another (e.g., high barriers to entry) and was

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[18] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 1 (Aug. 19 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf.

[19] *Id.* at 31.

[20] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES 1 (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

[21] *Id.* at 33.

[22] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 1 (Aug. 19 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf.

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not likely to spur rival firms to also benefit consumers in the same or a similar way, this merger would not, strictly speaking, be pro-competitive in the terms of the 2023 guidelines.

The following subsections of this note examine the more specific differences between the 2023 and 2010 merger guidelines.

A. The 2023 Guidelines Introduce New Thresholds for Presumptive Illegality

The two principal metrics by which the 2023 guidelines measure the competitive effect of a merger are the post-merger market share of the merged firms themselves and the Herfindahl-Hirschman Index (HHI).[23] Market share is the percentage of a market's total unit output, revenue, capacities, or reserves occupied by a given firm's individual unit output, revenue, capacities, or reserves.[24] The Herfindahl-Hirschman Index is the sum of squares of the market share of all firms in a market.[25] For instance, in a market with one firm, the firm would have a market share of 100 and the HHI would be 10,000; in a market with four firms of equal size, the market share of each firm would be 25%, and the HHI would be 2,500; in a market with three firms with equal market share, the HHI would be 3,333; and in a market with three firms where two have a market share of 25% and one has a market of 50%, the HHI would be 3,750.

The 2010 guidelines define "highly concentrated markets" as markets with an HHI over 2,500.[26] Mergers which would increase HHI by 200 points and result in highly concentrated markets are "presumed to be likely to enhance market power."[27] The purpose of this threshold was "not to provide a rigid screen to separate competitively benign mergers from anticompetitive ones," but to "provide one way to identify some mergers unlikely to raise competitive concerns and some others for which it is particularly important

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[23] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES 5 (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

[24] *Id.* at 50. Which variable—unit output, revenue, capacities or reserves—is the most useful metric to measure market share depends on the given market.

[25] *Id.* at 5.

[26] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 19 (Aug. 19 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf.

[27] *Id.*

to examine whether other competitive factors confirm, reinforce, or counteract the potentially harmful effects of increased concentration."[28]

In contrast, Guideline 1 of the 2023 guidelines set the threshold for "highly concentrated markets" at 1,800.[29] Mergers which result in an increase HHI by 100 points and result in a "highly concentrated market" or in a merged firm with a market share of 30% are "presumptively illegal" under the 2023 guidelines, although this presumption can be rebutted or disproved.[30]

B. The 2023 Guidelines Present a New Focus on a Merger's Potential Entrenchment of a Firm's Dominant Position

Guideline 6 of the 2023 guidelines introduces several structural concerns which were not present in the 2010 guidelines. Guideline 6 states that mergers can violate the law when they entrench or extend a dominant position.[31] Generally, this guideline looks at how a merger can play a role in a firm's strategy and tactics for maintaining market power over the long term.[32] When the facts of a particular merger lend credence to this perception, the merger will be subject to additional scrutiny.[33]

Guideline 6 recites several different ways in which a merger can harmfully solidify or extend a dominant position in the long term "even when it initially provides short-term benefits to some market participants."[34] The first group of ways mergers entrench a dominant position falls under the general category of "means to increase barriers to entry or expansion by competitors."[35] Mergers can increase barriers to entry by increasing switching costs; by interfering with the use of competitive alternatives; and by depriving rivals of scale economies or network effects.[36] The other

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[28] *Id.*

[29] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES 6 (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

[30] *Id.*

[31] *Id.* at 18.

[32] *Id.*

[33] *Id.* at 21.

[34] *Id.* at 18.

[35] *Id.* at 19.

[36] *Id.*

principle means by which mergers entrench a dominant position in a market is by eliminating nascent competitive threats.[37]

Guideline 6 distinguishes extension from entrenchment, but both are reasons to subject a merger to scrutiny.[38] Extension, like entrenchment, is not merely the acquisition of a greater market share; it is the exploitation of the dominant position of a merging party in its market to create a dominant position in another market through the merger.[39]

C. The 2023 Guidelines Present a New Focus on Trends Toward Concentration in the Particular Industry Which Merging Firms Inhabit

Guideline 7 of the 2023 guidelines introduces a new concern which was not present in the 2010 Guidelines: whether an industry as a whole displays a trend toward concentration.[40] The choice of the word "industry" is noteworthy. If the word "market" were used, this guideline would not be very different from Guideline 1, except perhaps with more attention to the behavior of other firms in the same market. However, markets are defined both by products involved and the geographic reach of a market. The use of the term "industry" suggests a broader reach than the determination of market definition laid out in Section 4.3 of the guidelines.[41] This could be a broader reach in products, for example encompassing non-substitutable products in the same supply chain, but more significantly, encompassing a broader reach than the geographic market in market definition. In the industry covered by this Note, for instance, a hospital care market would be defined within a limited geographic region wherein patients travel for healthcare, whereas the "hospital care industry" probably includes all of the hospitals within the United States.

Thus, whereas an analysis of whether a trend towards concentration exists in a given hospital care market would analyze the HHI data of a hospital market in a limited geographic over a relevant period of time, an analysis of whether a trend towards concentration in the hospital care

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[37] *Id.* at 20.
[38] *Id.* at 21.
[39] *Id.*
[40] *Id.* at 22.
[41] *See id.* at 39–47.

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industry would analyze the HHI data of all the different geographic markets in the United States.

Guideline 7 provides several policy justifications for additional scrutiny of mergers in industries displaying a trend towards concentration.[42] First, the trend toward concentration in an industry can indicate that "new entry may be less likely to replace or offset the lessening of competition the merger may cause."[43] Similarly, a trend towards concentration in an industry by way of vertical integration directly magnifies concerns over the creation of new barriers to entry "by making entry at a single level more difficult and thereby preventing the emergence of new competitive threats over time."[44] Finally, the trend toward concentration in an industry can create an "arms race for bargaining leverage."[45] Where concentration in an industry creates bargaining leverage for firms with high market share over their trading partners, this trend can:

> [Encourage] those other firms to consolidate to obtain countervailing leverage, encouraging a cascade of further consolidation. This can ultimately lead to an industry where a few powerful firms have leverage against one another and market power over would-be entrants or over trading partners in various parts of the value chain . . . . This can exacerbate . . . problems . . . including . . . increasing barriers to single-level entry, encouraging coordination, and discouraging disruptive innovation.[46]

D. The 2023 Guidelines Present a New Focus on a Merging Firm's Series of Acquisitions

Whereas the 2010 guidelines' focus is implicitly directed towards individual mergers—as is natural, considering the language of Section 7 of the Clayton Act—Guideline 8 of the 2023 guidelines identifies a policy of looking at individual mergers within the context of a merging party's overall behavior with respect to mergers and acquisitions.[47] Guideline 8 reads:

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[42] *Id.* at 22.
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] *Id.* at 23.

"when a merger is part of a series of multiple acquisitions, the agencies may examine the whole series."[48]

E. The 2023 Guidelines State Their Focus on Monopsony with Respect to Labor

Monopsony, like monopoly, is a market structure which creates market power for a monopsonist, but in the opposite direction: whereas monopoly is a market structure in which there is one dominant seller of a product, monopsony is a market structure in which there is one dominant buyer of a product.[49]

The 2010 guidelines did not altogether ignore monopsony.[50] The 2010 guidelines more or less state that in regard to mergers, the analysis of a merger's effect on market power for buyers essentially mirrors its analysis for sellers.[51]

The 2023 guidelines say the same thing in different words.[52] The novelty of Guideline 10 of consists in a new focus on how a merger can effect a monopsony in labor markets absent from the 2010 guidelines.[53] The 2010 guidelines did not identify or enumerate the characteristics of any particular product market with regard to monopsony.[54] The 2023 guidelines not only identify labor as a particular product market where monopsony power is a focus of attention for the FTC and DOJ, but announce a policy of treating monopsony power in labor markets as particularly salient due to the characteristics of labor markets.[55] These characteristics are high switching

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[48] *Id.* The guidelines cite *Brown Shoe Co. v. United States*, 370 U.S. 294, 334 (1962) to support an interpretation of section 7 which justifies this policy.

[49] Julie Young, *Monopsony: Definition, Causes, Objections, and Example*, INVESTOPEDIA (Feb. 20, 2023), https://www.investopedia.com/terms/m/monopsony.asp#:~:text=A%20monopsony%20is%20a%20market,difference%20between%20the%20controlling%20entities.

[50] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 32–33 (Aug. 19 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf.

[51] *Id.*

[52] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES 26 (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

[53] *Id.* at 26–27.

[54] *See* U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 32–33 (Aug. 19 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf.

[55] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES 26–27 (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

costs for employees and the narrowness of certain relevant markets for buyers with respect to specialized labor.[56]

F. The 2023 Guidelines Create a Structural Standard for "Cognizable Efficiencies"

The 2010 guidelines, just like the 2023 guidelines, separate efficiencies resulting from a merger that can present a valid defense to the presumption of a merger's illegality from those which do not by the label "cognizable efficiencies."[57] However, the pool of cognizable efficiencies is narrower in the 2023 guidelines. As discussed above, the 2023 guidelines define competition in terms of process and market structure instead of outcome.[58] Thus, while both guidelines speak of "procompetitive efficiencies," it cannot be assumed that both sets of guidelines mean the same thing.

III. UNIQUE FEATURES OF HEALTHCARE MARKETS AS IDENTIFIED BY CASE LAW AND GOVERNMENT POLICY

In order to analyze whether a merger may substantially lessen competition in a given market under Section 7 of the Clayton Act, it is necessary to identify the unique competitive features of that market and, more broadly, the industry to which the market belongs.[59]

Private parties and the FTC have challenged hospital mergers in the past.[60] Some of these cases have exercised a substantial influence on antitrust law as a whole.[61] Similarly, significant federal and state statutory and regulatory policies have identified and, in some cases, created important

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[56] *Id.*

[57] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 30 (Aug. 19 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf.

[58] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES 1 (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

[59] United States v. General Dynamics Corp., 415 U.S. 486, 498 (1974).

[60] *See, e.g.*, Hosp. Corp. of Am. v. FTC, 807 F.2d 1381 (7th Cir. 1986); FTC v. Freeman Hosp., 911 F. Supp. 1213 (W.D. Mo. 1995); FTC v. Tenet Health Care Corp., 186 F.3d 1045 (8th Cir. 1999); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997); HTI Health Servs., Inc. v. Quorum Health Grp., Inc., 960 F. Supp. 1104 (S.D. Miss. 1997); Saint Francis Hosp. & Med. Ctr., Inc. v. Hartford Healthcare Corp., 655 F. Supp. 3d 52 (D. Conn. 2023).

[61] *See, e.g.*, Hosp. Corp. of Am. v. FTC, 807 F.2d 1381, 1388 (7th Cir. 1986); FTC v. Freeman Hosp., 911 F. Supp. 1213 (W.D. Mo. 1995).

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competitive features of healthcare markets.[62] Generalizable competitive features of healthcare markets will be identified here.

A. Demand Is Relatively Price Inelastic in Healthcare Markets

Price elasticity of demand is the sensitivity of consumer demand to increases and decreases in prices.[63] The more or less of a product consumers buy in response to a price decrease or increase, the more price-elastic a product is.[64]

The more price-inelastic the demand for a product is, the greater the harm to consumers by market concentration.[65] A more intuitive way of putting this is that market concentration is relatively benign in markets for highly price-elastic products.[66] Since, in such markets, a relatively small price increase will lead to a relatively high loss of demand, a monopolist or firm in a highly concentrated market will have less incentive to dramatically raise prices, because a great increase in prices will lead, at a certain point, to a loss of revenue.[67] Thus, a firm in a monopolistic market for a relatively elastic product's profit-maximizing price will not be as high in relation to what that price would be in a competitive market than a firm in a monopolistic market for a relatively inelastic product.[68]

Demand is relatively inelastic in healthcare markets as a whole, though price-elasticity varies greatly between healthcare products.[69] Accordingly,

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[62] *See* Matthew D. Mitchell & Christopher Koopman, *40 Years of Certificate-of-Need Laws Across America*, MERCATUS CENTER (Sept. 27, 2016), https://www.mercatus.org/research/data-visualizations/40-years-certificate-need-laws-across-america.

[63] *Price Elasticity of Demand: Meaning, Types, and Factors That Impact It*, INVESTOPEDIA, https://www.investopedia.com/terms/p/priceelasticity.asp#:~:text=Price%20elasticity%20of%20demand%20is%20the%20ratio%20of%20the%20percentage,when%20a%20product%27s%20price%20changes (updated Feb. 7, 2024).

[64] *Id.*

[65] HERBERT HOVENCAMP, PRINCIPLES OF ANTITRUST 62–64 (2d ed. 2020).

[66] *See id.*

[67] *See id.*

[68] *See id.*

[69] *See* Randall P. Ellis, Bruno Martins & Wenjia Zhu, *Health care demand elasticities by type of service*, 55 J. OF HEALTH ECON. 232, 237–39 (2017).

inelasticity of demand in healthcare markets has been identified as a reason to believe mergers may substantially lessen competition.[70]

B. Competitors Closely Cooperate in Healthcare Markets, Raising Sherman Act Section 1 Concerns

The nature of the healthcare industry requires close cooperation among competitors.[71] The effective transfer referral of patients, sharing of patient data, sharing of laboratory equipment, etc. necessitate close relationships of cooperation among competitors.[72] The facilitation of this need is one of motivations for and legal defenses of hospital mergers,[73] as will be discussed below.[74]

While, with respect to efficiencies defenses, the necessity of coordination in the healthcare services industry giveth, it taketh away in Section 7 of the Clayton Act's relation to Section 1 of the Sherman Act.[75] Both the 2010[76] and 2023 guidelines[77] identify a policy priority of the Section 7 enforcement as the prevention of tacit collusion among competitors as a kind of gap filler remedying the failure of Sections 1 and 2 of the Sherman Act to prevent tacit as opposed to explicit price collusion. The existing high levels of coordination among healthcare providers have been cited as a reason why mergers in hospital care markets are particularly likely to "substantially

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[70] *See* Hosp. Corp. of Am. v. FTC, 807 F.2d 1381, 1388 (7th Cir. 1986) (Posner, J.) ("[Demand] for hospital services by patients and their doctors is highly inelastic under competitive conditions. This is not only because people place a high value on their safety and comfort and because many of their treatment decisions are made for them by their doctor, who doesn't pay their hospital bills; it is also because most hospital bills are paid largely by insurance companies or the federal government rather than by the patient.").

[71] *See* Paolo Berta, Veronica Vinciotti & Francesco Moscone, *The association between hospital cooperation and the quality of healthcare*, 56 REG'L STUD. 1858, 1858–59 (2022), https://www.tandfonline.com/doi/full/10.1080/00343404.2021.2009792.

[72] *Id.*

[73] *See, e.g.*, Saint Alphonsus Med. Ctr.-Nampa, Inc. v. Saint Luke's Health Sys., Ltd., 778 F.3d 775, 791 (9th Cir. 2015).

[74] *See infra* section IV.F.

[75] *See, e.g.*, Hosp. Corp. of Am. v. FTC, 807 F.2d 1381, 1388–89 (Posner, J.) (7th Cir. 1986).

[76] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 25–36 (Aug. 19 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf.

[77] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES 8–10 (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

lessen" competition.[78] To illustrate, if mergers in a geographic market lead to a healthcare market with only two healthcare network competitors, pre-existing cooperation among the hospitals across both networks may facilitate anticompetitive collaboration among the two networks, and raise the probability of such anticompetitive collaboration in line with the prospective analysis required by Section 7.[79]

C. Certificate-of-Need Laws Restrict Healthcare Output and Raise Barriers to Entry

Thirty-five states (and the District of Columbia) have certificate-of-need laws.[80] These laws require potential health care providers to acquire a license from respective state agencies to build or expand healthcare facilities.[81]

The economic theory behind this policy rests on the somewhat peculiar mode of reimbursement involved in healthcare services.[82] Typically, healthcare services are based on either a fee-for-service system or a value-based system.[83] Under a fee-for-service arrangement, healthcare providers are simply reimbursed for each service provided.[84] Under a value-based arrangement, reimbursement of care is based on the quality, efficiency, and effectiveness of care provided.[85] While a value-based arrangement might sound more appealing, it is difficult to administer, so most reimbursement is provided for on the simpler fee-for-service system.[86] The downside of fee-for-service is that this arguably creates perverse incentives to provide more healthcare services than necessary.[87]

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[78] Hosp. Corp. of Am. v. FTC, 807 F.2d 1381, 1388–89 (Posner, J.) (7th Cir. 1986).

[79] *Id.*

[80] *See* Mitchell & Koopman, *supra* note 62.

[81] *Id.*

[82] Dane Stuhlsatz, *Florida's Certificate of Need: A Prescription for Government-Private Collusion and Antitrust Violation*, 13 FIU L. REV. 241, 242 (2018).

[83] *Fee-for-service (FFS)*, DEFINITIVE HEALTHCARE, https://www.definitivehc.com/resources/glossary/fee-for-service (last visited Mar. 28, 2024).

[84] Leona Rajaee, *Fee for Service vs Value Based Care: The Differences, Explained*, ELATION HEALTH (June 7, 2023), https://www.elationhealth.com/resources/blogs/fee-for-service-vs-value-based-care-the-differences-explained.

[85] *Id.*

[86] *Id.*

[87] *Id.*

Because of the perception of national and state policymakers that these incentives pushed hospitals to spend too much money on providing unnecessary care, and these costs were being passed on to consumers, states enacted certificate-of-need laws to restrict output of healthcare services.[88] These laws are, to put it mildly, counterintuitive from the perspective of antitrust policy. Nevertheless, all new hospitals or expansions of hospitals in thirty-five states need to be licensed by state health departments, and state health departments have a legal mandate not to allow the supply of healthcare facilities to exceed a level the agency deems efficient and appropriate.[89]

Most legal issues that arise in relation to certificate-of-need laws and antitrust have to do with the state action doctrine.[90] Hospitals have tried to use their certificate-of-need licenses to entitle them to state-action immunity from antitrust law.[91] The Supreme Court unanimously rejected this flimsy argument in 2013.[92] Weak as that argument may be with respect to state-action immunity, it does point to a fundamental conflict of policy between federal antitrust law and state certificate-of-need laws. A certificate-of-need program, even if it is a good policy, substantially lessens competition. The theory behind the federal antitrust statutes is that competition is, at least prima facie, a necessary (if not sufficient) form of consumer protection.

Less prominent in the case law but just as relevant is the obvious barrier to entry this creates for potential competitors in healthcare markets.[93] If a geographic healthcare market has reached the capacity beyond which a state agency will not grant a certificate-of-need license, any merger within that market cannot be defended on the basis of the possibility of new market entrants. With the output of the two merged hospitals likely remaining at more or less the same quantity before or after the merger, nothing changes about the barriers to entry created by the need to obtain a certificate of need. The only relevant changes are to the slopes of the merged hospitals' marginal revenue curves.

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[88] Stuhlsatz, *supra* note 82.

[89] *See* Mitchell & Koopman, *supra* note 62.

[90] *See, e.g.*, FTC v. Phoebe-Putney Health Sys., Inc., 568 U.S. 216 (2013); North Carolina *ex. rel.* Edmiston v. PIA Asheville, Inc., 740 F.2d 274 (4th Cir. 1984).

[91] FTC v. Phoebe-Putney Health Sys., Inc., 568 U.S. 216, 222–23 (2013).

[92] *Id.* at 228.

[93] Stuhlsatz, *supra* note 82, at 241, 272.

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D. The Non-Pprofit Status of Hospitals Is Sometimes Considered Relevant to Antitrust Liability by Courts, Because Supracompetitive Profits Can (in Theory) Be Used on Welfare-increasing Cross-subsidization

Courts are divided as to the significance of the relevance of a hospital's non-profit status.[94] The underlying theory behind antitrust law assumes that firms are profit-maximizing entities.[95] Nominally, not-for-profit business entities are not-for-profit. Of course, that does not mean they do not behave as profit-maximizers do. Courts that have enjoined hospital mergers have taken note of merging hospitals' non-profit status and dismissed its relevance, or otherwise enjoined the hospitals without addressing the point.[96] Nonprofit status certainly does not take hospitals out of the jurisdiction of Section 7 of the Clayton Act.[97] Nevertheless, while not determinative, hospitals' non-profit statuses have gone a long way in their defenses to antitrust liability in many cases.[98]

This largely has to do with what the courts view as socially beneficial cross-subsidization.[99] That is, even where a merger might create supracompetitive profits, these profits are not paid out as dividends to shareholders: they are reinvested into healthcare services, including uncompensated and undercharged care for indigent patients.[100]

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[94] *Compare* Hosp. Corp. of Am. v. FTC, 807 F.2d 1381, 1390–91 (7th Cir. 1986), *with* United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 146 (E.D.N.Y. 1997).

[95] *See* Hovencamp, *supra* note 65, at 7–15.

[96] Hosp. Corp. of Am. v. FTC, 807 F.2d 1381, 1390–91 (7th Cir. 1986); United States v. Rockford Memorial Corp., 898 F.2d 1278, 1285–85 (7th Cir. 1990); FTC v. Univ. Health, Inc., 938 F.2d 1206, 1224 (11th Cir. 1991).

[97] FTC v. Univ. Health, Inc., 938 F.2d 1206, 1214 (11th Cir. 1991).

[98] *See* Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121, 121–22 (2007) (citing FTC v. Tenet Health Care Corp., 186 F.3d 1045, 1053 (8th Cir. 1999); FTC v. Freeman Hosp., 69 F.3d 260, 273 (8th Cir. 1995); California v. Sutter Health Sys., 84 F. Supp. 2d 1057, 1085 (N.D. Cal. 2000), *amended by* 130 F. Supp. 2d 1109, 1137 (N.D. Cal. 2001); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 149 (E.D.N.Y. 1997); FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1302–03 (W.D. Mich. 1996), *aff'd*, No. 96-2440, 1997 WL 420543, at *1 (6th Cir. July 8, 1997); United States v. Mercy Health Servs., 902 F. Supp. 968, 989 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632, 637 (8th Cir. 1997); Adventist Health Sys./West, 117 F.T.C. 224, 285 (1994)).

[99] *Id.* at 143–45.

[100] *Id.* at 143–44.

Cross-subsidization is a "cornerstone of the operation of nonprofit hospitals."[101] This has "not escaped the notice of courts" in antitrust cases.[102] Nevertheless, cross-subsidization is an opaque process.[103] Transparency is provided to courts through the evidentiary process of antitrust litigation. Whether cross-subsidization is so socially beneficial as to provide immunity to antitrust liability is always analyzed on a case-by-case basis.[104] Moreover, supracompetitive profits are not a necessary condition for socially beneficial cross-subsidization; normal profits can do the job. Entrusting merged hospitals with the responsibility to altruistically use supracompetitive profits for cross-subsidization can cut against the prospective purposes of Section 7 of the Clayton Act. Nevertheless, the non-profit status of hospitals has been a relevant and even determinative factor in Section 7 cases of hospital mergers.

E. Whether a Merger of Hospitals Will Create Significant Efficiencies Is a Very Case-specific Inquiry

The measurement of efficiencies that result from hospital mergers is a "battle of the experts" type of issue and is heavily case-dependent.[105] Whether under the 2010[106] or 2023 guidelines,[107] efficiencies must be "merger-specific" to be relevant to antitrust liability: in other words, the merger must be the only realistic means of achieving the alleged efficiencies. Some examples of merger-specific efficiencies in the health services industry include:

> (1) reduction in personnel in various departments at both hospitals; (2) some reduction in the cost of clinical laboratory services and medical supplies;

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[101] *Id.* at 145.
[102] *Id.* at 146.
[103] *Id.* at 146–47.
[104] FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1302 (W.D. Mich. 1996).
[105] *Id.* at 1293–97.
[106] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 30 (Aug. 19, 2010), https://www.ftc.gov/system/files/documents/public_statements/804291/100819hmg.pdf.
[107] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES 32 (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

(3) claims recovery costs; (4) utilities; (5) laundry costs; (6) in-house consulting services; and (7) computer and information services.[108]

While the efficiencies resulting from hospital and other health facilities mergers are unique to the health services industry, the characteristics of these efficiencies are not especially unique to antitrust liability analysis.

IV. APPLICATION OF THE GUIDELINES' CHANGES TO MERGERS OF HOSPITALS AND OTHER HEALTHCARE SERVICE FACILITIES

A. The Lowered HHI Threshold for "Highly Concentrated Markets" Does Not Change Much with Respect to Antitrust Liability for Hospital Mergers, but the Lowered "Marginal" HHI Threshold Could

In 2021, a study of healthcare services markets in 183 metropolitan areas around the United States found that 140 of the studied areas had HHI scores above 2500, thirty above 1800, and only thirteen below the 1800.[109] Even under the 2010 guidelines, 140 of these metropolitan areas constitute highly concentrated markets.[110] Thus, the change in thresholds for "highly concentrated markets" in the 2023 guidelines does not actually do much to change the legal status of hospital mergers in many markets, since many of them were already highly concentrated markets (though DOJ's retraction of earlier policy statements does).

In the majority of cases, the important change from the 2010 to 2023 guidelines is the threshold for how large an HHI increase must be to be presumptively illegal from 200 to 100 points. The more important question for hospital and healthcare facilities mergers is whether the merger will result in an increase in the HHI of a health services market by 100 points.

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[108] Richard D. Raskin & Bruce M. Zessar, *Telling the Efficiencies Story: Practical Lessons from the Hospital Merger Field*, 13 ANTITRUST 21, 24 (1999).

[109] *Hospital Concentration Index: An Analysis of U.S. Hospital Market Concentration*, HEALTH CARE COST INSTITUTE, https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Concentration-Index (updated June 2023). One caveat of this data is that it does not base geographic market definition on the legal metrics for geographic market definition, but rather on the size of the metropolitan areas themselves. Accordingly, the source of the data discourages use of this data in antitrust legal analysis. Nevertheless, it is indicative of generalizable levels of concentration.

[110] *Id.*

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B. The New Focus on the Entrenchment of a Dominant Position Could Affect the Legality of Hospital Mergers, Especially in States with Certificate-of-Need Laws

By itself, there is nothing about a healthcare merger that increases barriers to entry and thus entrenches a dominant position. However, in states with certificate-of-need laws, concentration is essentially a zero-sum game. One way in which Guideline 6 states that a merger can "entrench a dominant position" is by depriving rivals of economies of scale.[111] This can be the case when a merger scoops up the only healthcare facility or facilities providing a particular health service in a given market.

C. The New Focus on Trends Towards Concentration in an Industry Is Particularly Damaging to Prospective Mergers

This change in the 2023 guidelines is relevant to all healthcare facilities interested in mergers, since the industry as a whole has been trending towards concentration for decades.[112] The policy justification for looking at such trends, as has been explained above, is to shed light on whether a merger's concentrating effect in the short term will be offset by new entrants into the market in the long term.[113] A trend towards concentration indicates it will not, and the longer the trend, the more this logic holds. Considering the long trend of concentration in the healthcare sector, this should concern all hospitals interested in mergers.

D. The New Focus on Merging Firms' Whole Series of Acquisitions Is Particularly Damaging to Prospective Mergers Within Healthcare Networks

For healthcare networks, this change in enforcement policy is especially relevant. A healthcare network is the result of a series of mergers. Much of

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[111] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES 19 (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

[112] Brent D. Fulton, *Health Care Market Concentration Trends In The United States: Evidence And Policy Responses*, 36:9 HEALTH AFFAIRS 1530, 1530 (Sept. 2017).

[113] U.S. DEP'T OF JUST. AND FED. TRADE COMM'N, MERGER GUIDELINES 22 (Dec. 18, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/2023_merger_guidelines_final_12.18.2023.pdf.

the concentration in the healthcare industry is due to the creation of healthcare networks.[114]

What Guideline 7 means for healthcare networks is that even mergers between the network and small facilities which do not even reach the 100-points-increase-threshold of the guideline may not be immune from antitrust litigation, in light of the series of previous mergers engaged in by the health network.

E. The New Focus on Labor Monopsony Means that Faculty Downsizing Should Not Be Part of Merging Hospitals' Efficiencies Defenses

The downsizing of faculty can sometimes be part of a hospital defendant's efficiencies defense.[115] Considering the new guidelines' new concentration on labor monopsony, this tool might be better left in the toolbox. It is interesting to note, however, that compensation for hospital labor has drastically increased in recent years.[116] This is largely attributable to labor shortages.[117] Still, it is not implausible that concentration actually has played a role in this increase. If healthcare facilities are earning supracompetitive profits, these can be used to cross-subsidize employee compensation. It may be that the agencies will look on this practice more favorably when done progressively (to lower earning employees) rather than regressively (to higher earning employees).

F. Under the New Structural Standard for "Pro-Competitive" Efficiencies, Many Efficiencies Defenses Could Fail, and Merging Hospitals Should Reframe Their Efficiencies Defenses to Fit with This Standard

A dramatic change in these guidelines is that a certain reading renders efficiencies which are passed on to consumers, but which are not likely to change the behavior of a firm's competitors as "non-cognizable." It is hard to imagine how, under the 2023 guidelines, much of the cross-subsidization

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[114] *See* Vadim Egoul, *Redirecting the Analysis in Hospital Mergers*, 105 GEO. L.J. 1681, 1683 (Aug. 2017).

[115] *See, e.g.*, United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 148 (E.D.N.Y. 1997).

[116] Jeff Lagasse, *Hospitals' labor costs increased 258% over the last three years*, HEALTHCARE FINANCE (Mar. 10, 2023), https://www.healthcarefinancenews.com/news/hospitals-labor-costs-increased-258-over-last-three-years.

[117] *Id.*

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in the healthcare industry could constitute an "efficiencies defense" to supracompetitive profits unless such cross-subsidization impacts the behavior of a healthcare company's competitors.

While the existing close collaboration among competitors in the healthcare industry is more detrimental than beneficial to antitrust scrutiny under the guidelines old and new, there could be an interesting opportunity to take advantage of this collaboration for competitive purposes. Cross-subsidization using supracompetitive profits means nothing under these new guidelines, even if it directly benefits patients of a hospital or health network, unless it impacts the behavior of competitors. It is hard to see how it would, unless administrative data were shared among hospitals, given the opaqueness of how hospitals cross-subsidize.

This could land hospitals in interesting antitrust territory. Such sharing of cross-subsidization data across hospitals would be the inverse of the "contracts, combinations, and conspiracies in restraint of trade" forbidden by the Sherman Act. They would be more like combinations in the promotion of trade, such that hospitals could coordinate cross-subsidization quasi-competitively, to the maximal benefit of consumers. Whether such coordinated behavior would immunize hospitals from antitrust liability or prosecution is a difficult question to answer. But it seems somewhat naive to believe that price or quality competition in healthcare resulting from traditional direct competition for consumers in e.g., commodities markets, could be as efficacious in the market for healthcare services, given the lack of price transparency to consumers resulting from insurance payment structures and the general inelasticity of demand for healthcare services. Coordinated efforts to reduce prices through cross-subsidization would have more to do with gaining bargaining leverage in negotiations between providers and insurance companies.[118]

On the other hand, normal price and quality competition having nothing to do with cross-subsidization can, of course, generally have a positive impact on the behavior of competitors normally expected in consumer markets. Efficiencies resulting from mergers can have such an impact. Still, a merger or series of mergers that make this process of competition impossible cannot assert this defense. In communicating with the FTC and

[118] *See generally* Zack Cooper, Stuart V. Craig, Martin G. Gaynor & John V. Reegan, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q. J. OF ECON. 51 (Feb. 2019).

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DOJ, hospitals should emphasize not only how efficiencies will be passed on to their direct consumers, but also how such efficiencies will incentivize their competitors to do the same.

V. CONCLUSION

Every change the 2023 guidelines make to antitrust enforcement policy makes it more difficult for hospitals to merge with other hospitals. Supposing the 2023 guidelines were adopted as hard law, some, though very few, hospital and healthcare services facilities mergers would be legal. Where possible, hospitals looking to avoid antitrust litigation should seek the efficiencies they seek through mergers by alternative means.

But if a merger looks so attractive that a board of healthcare managers cannot resist the temptation, if they are trying to persuade the agencies of pro-competitive efficiencies, they should emphasize not only how such efficiencies would benefit their own patients, but also how they would affect the behavior of their competitors.

Finally, the repeal of certificate of need laws and other regulations creating barriers to entry in the healthcare services industry could, to a limited extent, allow the trend of mergers to continue without a corresponding trend in long-term concentration. But that policy is not in the hands of the FTC, DOJ, or the management or boards of directors of hospitals or health networks: it is in the hands of state legislatures.

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