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Health Reform's Push Towards Hospital Mergers: Will Antitrust Laws Adapt to Reach Reform Goals?

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I. INTRODUCTION

The health care landscape is drastically changing as the federal government pushes towards a higher quality, more efficient health care system.[1] With the adoption of the Patient Protection and Affordable Care Act ("PPACA"), discussion has been centered on the estimated thirty-two million Americans who will gain insurance coverage by 2019 and the massive budget deficit reduction the federal government hopes to achieve.[2] However, there has been little discussion on health reform's impact on the hospital industry.[3] As the federal government seeks to achieve a value-based system of care, hospitals will be required to play a lead role in improving efficiency while providing high-quality care.[4] To achieve these goals, health care providers must adopt new payment and delivery approaches that integrate clinical outcomes with effective cost containment.[5] Taking these actions required or encouraged under the

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1. *Health Care Consolidation and Competition after THE PPACA: Before the Subcomm. On Intellectual Prop., Competition & the Internet of the H. Comm. Judiciary*, 112th Cong. (2012) (statement of American Hospital Association)[hereinafter *AHA: Health Care Consolidation and Competition after THE PPACA*], *available at* http://www.aha.org/advocacy-issues/testimony/2012/120518-tes-the PPACA.pdf.

2. Paul Wierbicki & Jennifer Bisenius, COST PRESSURES COULD FORCE DISTRESSED M&AS IN U.S. HOSPITAL MARKET, 20 BNA HEALTH CARE POL'Y R. 14 (2012), *available at* http://www.kirkland.com/siteFiles/Publications/BloombergBNA%20_April%202012.pdf.

3. *Id.*

4. *See* Lisa Goldstein, *The New Wave of Hospital Consolidation*, HEALTHCARE FIN. MGMT. ASS'N, http://www.hfma.org/Templates/Print.aspx?id=31501 (last visited Oct. 15, 2012).

5. *Value In Health Care: Current State and Future Directions*, HEALTHCARE FIN. MFMT

PPACA places considerable cost pressures on hospitals to transform their systems to achieve the PPACA's initiatives.[6]

The reform agenda assumes that hospitals have the financial strength to invest large amounts of capital in restructuring their hospitals while simultaneously absorbing decreased revenues from payment reform.[7] However, at the intersection of an economic crisis and health reform[8], many hospitals, especially stand-alone hospitals, cannot maintain the necessary capital to survive.[9] In effect, hospitals faced with these unprecedented demands will close and patients will suffer as physicians leave for more hopeful opportunities.[10] Closures will result in reduced specialty services, overcrowding, and an overall decrease in access to care.[11] Thus, the PPACA's purpose to expand access to care will be depleted if hospitals cannot survive to treat their communities.[12]

As hospitals face tightening payment, rising bad debt, and increased investment demands hospitals are merging to ensure their stability and access essential capital.[13] Federal agencies, like the Centers for Medicare and Medicaid Services (CMS), look to mergers as a way to build the continuum of care by better aligning hospitals' economic incentives to

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ASS'N 1 (June 2011) http://www.hfma.org/HFMA-Initiatives/Value-Project/Value-Project-Report-One/ [hereinafter *Value In Health Care*].

6. Wierbicki & Bisenius, *supra* note 2.

7. Mark E. Grube & Kenneth Kaufman, *Positioning Your Organization For Success in the New Era*, HEALTHCARE FIN. MFMT ASS'N, Jan. 2010, http://www.hfma.org/Templates/Print.aspx?id=2158 (last visited Oct. 28, 2012).

8. *See Id*.

9. *See* Wierbicki & Bisenius, *supra* note 2.

10. Brief for Petitioner at 7, F.T.C. v. ProMedica Health Sys., Inc., 3:11 CV 47 (N.D. Ohio Mar. 29, 2011) (No. 12-3583).

11. *Id* at 24.

12. *See id* at 2.

13. *Id* at 25. *See also* Chris Myers & Jason Lineen, *Hospital Consolidation Outlook: Surviving in a Tough Economy*, HEALTHCARE FIN. MGMT. ASS'N (2009), http://www.hfma.org/Templates/InteriorMaster.aspx?id=2463 (last visited Oct. 15, 2012).

reduce costs and improve value.[14] However, the federal government's stance towards consolidation appears highly unharmonious as federal antitrust agencies remain aggressive in their efforts to prevent hospital mergers that impede competition.[15]

The conflict between health care policy and antitrust enforcement has played out in a series of federal challenges to hospital mergers.[16] The outcomes of these mergers demonstrate that even as the PPACA aims to increase value in health care, traditional antitrust measures of cost containment and market consolidation continue to guide the FTC's enforcement decisions.[17] With health care experiencing a drastic change, antitrust enforcement must coincide to reach a desired outcome and begin to place greater weight on other factors driving health reform, like quality and efficiency.

This article will begin by highlighting certain health reform efforts that are transforming the landscape of the American health care system. Next, this article will discuss how these market changes are directly and indirectly spurring an influx of hospital mergers. Following that discussion, this article will examine the legal barriers in place thwarting hospital consolidation. This article will conclude by proposing adjustments to the

14. *See* Thomas C. Brown, Jr. et al., *Current Trends in Hospital Mergers and Acquisitions*, HEALTHCARE FIN. MFMT ASS'N,, www.hfma.org/Templates/Print.aspx?id=31062 (last visited Sept. 28, 2012).

15. *See* Brent Kendall, *Regulators Seek to Cool Hospital-Deal Fever*, WALL ST. J., March 18, 2012, *available at* http://online.wsj.com/article/SB10001424052702303863404577286071837740832.html.

16. Kathleen Roney, *An Overview of Recent Challenges to Hospital Transactions: Is the FTC Really More Aggressive?*, BECKER'S HOSP. REV. (May 1, 2012), http://www.beckershospitalreview.com/hospital-transactions-and-valuation/an-overview-of-recent-challenges-to-hospital-transactions-is-the-ftc-really-more-aggressive.html (last visited Oct. 28, 2012).

17. *See Understanding Recent Developments in Hospital Merger Enforcement*, Foley & Lardner LLP (May 9, 2009), http://www.foley.com/understanding-recent-developments-in-hospital-merger-enforcement-05-09-2012 (last visited Sept. 28, 2012).

current antitrust analysis to achieve the goals of health reform.

II. CHANGING MARKET CONDITIONS

The American health system is transforming and challenging the platform upon which hospitals operate into the near future.[18] While some commentators have compared hospital consolidation today to the "merger mania" of the 1990's[19], the range and magnitude of forces confronting independent hospitals today are unprecedented.[20] Current consolidation participants have unique risks with quality improvements, adopting strategies to control costs, flat or declining volumes of reimbursement, clinical and operational IT spending, and increased capital demands related to physician affiliation and employment.[21] Adoption of the PPACA did not create these driving forces, but it did increase the momentum towards a different economic and market environment, to which hospitals must respond.[22]

A. Decrease In Revenues

Of the many forces transforming American health care, none is more significant than the shift towards a value-based purchasing system.[23] Currently, hospitals operate under a fee-for-service payment system.[24] Hospitals survive off Medicare and Medicaid payments, which account for

18. Grube & Kaufman, *supra* note 7.
19. The forces behind the current consolidation and the past wave of consolidation in the late 1990's include payment challenges, spiraling healthcare costs, and a slow economic recovery. Goldstein, *supra* note 4.
20. Molly Gamble, *12 Challenges and Opportunities for Hospitals in 2012*, BECKER'S HOSP. REV. (Dec. 13, 2011), http://www.beckershospitalreview.com/hospital-management-administration/12-challenges-and-opportunities-for-hospitals-in-2012.html (last visited Oct. 28, 2012).
21. *Id.*
22. *See* Thomas C. Brown, Jr. et al., *supra* note 14.
23. *Value In Health Care*, *supra* note 5.
24. Grube & Kaufman, *supra* note 7.

forty-three percent of a hospital's gross revenues.[25] Under the Medicare fee-for-service model, hospitals are reimbursed based on the volume of services provided.[26]

Beginning in fiscal year 2013, CMS will implement a national Medicare hospital value-based program[27] designed to pay hospitals a better Medicare rate conditional upon achieving a targeted threshold of clinical performance.[28] The new plan will displace the current fee-for-service volume based payment system[29], thus impacting hospitals significantly as reimbursement per unit of service and inpatient user rates are expected to drop.[30] Providers will no longer be compensated for high volumes of patient care, but rather incentivized to improve preventative care, and reduce readmissions and avoidable hospitalization.[31] These market changes will force hospitals to respond quickly, as those that do not meet certain quality thresholds will face penalties.[32] Hospitals will be hit hard as they

25. MOODY'S INVESTORS SERVICE, HOSPITAL REVENUES IN CRITICAL CONDITION; DOWNGRADES MAY FOLLOW ANNOUNCEMENT, at 1 (Aug. 9, 2011), *available at* www.hhnmag.com/hhnmag/PDFs/2011PDFs/moodys.pdf.

26. Grube & Kaufman, *supra* note 7.

27. *Medicare Delivery and Payment System Reforms*, PREMIER INC. at 1, (Mar. 2012), *available at* https://www.premierinc.com/about/advocacy/iss/Position%20Papers/Medicare-Reform-Premier-Policy-Paper-March2012.pdf. In 2013, the government will also establish a bundle payment program. *Id.* Bundled payment programs will pay hospitals a flat amount that must cover hospital, physician, and postacute care costs, driving the need for greater efficiencies. Goldstein, *supra* note 4.

28. Grube & Kaufman, *supra* note 7.

29. *Id.*

30. Martin D. Arrick et al., *The U.S. Not-For-Profit Health Care Sector's Rating Stability is Vulnerable to Headwinds After 2012*, STANDARD & POOR'S 4 (January 25, 2012), *available at* http://www.standardandpoors.com/spf/. . .US/US_FI_Event_hc6512art7.pdf.

31. Debra J. Lipson & Samuel Simon, *Quality's New Frontier: Reducing Hospitalizations and Improving Transitions in Long-Term Care*, MATHEMATICAL POL'Y RES., 3 Mar. 2010, *available at* http://www.mathematica-mpr.com/publications/pdfs/health/LTQA_brief.pdf. Implementation of value-based programs will demand significant facility-specific improvement to produce a financial reward, which is a burden many hospitals cannot bear. Wierbicki & Bisenius, *supra* note 2.

32. *AHA: Health Care Consolidation and Competition after THE PPACA*, *supra* note 1, at 2.

face new Medicare payment eligible guidelines enacted by the PPACA and absorb the $155 billion in Medicare cuts.[33]

B. Increasing Costs

The cost to replace the current fragmented system of care comes at a price, especially for providers.[34] For example, the PPACA requires healthcare providers to adopt Electronic Health Record (EHR) systems that can be used to gauge the quality of care and assist in developing cost-effective treatment patterns.[35] This record keeping system is designed to reduce administrative burdens, cut costs, and reduce medical errors.[36] However, the initial financial burden rests on the hospital to incur the short-term implementation costs or face penalties in 2015.[37]

For a mid-size hospital, the cost of transitioning from paper records to EHRs could amount to over fifty million dollars.[38] The PPACA initially incentivizes hospitals to adopt EHRs by providing roughly six million dollars in Medicare subsides.[39] However, these subsidies cover only ten percent of the overall cost of the transition to EHRs.[40] Plus, hospitals must invest in dedicated staff to develop and sustain these systems.[41] One study projected roughly half of all U.S. hospitals will be unable to implement the

33. PREMIER INC., *supra* note 27.
34. *AHA: Health Care Consolidation and Competition after PPACA*, *supra* note 1, at 2.
35. *See generally* 45 C.F.R. § 164.308 (2010).
36. Wierbicki & Bisenius, *supra* note 2. Hospitals also must meet "meaningful use" targets for implementing patient and electronic medical systems to receive federal government rewards. *See id.*
37. *Hospitals: The Changing Landscape is Good for Patients & Health Care*, AM. HOSP. ASS'N 3 (2012), *available at* http://www.aha.org/content/12/12-03-02-landscape.pdf [hereinafter *Changing Landscape*].
38. *Id.*
39. Wierbicki & Bisenius, *supra* note 2.
40. *Id.*
41. *Id.*

required technology standards by 2015, thus incurring penalties.[42]

C. Encouraging Integration

Further, health care reform will directly reward greater clinical integration through the Accountable Care Organization (ACO) model promoted by the Medicare Share Saving Program (MSSP).[43] THE PPACA incentivizes hospitals and physician practices to participate in these programs by reimbursing ACOs that meet quality-of-care targets and reduce the costs of patients relative to a spending benchmark.[44] Clinical integration is defined as a structured collaboration among hospitals, physicians, and other providers to improve quality and efficiency, which employs vertical and horizontal consolidation in its very nature.[45]

III. HEALTH REFORM IS CREATING AN URGE FOR HOSPITALS TO MERGE

As hospitals are hard-pressed to invest in an array of initiatives to meet reform goals, many hospitals are being driven towards consolidation.[46] For many hospitals, particularly those with lower bond ratings[47], the best and perhaps only strategy to remain in the community is merging with another hospital that possesses the financial resources it lacks.[48] While many stand-alone hospitals believe cost-containing measures are an effective tactic

42. *Id.*
43. Thomas C. Brown, Jr. et al., *supra* note 14.
44. PREMIER INC., *supra* note 27.
45. *See* Grube & Kaufman, *supra* note 7. Integration will also be encouraged as ACO participation allows for the sharing of cost and payments between hospitals and physicians to achieve improved value. Thomas C. Brown, Jr. et al., *supra* note 14.
46. Goldstein, *supra* note 4. *See also* Karen Minich-Pourshadi, *Hospitals & Acquisitions: Opportunities and Challenges*, HEALTH LEADERS MEDIA, Nov. 2010, at 3, *available at* http://www.healthleadersmedia.com/intelligence/detail.cfm?archive=AR&year=2011&content_id=259008.
47. A higher bond rating indicates a lower investment risk, which allows hospitals to pay a lower interest rate on bonds to access capital at a lower price. Brief for Petitioner, *supra* note 10, at 14.
48. *Changing Landscape*, *supra* note 37.

amid health care reform,[49] managing costs is only an effective near-future strategy.[50] Its effectiveness is limited in the long term as it is hard to find new cost-cutting initiatives year after year.[51] However, merging with a larger hospital allows independent hospitals to spread fixed costs over a larger patient base and expand patient access to services, better managing costs and improving patient care.[52]

Even for hospitals not experiencing financial distress, merging into a larger health system creates greater efficiencies and drives waste and costs out of the delivery system.[53] A merger between two hospitals can also enable economies of scale, shared branding, improved access to capital, and limited consolidation of clinical programs.[54] Hospitals with a strong infrastructure and steady supply of capital are more able to take advantage of the opportunities the PPACA presents.[55] Hospitals who evaluate the options of a partnership before a experiencing a financial decline will be in a better position for success.[56]

IV. ANTITRUST ANALYSIS OF HOSPITAL MERGERS

As the landscape of the health industry transforms and drives hospitals to merge, an important question is raised: how will antitrust laws coincide with the changing market realities?[57] Whether hospitals faced with unprecedented market forces will be evaluated under a traditional antitrust

49. Wierbicki & Bisenius, *supra* note 2.
50. STANDARD & POOR'S, *supra* note 30.
51. *Id*.
52. Wierbicki & Bisenius, *supra* note 2.
53. Brief for Petitioner, *supra* note 10, at 26. Mergers also allow hospitals to eliminate duplicative services and technology. *Id.*
54. Myers & Lineen, *supra* note 13.
55. Thomas C. Brown, Jr. et al., *supra* note 14.
56. Myers & Lineen, *supra* note 13.
57. *See* Foley & Lardner LLP, *supra* note 17.

review, or whether other factors will be considered, is a key concern for the future of providers and the communities they serve.

The Federal Trade Commission ("FTC") and the United States Department of Justice ("DOJ") equally possess the regulatory right to intervene in a merger,[58] primarily through enforcement of the Clayton Act.[59] Under section seven of the Clayton Act, federal antitrust agencies restrict acquisitions that may have the effect of lessening competition, or to create a monopoly.[60] Although Congress does not provide a definite test to determine whether mergers may substantially lessen competition, it has indicated that a merger must be viewed in the context of its particular industry.[61] Federal agencies must also examine the structure, history, and future for determining the probable anticompetitive effect of the merger.[62]

In analyzing section seven Clayton Act cases, courts generally adopt the framework set out in the FTC and DOJ Merger Guidelines.[63] In 2010, the *Horizontal Merger Guidelines* were revised to emphasize the ways in which

58. Mark E. Rust, *From HCQIA to ACA*, 33 J. LEGAL MED. 21, 28 (2012).

59. *See* Richard A. Feinstein et al, *FTC Antitrust Actions In Health Care Services And Products*, AM. BAR. ASS'N 2 (2001).

60. Jamie Moffitt, *Merging in the Shadow of the Law: The Case for Consistent Judicial Efficiency Analysis*, 63 VAND. L. REV. 1697, 1747 (2010). When violation of antitrust laws leads to litigation, many of the FTC's adjudicative matters are conducted before an FTC Administrative Law judge. Feinstein et al, *supra* note 59. This provides complex legal and economic issues to be heard in a forum specially suited for dealing with such matters. *Id.* The FTC also has the authority to seek a preliminary injunction in federal district court when they have reason to believe a party is violating any provision of law enforced by the FTC. *Id.*

61. Brief for Petitioner, *supra* note 10, at 27.

62. *Id.*

63. Moffitt, *supra* note 60. *See generally*, U.S. Dep't of J. & Fed. Trade Comm'n, Horizontal Merger Guidelines 1 (2010), *available at* http://ftc.gov/os/2010/08/100819hmg.pdf (federal agencies' analysis of mergers and acquisitions). Although Courts often look to the merger guidelines as a framework for interpreting the law, the guidelines do not bind judges. Melanie Evans, *ProMedica to Test Merger Guidelines in Federal Court*, MODERNHEALTHCARE.COM, Mar. 2012, *available at* http://www.modernhealthcare.com/article/20120331/MAGAZINE/303319982 (last visited Oct. 28, 2012).

the federal antitrust agencies analyze mergers involving actual or potential competitors.[64] In doing so, they de-emphasized market definition and increased the threshold for market concentration.[65] The updated policy has a great effect on how future mergers will be analyzed as more organizations integrate within clinical, operational, and technological systems.[66]

After the revisions to the *Merger Guidelines* in 2010, the FTC "redoubled its efforts" to prevent hospital mergers that may level insufficient local options for inpatient services.[67] The FTC has since moved to challenge three hospital mergers in federal court.[68] In two of the three cases, the FTC succeeded, which indicates that their enforcement efforts will likely not decline, or even adjust, in the rapidly changing health care environment.

A. FTC v. ProMedica

The first transaction tested under the new merger guidelines in federal

64. *FERC Reaffirms Merger Policy; Does Not Adopt DOJ/FTC 2010 Horizontal Merger Guidelines*, McDermott Will & Emery (Feb. 27, 2012), http://www.mwe.com/FERC-Reaffirms-Merger-Policy-Does-Not-Adopt-DOJFTC-2010-Horizontal-Merger-Guidelines-02-27-2012/?PublicationTypes=d9093adb-e95d-4f19-819a-f0bb5170ab6d.

65. *Id.* Courts also look to whether any defense or exemptions apply. Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, L. & CONTEMP. PROBS., Spring 1988, at 163. A defense to an anticompetitive merger is the failing firm defense, which allows a merger if one of the firms is in poor financial condition in order to preserve the failing firm's assets as a competitive force. *Id.*

66. *See* Thomas C. Brown, Jr. et al., *supra* note 14.

67. FTC ANNUAL HIGHLIGHTS 2012, FTC.GOV at 4 (2012), *available at* ftc.gov/highlights (last visited Oct. 28, 2012).

68. Roney, *supra* note 16. The third challenged merger involves the acquisition of Palmyra Medical Center in Albany, Ga., by Phoebe Putney Health System. Mary K. Marks, *Hospital Consolidations: Facing Competing Pressures to Merge and Remain Independent*, NATIONAL L. REV. (June 2012), *available at* http://www.natlawreview.com/article/hospital-consolidations-facing-competing-pressures-to-merge-and-remain-independent (last visited Oct. 28, 2012). Similarly, the FTC argued the transaction would greatly enhance Phoebe Putney's bargaining position in negotiations with health plans. *See Id.* However, the district court dismissed the FTC's compliant on the ground that the hospital's actions were immune from antitrust liability as a state actor. *Id.* The FTC has requested the US. Supreme Court grants certiorari to review the state action ruling. *Id.*

court was the FTC's retrospective challenge to the merger of St. Luke's Hospital and ProMedica Health System.[69] In January 2011, the FTC and the state of Ohio filed a complaint challenging ProMedica Health System's acquisition of control over St. Luke's Hospital, claiming anticompetitive harm due to the merger.[70] According to the commission, the transaction would reduce the number of competitors in general acute-care inpatient hospital services in Lucas County from four to three, creating a sixty percent market share.[71] ProMedica reasoned the acquisition was necessary in order to create efficiencies.[72] Further, the entities pled a variation of the "failing firm" defense, claiming that St. Luke's was a "weakened competitor" and therefore should not be analyzed as a viable independent market participant.[73]

After a full administrative trial, the Administrative Law Judge (ALJ) found the reduction from four to three hospitals in the area, would increase ProMedica's bargaining power with commercial health plans, thus leading to higher reimbursement rates for customers.[74] The FTC upheld most of the ALJ's Initial Decision and rejected all of ProMedica's arguments of efficiencies gains.[75] Further, the court dismissed St. Luke's "failing firm" defense.[76] The FTC reasoned that St. Luke's existing focus on quality care would make for a smooth transition to health reform.[77] The FTC ordered ProMedica to divest St. Luke's either to a new purchaser or to a newly

69. *See* Evans, *supra* note 63.
70. F.T.C. v. ProMedica Health Sys., Inc., No. 3:11 CV 47, 2011 WL 1219281 (N.D. Ohio 2011). *See also* Roney, *supra* note 16.
71. *F.T.C. v. ProMedica Health Sys*., *supra* note 70.
72. *Id.*
73. Foley & Lardner LLP, *supra* note 17.
74. Marks, *supra* note 68.
75. *Id.*
76. Foley & Lardner LLP, *supra* note 17.
77. *Id.*

constituted St. Luke's.[78] However, a month after the FTC's final order, officials from ProMedica and St. Luke's decided to file an appeal in the 6th U.S. Circuit Court of Appeals in Cincinnati, expected to take place in 2013.[79]

B. FTC v. OSF

In *Federal Trade Commission v. OSF*, a U.S. District judge ordered OSF Healthcare System and Rockford Health System to suspend their planned merger, until the FTC could hold an administrative trial in Washington.[80] Again, high concentration of market activity became the decisive issue.[81] The FTC reached its conclusion of anticompetitive effects by measuring the combined current patient admissions and patient days of the merged hospitals.[82]

In response, the hospitals reasoned the substantial efficiencies outweighed any anticompetitive effects.[83] The entities claimed increased efficiencies both in terms of annual recurring savings and one-time capital avoidance, which would permit the parties to gain capital in order to improve and expand medical services.[84] By merging, the hospitals argued they could improve their ability to recruit and retain specialists and subspecialists, which would increase the scope of services offered locally.[85]

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78. Marks, *supra* note 68.

79. Kris Turner, *ProMedica: FTC gear up for next legal battle*, TOLEDOBLADE.COM, July 25, 2012, *available at* http://www.toledoblade.com/Courts/2012/07/26/ProMedica-FTC-gear-up-for-next-legal-battle.html (last visited Sept. 15, 2012).

80. Roney, *supra* note 16.

81. *Id*.

82. *F.T.C. v. OSF Healthcare Sys*., 852 F. Supp. 2d 1069, 1078 (N.D. Ill. 2012).

83. *Id at 1088.*

84. *Id*.

85. *Id* at 1093. *See also* Katherine A. Ambrogi, *Analysis in Merger Enforcement: Lessons from FTC v. OSF Healthcare, 26* ANTITRUST HEALTH CARE CHRONICLE 2 (Sept., 2012), http://www.americanbar.org/content/dam/aba/publications/antitrust_law/at301000_chronicle_201209.authcheckdam.pdf

The district court rejected the hospitals' efficiency and community benefits arguments,[86] and instead accepted the FTC's contention that the claimed efficiencies were speculative, unreliable, and not merger-specific.[87] The district court reasoned the anticompetitive effects resulting from the reduction of three to two general acute-care hospitals in Rockford was too compelling to rebut.[88] At the same time, the court commended the hospitals for having the desirable goals of increasing quality of care, but concluded it was unable to declare if these goals could only be realized with the proposed merger.[89] In the end, the two-year legal battle dissuaded the defendants from pursing an appeal and they dropped the deal.[90]

C. Analysis

The hospital merger case law and pronouncements by the federal enforcement agencies make clear that any hospital merger resulting in high market shares faces a steep uphill climb to win FTC approval. The traditional analysis applied to these mergers illustrates an important challenge for providers to come up with ways to deliver services more effectively while at the same time receiving strict antitrust scrutiny.

At issue in each of these challenges was the anticipated consolidation of inpatient general acute care services.[91] The FTC found both cases to include an increase in market concentration, which they concluded would result in an increase in costs, reduction in quality and range of choices for

86. *F.T.C. v. OSF Healthcare Sys*., 852 F. Supp. 2d 1069, 1078 (N.D. Ill. 2012).
87. *Id* at 1093.
88. *Id* at 1082.
89. *Id* at 1094.
90. Joe Carlson, *OSF Healthcare, Rockford Health drop Merger Plans*, MODERNHEALTHCARE.COM, (Apr. 12, 2012, 5:45 PM), http://www.modernhealthcare.com/article/20120412/NEWS/304129969# (last visited Oct. 28, 2012).
91. Marks, *supra* note 68.

local consumers.[92] Yet, the court in *FTC v. ProMedica*, broadly defined the relevant market in Locus County, failing to include distinguishing services that set the hospitals apart.[93] By excluding distinguishing services of the two hospitals, the FTC failed to encompass the actual anti-competitive effects on the community.

Further, the FTC placed great weight on past performance as an indicator for an unlawful merger in *FTC v. OSF*.[94] In determining the relevant market share of the merged entities, the FTC based its presumption of unlawful activity solely on a showing that the combined entity would have fifty-five percent of the market share in past patient admissions and past days spent in the hospital.[95] Yet, as health reform is incentivizing providers to decrease patient admission and days spent in the hospital, past performance cannot be a conclusive measure for determining a hospital's future ability to compete.[96]

Additionally, while the 2010 *Merger Guidelines* revisions placed more weight on market concentration, the FTC and DOJ framework still states it is necessary to balance these anticompetitive effects with precompetitive efficiencies.[97] Yet, the courts dismissed the potential efficiencies created through these mergers. The courts reasoned the improved quality of care was speculative and hard to quantify. However, efficiencies gained from better alignment are not speculative if the necessary systems are adopted to appropriately measure their effects, which requires great capital.[98] While it

92. *Id.*
93. Foley & Lardner LLP, *supra* note 17. This definition excluded tertiary services and OB services, which are key distinguishing factors in the community. *Id.*
94. *See F.T.C. v. OSF Healthcare Sys*., *supra* note 82.
95. *Id*.
96. *See* Brief for Petitioner, *supra* note 10.
97. Moffitt, *supra* note 60.
98. Wierbicki & Bisenius, *supra* note 2.

is necessary for these hospitals to provide sufficient evidence for quality projections, only once investments of the merged entities are made can real quality measures be displayed. The break-up of these two mergers signals a challenge for future hospital to establish precompetitive benefits from potential cost-savings and efficiencies.

V. WHAT SHOULD BE DONE?

To accomplish a new continuum of care, antitrust laws must adapt to meet the realities of the health care market. As the American health care system is becoming one that stresses wellness rather than sickness, past performance indicators will not reveal accurate projections for the future of a hospital's anticompetitive effects. It is imperative to incorporate potential quality measures instead of patient admissions in measuring future health care mergers.

Moreover, antitrust laws must recognize that hospitals today are faced with decreasing reimbursement rates, increases in costs, and encouragement to integrate. Stand-alone hospitals face increased pressures to respond to these market realities and must be evaluated as such. Antitrust enforcement should not only execpt a "failing firm defense," but also evaluate a hospital's weak status. As illustrated in *ProMedica*, the court found that St. Luke's existing display of quality measures implied its financial stability into the future.[99] However, past quality care performance does not indicate their future financial strength, as the PPACA requires extensive capital demands for new technological quality-measurement systems.[100]

Additionally, smaller cities cannot support as many hospitals as they

99. *See F.T.C. v. ProMedica Health Sys*., *supra* note 70.
100. *See* Brief for Petitioner, *supra* note 10.

once did.[101] The market concentration in rural areas is often higher than urban cities, but in order for these hospitals to take part in health reform, the financial implications must be more proportionately weighed. If ignored both patients and the community will suffer as hospital services slowly deteriorate.[102]

Moreover, antitrust analysis must begin to properly weigh efficiencies as gained efficiencies are the driving force behind health reform. However, the case law makes clear that judicial treatment of efficiencies is aggressive and easily dismissed. Better integration of hospitals and physicians can achieve these efficiencies. Meeting these expectations cannot be achieved overnight and thus the FTC must begin to accept evidence demonstrating how efficiencies can be created. Since decreased costs for patients is the ultimate goal of both reform and antitrust efforts, the FTC must place greater weight on approaches that cut costs. As hospital mergers are likely to continue into the future, courts must accept these reform efficiencies as they warrant proper precompetitive effects.

VI. CONCLUSION

The direction of antitrust enforcement must coincide with the accelerating pace of consolidation of the American health care system. The federal government and private sector are creating great incentives for hospitals to consolidate that have the potential to increase cost-savings and streamline our system into a more efficient continuum of care. However, hospitals are particularly sensitive to changes in the law and their progress can be easily deterred by over-restrictive legislation and regulations. Therefore, antitrust analysis must recognize the current market realties.

101. Kendall, *supra* note 15, at 2.
102. Brief for Petitioner, *supra* note 10.

Once these unprecedented realities facing the health care industry are properly factored into antitrust enforcement, providers can begin to transform the current fragmented system into a coordinated one that produces more affordable, more accessible, and higher-quality health services.