BLACKOUTS AND HOLES: ANALYZING CROSS-MARKET GEOGRAPHIC MERGERS IN THE HEALTHCARE SERVICES MARKET

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I. INTRODUCTION

Hospitals are critical upstream suppliers to health plans, accounting for nearly one third of healthcare spending in the United States today.[1] Many Americans rely on private health insurance to receive healthcare services. Since 2017, private health insurance coverage continued to be more prevalent than public coverage, insuring 67.3 percent of the population and 33.4 percent of the population, respectively.[2] Of the subtypes of health insurance coverage, employer-based insurance is the most common, covering 55.1 percent of the population for all or part of 2018.[3] Healthcare providers have an incentive to merge because a merged firm lowers its costs and increases its profits by achieving "clinical integration."[4] On the other hand, many health economists are concerned about the the growing number of hospital mergers.[5] When individual hospitals merge into larger systems (e.g., Partners HealthCare),[6] they gain a larger share of the consumer healthcare market, which gives them bargaining power to ask health insurance companies to pay more for medical care and procedures.[7] Insurers may pass the increased costs onto consumers in the form of higher premiums.[8] Some economists argue

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1 CMS National Health Expenditure Accounts, www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html.

2 Edward R. Berchick et al., *Health Insurance Coverage in the United States: 2018*, U.S. CENSUS (Nov. 8, 2019). https://www.census.gov/library/publications/2019/demo/p60-267.html#:~:text=Of%20the%20subtypes%20of%20health,part%20of%20the%20calendar%20year.

3 *Id.*

4 AM. HOSP. ASS'N., CLINICAL INTEGRATION – THE KEY TO REAL REFORM 1 (2010), http://www.aha.org/research/reports/tw/10feb-clinicinteg.pdf. Clinical integration is the coordination of healthcare services across patients and facilities to maximize the quality and value of those services. *See* STEPHEN M. SHORTELL ET AL., REMAKING HEALTH CARE IN AMERICA: THE EVOLUTION OF ORGANIZED DELIVERY SYSTEMS 129 (2d ed. 2000).

5 From 2010 to 2015, there was a 70 percent increase in announced hospital mergers. *Hospital Merger and Acquisition Activity up Sharply in 2015, According to Kaufman Hall Analysis*, KAUFFMAN HALL (Jan. 20, 2016), https://www.kaufmanhall.com/news/hospital-merger-and-acquisition-activity-sharply-2015-according-kaufman-hall-analysis.

6 There are several definitions of "hospital system" used by different research institutes, but for purposes of this note, the term will be limited to a hospital with at least one group of physicians. See Agency for Healthcare Research and Quality, *Defining Hospital Systems* for more definitions of "hospital system" used by different institutes. https://www.ahrq.gov/chsp/chsp-reports/resources-for-understanding-health-systems/defining-health-systems.html.

7 Gregory Curfman, *Everywhere, Hospitals Are Merging – But Why Should You Care?*, HARV. HEALTH BLOG (April 1, 2015, 5:00 P.M.), https://www.health.harvard.edu/blog/everywhere-hospitals-are-merging-but-why-should-you-care-201504017844.

8 *Id*. *But see*, Kenneth L. Davis, *Hospital Mergers Can Lower Costs and Improve Medical Care*, WALL ST. J. (Sept. 15, 2014, 7:17 P.M.) ("The fear that mergers curtail competition, leading to higher prices for medical care, reflects an old way of thinking. Thanks to cataclysmic changes in the delivery of health care, hospital mergers now offer the potential for higher quality and more efficiency."), https://www.wsj.com/articles/kenneth-l-davis-hospital-mergers-can-lower-costs-and-improve-medical-care-1410823048.

that mergers drive up healthcare costs and place added financial pressure on consumers.[9]

Over the last decade, hospital mergers became increasingly popular with the enactment of the Affordable Care Act ("ACA"). The ACA provides financial incentives for healthcare providers to control the entire "continuum" of healthcare for their patients, from diagnosis, to treatment, to rehabilitation (referred to as population health management) driving them to merge.[10] This trend is likely to continue in the Biden administration.[11]

A review of economic studies between 2006 to 2012 shows that higher concentration in the healthcare services market has led to increases in the price of hospital care,[12] with some studies observing more than a 20 percent increase in price when hospitals merged in already concentrated markets. Recently, researchers and antitrust authorities have expressed concern about cross-market health provider mergers.[13] Mergers between firms that operate in separate and distinct geographic areas, known as "cross-market mergers," pose a unique challenge to antitrust enforcers and courts because the anticompetitive effects of such transactions are unclear.[14]

Between 2000 to 2010, approximately one-third of hospital mergers involved cross-market acquisitions, while some calculations between 2000 to 2012 demonstrated that more than half of the 528 general acute care hospital mergers involved hospitals in different geographic areas.[15] Economic studies comparing the price of hospital care between independent hospitals and

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9 *See infra*, Section III.A. and accompanying texts.

10 *See* Laura Wood, *Research and Markets: Avoiding the Readmissions Penalty Zone: Population Health Management for High-Risk Populations*, BUS. WIRE (Mar. 7, 2013, 5:12 AM), https://www.businesswire.com/news/home/20130307005474/en/Research-Markets-Avoiding-Readmissions-Penalty-Zone-Population; *See also*, Patient Protection and Affordable Care Act (ACA) § 3025, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended and scattered sections 26 & 42 U.S.C.) (establishing the Readmissions Reduction program, which, by withholding Medicare funding, penalizes healthcare providers who readmit previously discharged).

11 Fact Sheet: President Biden to Sign Executive Orders Strengthening Americans' Access to Quality, Affordable Health Care, WHITE HOUSE (Jan. 28, 2021) (demonstrating the Biden-Harris administration's commitment to protecting and building on the ACA), https://www.whitehouse.gov/briefing-room/statements-releases/2021/01/28/fact-sheet-president-biden-to-sign-executive-orders-strengthening-americans-access-to-quality-affordable-health-care/.

12 MARTIN GAYNOR ET. AL., THE IMPACT OF HOSPITAL CONSOLIDATION – UPDATE 1 (June 2012), https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html (reviewing economic literature from 2006 to 2012 with a focus on the impact of hospital mergers on prices and quality).

13 *See e.g.*, Edith Ramirez, Former Chairwoman, Fed. Trade Comm'r, Keynote Address: Antitrust in Healthcare Conference (May 16, 2016) (stating that the agency now "hear[s] growing concern that provider consolidation in non-overlapping product or geographic markets may also lead to higher prices. Examples of these combinations might include center city hospitals acquiring smaller hospitals in outlying areas, or vertical acquisitions of physician groups by hospitals.").

14 Jaime S. King & Erin C. Fuse Brown, *The Anti-competitive Potential of Cross-Market Mergers in Healthcare*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y 43, 46 (2017).

15 *Id.*, at 47.

hospitals subject to cross-market mergers show that prices in the latter increased by almost 20 percent.[16]

Antitrust authorities are limited to the economic models and legal precedent that do not account for potential anticompetitive effects of cross-market mergers. However, the Justice Department ("DOJ") has presented similar economic and legal theories in merger cases involving the video programming distribution industry.[17] The DOJ and the Federal Trade Commission ("FTC") have yet to litigate a hospital merger challenge alleging a cross-geographic market theory of harm. With growing economic research into cross-market theories in the healthcare context, antitrust authorities should develop further empirical evidence to evaluate the full extent of the effects of such transactions. As one scholar observes, "cross-market mergers will be the likely strategy that healthcare systems take on to merge."[18] Dismissing such transactions simply on the basis that they do not pose any harm under a traditional merger analysis may encourage hospital systems to use cross-market mergers as a strategy to increase price while evading antitrust scrutiny.

This Note aims to compare the structure of the video programming distribution market and the healthcare services market and assess whether the government's theories in the former apply to the latter. Part II outlines the relevant background information on antitrust merger enforcement and the structure of the market for healthcare services. Part III provides a review of the economic literature on cross-market hospital mergers and recent legal theories and claims. Part IV compares the video programming industry with the healthcare services market and proposes other factors the government should consider when evaluating cross-market hospital mergers.

II. BACKGROUND OF ANTITRUST MERGER REVIEW

Relevant Authority

In the United States, the DOJ and the FTC are the primary enforcers of federal antitrust laws. Private parties may also bring private federal lawsuits under Section 4 of the Clayton Act.[19]

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16 Matthew S. Lewis & Kevin E. Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, 48 RAND J. ECON. 579, 579 (2017) (finding that prices at hospitals acquired by healthcare systems in a different geographic market increased by about 17% more than un-acquired, stand-alone hospitals).

17 *See infra*, Section IV Part A.

18 King & Brown, *supra* note 14, at 48.

19 15 U.S.C. § 15.

The relevant statute for analyzing mergers and acquisition is Section 7 of the of the Clayton Act,[20] which prohibits mergers and acquisitions "in any line of commerce . . . in any section of the country," where "the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."[21] Additionally, Section 5 of the Federal Trade Commission Act provides authority to the FTC to challenge businesses engaged in unfair methods of competitions, including unlawful mergers under Section 7 of the Clayton Act.[22] The FTC is further empowered to order and collect vast amounts of data from businesses to conduct wide-ranging studies or for investigative purposes under Section 6 of the FTC Act.[23] Although both the DOJ and the FTC evaluate healthcare provider mergers, the FTC is usually responsible for the vast majority of merger investigations and enforcement actions involving healthcare providers.[24] State Attorney Generals often join the FTC in its investigations and litigation.[25]

The jointly issued Horizontal Merger Guidelines (Guidelines) by the DOJ and the FTC also serve as a persuasive authority in court. Although the Guidelines are not binding, courts have relied on them for guidance in merger cases.[26]

Market Definition

Generally, antitrust authorities begin their analysis by defining the relevant product and geographic markets. A common method used to determine the relevant geographic market is to find whether a hypothetical monopolist could impose a "small but significant nontransitory increase in price" ("SSNIP") in the proposed market.[27] If a single firm became the only seller (hypothetical monopolist) in a candidate geographical region and could profitably raise prices above competitive levels in that region, that region

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20 15 U.S.C. § 18.

21 15 U.S.C. § 18.

22 FTC Act § 5(a), (b), 15 U.S.C. § 45(a), (b).

23 FTC Act § 6, 15 U.S.C. § 46.

24 Alexis J. Gilman, Joseph M. Miller, & Angel Prado, *Healthcare Providers and Insurers: FTC Approach to Provider Mergers and Acquisitions*, LEXIS PRAC. ADVISOR J. (Healthcare Practice Special ed. 2019), https://www.lexisnexis.com/lexis-practical-guidance/the-journal/b/pa/posts/healthcare-providers-and-insurers-ftc-approach-to-provider-mergers-and-acquisitions#:~:text=Horizontal%20Merger%20Guidelines&text=In%20particular%2C%20the%20Merger%20Guidelines,def.

25 *Id.*

26 *See* FTC v. Sysco Corp., 113 F. Supp. 3d 1, 38 ("The Merger Guidelines are not binding but the Court of Appeals and other courts have looked to them for guidance in previous merger cases."); *See also*, FTC v. H.J. Heinz Co., 246 F. 3d 708, 716 n.9 (D.C. Cir. 2001) (referencing the HHI in the Horizontal Merger guidelines to analyze market concentration).

27 Saint Alphonsus Medical Center-Nampa, Inc. v. St. Luke's Health Syst., Ltd. 778 F.3d 775, 784 (9th Cir. 2015).

would constitute a relevant geographic market.[28] However, "[i]f customers would defeat the attempted price increase by buying from outside the region, it is not a relevant market; the test should be rerun using a larger candidate region."[29] Courts have recognized that a hypothetical monopolist's ability to impose a SSNIP of five percent may satisfy the hypothetical monopolist test and the candidate market is included in the relevant geographic market.[30]

The relevant product market is also found using the same hypothetical monopolist test on the products in question. In hospital mergers, agencies generally look at so-called "cluster markets"[31] for inpatient general acute-care services (GAC)[32] sold to commercial health plans.[33] If a certain specialized or "high value" service is the product (e.g. heart bypass surgery), that service on its own will be considered the relevant product market, apart from inpatient GAC services.[34]

Market Concentration

Next, agencies will determine the market concentration. The first step is to identify the firms that compete in the same product and geographic markets, commonly known as market participants.[35] For hospital mergers, market participants include all other healthcare providers within the relevant market.[36] Agencies then calculate the market shares of all market participants

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28 U.S. Dep't of Just. & Fed. Trade Comm'n, *Horizontal Merger Guidelines* § 4.2 (2010).

29 Saint Alphonsus Med. Ctr.-Nampa Inc., 778 F.3d at 784.

30 *See e.g.*, Saint Alphonsus Med. Ctr.-Nampa Inc., 778 F.3d at 784 n. 9; FTC v. Penn State Hershey, 838 F.3d 327, 338 nn.1-2 (3d Cir. 2016); *see also*, U.S. Dep't of Just. & Fed. Trade Comm'n, *Horizontal Merger Guidelines* § 4.1.2 (2010).

31 *See* Gilman et al., *supra* note 24. ("A cluster market is a product market consisting of multiple, non-substitutable products or services, which are included in a single product market for analytical and administrative convenience when the competitive conditions—such as the number of competitors and entry conditions—are similar for the products or services included in the cluster market.").

32 Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OREGON L. REV. 847, 869 (2011); *See* Jon Mark Hirshon et al., *Health Systems and Services: The Role of Acute Care*, WHO BULLETIN (Jan. 31, 2013) (inpatient acute care services refer to brief but severe episode of illness, for conditions that are the result of disease or trauma, and during the recovery from surgery).

33 *See* Gilman et al., *supra* note 24 (For antitrust purposes, product markets are defined around products and services that are substitutable for one another. Individual hospital services are not substitutes for another (e.g., neurosurgery cannot be substituted for cardiac surgery), so each inpatient hospital service could be its own separate product market for antitrust purposes. But since hospital mergers generally involve dozens, if not hundreds, of overlapping inpatient hospital services, it is often not practical to separately analyze (or litigate) so many markets. Therefore, the FTC alleges—and courts have accepted—the inpatient GAC hospital services cluster market).

34 Michael J. Perry & Matthew B. Adler, *Antitrust Enforcement Policy for Cross-Market Health Care Mergers: Legal Theories, Limiting Principles, and Practical Considerations*, 83 ANTITRUST L.J. 483, 492 ("[T]he relevant geographic market could well be broader for certain specialized or 'high value' services, for which patients may be willing to travel longer distances.").

35 U.S. Dep't of Just. & Fed. Trade Comm'n, *Horizontal Merger Guidelines* 18 (2010).

36 *See* Michael A. Morrisey, Frank A. Sloan, T & Joseph Valvona, *Defining Geographic Markets for Hospital Care*, 51 LAW & CONTEMP. PROBS. 165, 171, 176 (1988) (noting that the geographic market for a hospital may be defined as the area from which the hospital receives virtually all of its admissions; "virtually all" for these purposes is defined as either 75% or 90%).

typically based on historical evidence of revenues, but agencies may also consider any indicator of the firms' future competitive significance in the relevant markets.[37] In *United States v. Philadelphia National Bank*, the Supreme Court set a rebuttable presumption of illegality when a merger yields a combined market share of 30 percent or more, which the FTC cites in litigated cases.[38]

For healthcare providers, the number of hospital beds each firm maintains in proportion to the total number of beds available within the relevant market serves as a reasonable proxy for the firm's market share.[39] Antitrust authorities use this information to calculate market concentration.[40] A highly concentrated market has the greatest potential to have anticompetitive effects, while a moderately concentrated market has a lower risk of producing anticompetitive effects. Authorities are usually not concerned about anticompetitive effects in markets that are not concentrated.[41] Both enforcers and courts presume that a merger resulting in a highly concentrated market is anticompetitive.[42]

Merger Screening Tools

A commonly-accepted measure of market concentration is the Herfindahl-Hirschman Index ("HHI"). The HHI takes into account the relative size distribution of the firms in a market.[43] The HHI increases both as the number of firms in the market decreases and as the disparity in size between those firms increases.[44] The agencies generally consider markets in which the HHI is between 1,500 and 2,500 points to be moderately concentrated, and consider markets in which the HHI is in excess of 2,500

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37 U.S. Dep't of Just. & Fed. Trade Comm'n, *Horizontal Merger Guidelines* 16-17 (2010).

38 United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 364 (1963) (concluding that a 30% market share presents a clear threat to undue concentration).

39 *See* Morrisey et al., *supra* note 36, at 179.

40 U.S. Dep't of Just. & Fed. Trade Comm'n, *Horizontal Merger Guidelines* 18-19 (2010) (Generally, market concentration is measured using the Herfindahl-Hirschman Index (HHI), which is calculated by summing the square of each market participant's market share. A market with an HHI greater than 2,500 is deemed highly concentrated by antitrust enforcers).

41 *Id.*, at 19.

42 *Id.* (A merger that observes an increase in HHI by more than 200 is presumed to result in highly concentrated markets and presumed to increase market power of the merger firm to an anticompetitive level).

43 *Herfindahl-Hirschman Index*, U.S. DEP'T OF JUST. (citation omitted), https://www.justice.gov/atr/herfindahl-hirschman-index (last updated July 31, 2018) (The HHI is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. For example, for a market consisting of four firms with shares of 30, 30, 20, and 20 percent, the HHI is 2,600 (302 + 302 + 202 + 202 = 2,600).

44 *Id.*

points to be highly concentrated.[45] Transactions that increase the HHI by more than 200 points in highly concentrated markets are presumed likely to enhance market power under the Horizontal Merger Guidelines issued by the DOJ and the FTC.[46]

Agencies also rely on diversion ratios as a merger screening tool. Diversion ratios measure the substitutability of one product from its competing product.[47] In the hospital setting, it measures the percentage of patients who would divert from the target hospital to the acquiring hospital and vice versa if one of the parties were to be dropped from a health plan network.[48] A high diversion ratio indicates that two firms are close competitors,[49] and suggests a greater risk of unilateral effects.[50] A low percentage indicates that significant unilateral price effects are unlikely. Although some economists and the Horizontal Merger Guidelines itself state that market definition may not be required with the use of diversion ratios,[51] courts are unlikely to rule in favor of plaintiffs without a market definition.[52]

Competitive Effects

Generally, the government is concerned about coordinated and/or unilateral effects of a merger. A transaction will likely be deemed to have a coordinated effect if post-merger, the market will be more conducive to coordinated or tacit collusion.[53] A merger between firms selling

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45 *Id.*

46 *Id.*

47 *See* U.S. Dep't of Just. & Fed. Trade Comm'n, *Horizontal Merger Guidelines* 21 (2010) ("The diversion ratio is the fraction of unit sales lost by the first product due to an increase in its price that would be diverted to the second product."). In hospital markets, diversion ratios are formally calculated as the expected share of volume, or discharges, captured by the merging firm if the other merging firm is excluded from a provider network.

48 *See* Christopher Garmon, *The Accuracy of Hospital Merger Screening Methods* 10-11 (Fed. Trade Comm'n, Working Paper No. 326, 2016).

49 Jan Peter van der Veer, *UPP – Frequently Asked Questions*, KLUWER COMPETITION LAW (Dec. 4, 2021), http://competitionlawblog.kluwercompetitionlaw.com/2012/12/04/upp-frequently-asked-questions/#:~:text=A%20high%20diversion%20ratio%20indicates,often%20estimated%20through%20consumer%20surveys.

50 U.S. Dep't of Just. & Fed. Trade Comm'n, *Horizontal Merger Guidelines* 21 (2010) ("Diversion ratios between products sold by one merging firm and products sold by the other merging firm can be very informative for assessing unilateral price effects, with higher diversion ratios indicating a greater likelihood of such effects.").

51 *See* Christopher Garmon, *The Accuracy of Hospital Merger Screening Methods* 8 (Fed. Trade Comm'n, Working Paper No. 326, 2016); *See also*, U.S. Dep't of Just. & Fed. Trade Comm'n, *Horizontal Merger Guidelines* 21 (2010) ("Where sufficient data are available, the Agencies may construct economic models designed to quantify the unilateral price effects resulting from the merger. These models often include independent price responses by non-merging firms. They also can incorporate merger-specific efficiencies. These merger simulation methods need not rely on market definition.").

52 *Id.*

53 U.S. Dep't of Just. & Fed. Trade Comm'n, *Horizontal Merger Guidelines* 24 (2010) ("Coordinated interaction involves conduct by multiple firms that is profitable for each of them only as a result of the accommodating reactions of the others. These reactions can blunt a firm's incentive to offer customers better deals by undercutting the extent to which such a move would win business away from rivals. They also can enhance a firm's incentive to raise prices, by assuaging the fear that such a move

differentiated products[54] may have a unilateral effect and diminish competition by enabling the merged firm to profit by unilaterally raising the price of one or both products above the pre-merger level.[55] Some of the sales lost due to the price increase will merely be diverted to the product of the other merging party and, depending on relative margins, capturing such sales loss through merger may make the price increase profitable even though it would not have been profitable prior to the merger.[56] Simply stated, if the merged firm could increase price on one product and capture any losses in sales by owning the second-choice substitute, it could be anticompetitive if there are limited players left in the market and barriers to entry are high.

Merging parties can rebut this presumption by producing evidence showing that entry into the market is easy and likely; thus the transaction is unlikely to actually increase market power.[57] They can also put forth other evidence that shows that the market-share statistics give an inaccurate account of the merger's probable effects on competition in the relevant market, including a "trend toward or away from concentration," the "continuation of active price competition," or "unique economic circumstances that undermine the government's statistics."[58]

Market Structure for Healthcare Services

Consumers

Consumers first adopt a health plan and can select from a menu of insurers based on their needs and preferences.[59] After selecting a particular health plan, patients generally make some fixed-term premium payments to the health plan and do not make any cash payments to the hospital they

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would lose customers to rivals."). Agencies will consider history of past collusion, the number of players in the market post-merger, the sharing of information to determine coordinated effects. *Id.* This Note will be limited to discussing unilateral effects, rather than coordinated effects of hospital mergers since generally, coordination among hospitals is difficult.

54 In differentiated product industries, some products can be very close substitutes and compete strongly with each other, while other products are more distant substitutes and compete less strongly. For example, one high-end product may compete much more directly with another high-end product than with any low-end product. *Id.*, at 20 (2010).

55 *Id.*

56 *Id.*

57 *Id.*, at 19.

58 United States v. Aetna 240 F. Supp. 3d 1,19 (D.C.C. 2017); *See also*, United States v. Baker Hughes, Inc., 908 F.2d 981, 985-986 (D.C.C. 1990) (listing additional evidence that defendants can show to rebut the government's prima facie case); *See, e.g.* U.S. v. General Dynamics, Corp., 415 U.S. 486 (1974) (concluding that the defendants successfully rebutted the government's prima facie case by showing that the government relied on inaccurate statistics).

59 *How Health Insurance Works*, BLUECROSS BLUESHIELD MINNESOTA, https://www.bluecrossmn.com/shop-plans/individual-and-family-plans/how-health-insurance-works (last visited March 26, 2020).

receive care from in the future.[60] Typically, patients will choose a hospital within the health plan's network ("in-network") if they need to be treated to avoid paying out-of-pocket costs if they go to one that is out of the plan's network.[61] After treating the patient, the health plan reimburses the hospital at some contracted rate to cover the cost of care.[62]

Most Americans receive their health insurance plan through their – or a family member's – employer.[63] The number of health plans an employer offers will generally affect the characteristics of the plan(s) it offers.[64] If employers only offer a single health plan to their employees, they will generally prefer to offer a plan that is attractive to all employees.[65] An employer that provides multiple plans may have less incentive to include strong provider coverage in every region its employees live because employees have an option to choose a plan that is more fitting for them.[66] The fewer health plan options employers give to their employees, the more likely it is that employers would offer plans that have relatively broad appeal to their employees.[67]

Two-Stage Model of Competition

Antitrust authorities examine hospital mergers under a two-stage model of competition: (1) stage one where hospitals negotiate with health plans for reimbursement rates;[68] and (2) stage two where hospitals compete for patients.[69]

At the first stage of competition, health plans (payers) negotiate contracts with hospitals over the reimbursement rates at which the health plan will accept a specific hospital to its network.[70] Traditionally, the health plan

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60 *Id.*

61 *Id.*

62 *Id.*

63 Gregory S. Vistnes & Yianis Sarafidis, *Cross-Market Hospital Mergers: A Holisitc Approach*, 79 ANTITRUST L.J. 253, 265 (2013).

64 *Id.*, at 265-66.

65 *Id.*, at 265-66.

66 *Id.*, at 266.

67 *Id*.

68 David A. Argue & Scott D. Stein, *Cross-Market Health Care Provider Mergers: The Next Enforcement Frontier*, 30 ANTITRUST MAG. 25, 25 (2015). Reimbursement rates are the percentage of the list price at which the health plan reimburses the hospital for treating the health plan holder. Each medical service has a list price on the hospital's chargemaster. The chargemaster price can be equated to the sticker or tag price of products at a retail store. After treating the patient, the hospital will file for reimbursement with the health plan for some contracted percentage of the chargemaster price. *See* Cory S. Capps & David Dranove, *Healthcare Provider and Payer Markets*, 1 OXFORD HANDBOOK OF INT'L ANTITRUST ECON. 63, 66 (2014).

69 David A. Argue & Scott D. Stein, *Cross-Market Health Care Provider Mergers: The Next Enforcement Frontier*, 30 ANTITRUST MAG. 25, 25 (2015).

70 *Id.*

will bargain for lower rates in exchange for steering "a significant proportion of its enrollees to the provider."[71] Health plans bargain for the lowest price to make the insurance plan more attractive to patients, while hospitals want to maximize price.[72] The hospital's bargaining power[73] depends on how substitutable it is – the more substitutes there are for health plans to choose from, the less bargaining power the hospital has.[74] On the flip side, the health plan's bargaining leverage depends on the number of patients that are enrolled in its plan – the more patients it has, the more attractive it is to the provider.[75] The insurers then bundle these services, adding in administrative and oversight features and sell commercial health plans to employers and households.[76] The outcome of these negotiations affects how much patients with commercial insurance plans[77] will ultimately pay for healthcare services. The more leverage a provider has, the more likely it is to negotiate for higher rates; conversely, the more leverage the insurer has, the more likely that it can resist rate increases.[78]

Authorities are concerned about provider mergers that substantially lessen competition since that may provide the merged firm with enhanced bargaining leverage and enable it to extract higher prices.[79] On the other hand, if merged providers' bargaining leverage with insurers would not substantially change after the transaction because, for example, there would be adequate alternatives to which the insurer could turn to, then the transaction is unlikely to raise competitive concerns.[80]

Once the insurance plan has negotiated terms with providers in the first stage, and established its network, providers within that network compete in the second stage for patients. Insofar as prices to the patient differ little across in-network providers, "the focus in the second stage of competition is

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71 Thomas R. McCarthy & Scott J. Thomas, *Antitrust Issues Between Payers and Providers*, Antitrust Health Care Chron., 2-3 (Spring 2002). https://www.nera.com/content/dam/nera/publications/archive1/3673.pdf.

72 *Id.*

73 Though bargaining literature distinguishes between the terms "bargaining power" and "bargaining leverage," this Note will use the jargon-free term "negotiating power" as a shorthand for "bargaining power" and/or "bargaining leverage." Bargaining power captures a party's relative negotiating skill vis-a'-vis its bargaining partner, whereas "bargaining leverage" captures a party's payoff in case the negotiation breaks down and the parties fail to reach an agreement. *See* Vistnes & Sarafidis, *supra* note 63, at 257 n.20.

74 Argue & Stein, *supra* note 69, at 25.

75 McCarthy & Thomas at 2.

76 Leemore Dafny, Kate Ho & Robin S. Lee, *The Price Effects of Cross-Market Hospital Mergers*, 50 RAND J. ECON. 286, 287 (2019).

77 Plans not provided by the government (e.g. Medicaid or Medicare).

78 Gilman et al., *supra* note 24.

79 *Id.*

80 *Id.*

primarily on non-price factors, such as location, reputation, patient experience, and convenience."[81] However, negotiations in the first stage influence the second stage because hospitals can negotiate for higher rates if consumers place a higher value on them.

The relevant inquiry in the hospital context is whether the merged hospital entity will be able to negotiate higher reimbursement rates with health plans, not due to better negotiating skills, but rather as a result of the increased bargaining leverage it gained post-merger by enhanced market power.

III. EXISTING ANALYSES ON THE POTENTIAL ANTICOMPETITVE EFFECTS OF CROSS-MARKET MERGERS

Cross-market mergers by definition involve the consolidation of firms in two distinct geographic markets, and do not pose competitive issues under traditional antitrust framework. Current methods of assessing the anticompetitive threat from hospital mergers assume there can be no increase in bargaining leverage unless the merging parties are vying to provide the same set of services to the same set of patients.[82] These methods implicitly assume that insurance markets do not impact upstream market power and assume insurers face demand that is separable across product and service markets.[83]

In at least one case, the DOJ recognized the potential for competitive harm from cross-market transactions in a business letter review regarding a proposal by Michigan Hospital Group (MHG) in 2002.[84] In that transaction, seven geographically dispersed hospitals in Michigan sought to engage in joint contracts.[85] Several health plans recognized that the hospitals operated in different geographic markets, but expressed concerns that the MHG hospitals might be able to increase their bargaining leverage with health plans by refusing to contract except through MHG.[86]

The agency recognized that, "a health plan seeking a hospital network to satisfy customers desiring state-wide or otherwise broad geographic coverage might be able to make do without one or two of the MHG hospitals in its network but, as a matter of commercial viability, could not make do

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81 Argue & Stein, *supra* note 69, at 25.

82 Dafny, Ho & Lee, *supra* note 76, at 287.

83 *Id.*

84 Letter from Charles A. James, Assistant Att'y Gen., U.S. Dept. of Justice, to Clifton E. Johnson, Att'y, Hall, Render, Killian, Heath & Lyman 2–3 (Apr. 3, 2002), http://www.justice.gov/atr/public/busreview/10933.pdf.

85 *Id.*

86 *Id.*

without all seven MHG hospitals."[87] While the agency ultimately concluded that MHG's proposal was unlikely to significantly reduce competition, this decision turned in large part on the fact that the the hospitals agreed not to negotiate on an exclusive basis.[88] Absent this consideration, the DOJ recognized that joint contracting across those non-competing hospitals could pose a concern: "Whether the hospitals' bargaining leverage could in fact be expanded by negotiating exclusively through MHG is by no means clear and to make that determination would require additional investigation and analysis."[89] But recent economic studies suggest that cross-market mergers may potentially harm competition.

Economic Studies

Recent studies on cross-market hospital mergers focus on the resulting increase in bargaining leverage that hospitals might exercise post-merger.[90] Economists Gregory Vistnes and Yianis Sarfidis hypothesize two models involving employers whose employees live in separate geographic markets, and neither set of employees consider the hospitals in the other markets as substitutes.[91] In the Employer Choice model, the authors focus on the likelihood of an employer choosing a particular hospital network based on "holes" in the network.[92] Under this model, the employer is constrained to choose a health plan with a single, cross-market hospital network to serve all of its employees.[93] Insofar as a health plan's network has a hole in a local hospital market, it would affect those of the company's employees who live in that market, but would not affect employees living in other markets.[94] Therefore, a cross-market merger would allow the merged parties to create holes in multiple local markets, and increase the system's bargaining leverage by disproportionately affecting the probability of employers choosing the plan.[95]

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87 *Id.*, at 3 n.3.

88 *Id.* at 3.

89 *Id.*

90 For criticisms and limitations on the studies, see David A. Argue & Scott D. Stein, *Cross-Market Health Care Provider Mergers: The Next Enforcement Frontier*, 30 ANTITRUST MAG. 25, 27 (2015).

91 Vistnes & Sarafidis, *supra* note 63, at 253.

92 *Id.*, at 275-81. A hole in the health plan's networks are created when a hospital walks away from a deal with the health plan, leaving a "hole' in its network. *Id.*

93 *Id.*, at 274-81. The model further assumes that the hospital system engages in an all-or-nothing contracting. *Id.*, at 268

94 Argue & Stein, *supra* note 69, at 26.

95 Vistnes & Sarafidis, *supra* note 63, at 277-78.

Another variant of Vistnes and Sarfidis' Employer Choice model is the Common Customers model by economists Leemore Dafny, Kate Ho, and Robin Lee, which concludes that demand for insurance may not, in fact, be separable across service markets due to the presence of "common customers."[96] Common customers are "likely to be large employers that demand insurance products covering hospital services in multiple distinct geographic markets, that is, areas where their employees live and work."[97] To support their theory, the authors examined two distinct samples of acute-care[98] hospital mergers over the period from 1996 to 2012, and compared the price trajectories of: (i) hospitals acquiring a new system member in the same state but not the same narrow geographic market ("adjacent treatment hospitals"); and (ii) hospitals acquiring a new system member out-of-state ("nonadjacent treatment hospitals").[99] They found that cross-market hospital mergers within the same state yielded a price increase of 7 to 9 percent for acquiring hospitals, whereas out-of-state acquisitions did not yield significant increases.[100]

Legal Claims

One proposed legal mechanism by which cross-market mergers can harm competition is through anticompetitive tying.[101] Tying arrangements occur when the seller of multiple goods and services conditions the sale of one good or service ("the tying product") on the purchase of another good or service ("the tied product").[102] The essence of an antitrust tying claim is that

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96 Dafny, Ho & Lee, *supra* note 76, at 287.

97 *Id.* "Common customers for insurance products can also be households that demand services of hospitals in the same geographic area but different product markets, for example, pediatric and cardiac specialty hospitals." *Id*. *See e.g.*, Jaime S. King & Erin C. Fuse Brown, *The Anti-competitive Potential of Cross-Market Mergers in Healthcare*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y 43, 56 (2017) ("To understand the joint utility loss, imagine that you must choose a health plan for your family, and you care most about a network that covers both your kids' pediatrician and your cardiologist. A plan that includes both is the most desirable, a plan that includes one or the other has slightly less value, but you will not accept a plan that includes neither. A plan that includes both the pediatrician and the cardiologist would provide the most utility, whereas a plan with neither would have even less utility than the sum of the utility lost in plans that lacked either the pediatrician or the cardiologist. Dafny, Ho, and Lee call this the 'common customer effect.'"). *Id.*

98 Acute care is a level of health care in which a patient is treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery. CONNECTICUT OFFICE OF HEALTH STRATEGY, Hospital Today (2000) https://portal.ct.gov/-/media/OHS/ohca/HospitalStudy/HospTodaypdf.pdf?la=en.

99 Dafny, Ho & Lee, *supra* note 76, at 288.

100 Dafny, Ho & Lee, *supra* note 76, at 286.

101 King & Brown, *supra* note 14, at 56.

102 Fed. Trade Comm'n, *Guide to Antitrust Laws: Tying the Sale of Two Products*, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/single-firm-conduct/tying-sale-two-products (last visited Sep. 30, 2020). For example, if a drug maker required patients to only purchase its blood-monitoring services along with its medicine to treat schizophrenia it would be tying the two products together. If the drug maker is the sole entity that produces the medicine, then even if there are other great blood-monitor services that consumers would want to buy, they would be forced to buy the drug maker's product because consumers still need the medicine. With certain exceptions, enforcement agencies have found tying arrangements to be per se anticompetitive.

the seller is using its market power in the tying product market to influence sales in the tied product market.[103]

In a cross-market merger,[104] the potential for tying arises when the newly merged entity negotiates with insurance companies on an all-or-nothing basis, such that an insurer must include all of the hospital system's providers in its network or none at all.[105] Large, multi-hospital systems often include hospitals or provider organizations that insurers must provide when contracting with employers ("must have providers").[106] Must-have providers generate significant market power for their health systems, which can extend to all other providers within the system via contracting.[91] For instance, large hospital systems that engage in "all-or-nothing" contracting have reportedly added anti-tiering provisions to their contracts with payers to prevent them from accepting all system providers at inflated rates and developing tiered benefit packages that incentivize consumers to select lower priced alternatives.[107] The possibility of "anticompetitive tying exists when a large hospital organization spans several geographic and product markets, and contracts with insurers or customers that also span those markets."[108]

In *Sidibe v. Sutter Health*, plaintiffs – a class of insured members – asserted that Sutter Health, a large hospital organization, possessed monopoly power over inpatient hospital services in eight geographic areas in Northern California.[109] Plaintiffs alleged that such monopoly power made Sutter Health's inpatient hospital services a "must have" service and allowed Sutter to engage in all or nothing demands on health plans.[110] If health plans did not accede to Sutter's demand that they include the inpatient hospital services that it supplies in the tied markets in their provider networks, then health plans could not include Sutter's "must have" inpatient hospital services supplied in the tying markets in their provider networks.[111] Since health plans could not compete in Northern California without contracting

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103 King & Brown, *supra* note 14, at 56.

104 Here, cross-market merger refers to when a hospital system acquires another hospital in a different geographic market. *Id.*

105 *Id.*

106 *Id.*

107 *Id.*

108 *Id.*

109 Third Amended Complaint at 2, Sidibe v. Sutter Health, 51 F. Supp. 3d 870 (N.D. Cal. 2014) (No. C 12-04854), rev'd, 667 Fed. Appx 641 (9th Cir. 2016) (remanding the case back to the district court to determine the plausibility of the plaintiffs' alleged geographic market).

110 Third Amended Complaint at 2, Sidibe v. Sutter Health, 51 F. Supp. 3d 870 (N.D. Cal. 2014) (No. C 12-04854), rev'd, 667 Fed. Appx 641 (9th Cir. 2016) (remanding the case back to the district court to determine the plausibility of the plaintiffs' alleged geographic market).

111 *Id.*

for Sutter's inpatient hospital services in the tying markets, plaintiffs claimed that Sutter's "all or nothing" demands forced health plans to include Sutter's tied market inpatient hospital services in their provider networks at prices that Sutter dictated.[112] In effect, plaintiffs claimed they paid artificially higher premiums, co-payments, and deductibles than they would have but for Sutter's illegal tying arrangement.[113]

Though tying arrangements are more commonly brought under Section 1 of the Sherman Act,[114] the probable anticompetitive effects resulting from such conduct may justify a merger challenge under the Clayton Act. Section 7 of the Clayton Act provides an *ex-ante* measure that allows enforcers and courts to assess the likely competitive impact of a proposed merger based on past conduct, specific facts of the case, and economic modeling.[115] Courts only require evidence of a probable future adverse impact on competition.[116] If economic theory and research support a claim that a cross-market merger poses a substantial threat to competition, there is a legal basis to bring a pre-merger challenge.[117]

In a different industry, the DOJ challenged the Comcast/Time Warner merger applying a theory bearing a strong resemblance to the "common customers" or "holes" theories. For the most part, the two cable companies did not compete to serve the same households.[118] However, the government examined "the other end of the pipeline where Comcast and Time Warner [did] compete," and after a lengthy investigation, it determined that the transaction would result in a "disproportionate increase in the merged firm's bargaining leverage over content providers" (e.g., Fox, Disney, CBS).[119] Together, the parties would have controlled 30 percent of all pay television households and close to 60 percent of the high-speed broadband subscribers in the nation.[120] The government posited that "this leverage would allow Comcast to exert too much control with too few competitors in the relevant markets.[121] Ultimately, the parties abandoned the transaction after the DOJ

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112 *Id.*

113 *Id.*, at 5.

114 Section 1 of the Sherman Act prohibits "any agreements in restraint of trade." 15 U.S.C. § 1 (2012).

115 Clayton Act § 7, 15 U.S.C. § 18.

116 King & Brown, *supra* note 14, at 56.

117 *Id.*

118 Bill Baer, Former Assistant Att'y Gen., Antitrust Div., U.S. Dep't of Justice, Remarks at Duke Law Center for Innovation Policy, Fall Conference on the Future of Video Competition and Regulation, Video Competition: Opportunities and Challenges 6 (Oct. 9, 2015).

119 *Id.*

120 *Id.*

121 *Id.* (noting that "coupled with Comcast's understandable incentive to reduce the competitive threat posed by over-the-top programmers or streaming services, consumers would have been at risk.").

and the Federal Communications Commission expressed concerns. In 2018, the DOJ brought a similar claim in the AT&T/Time Warner merger, but ultimately did not prevail in court.

In light of the structural similarities between the video programming distribution industry and the healthcare services market, a comparison of the two industries might be useful to determine if some of the factors in the former can be applied in bringing a case for the latter.

IV. PROPOSAL

Comparison to the Video Programming Distribution Industry

Industry Background

In the video programming distribution industry, studios like Warner Bros. create a show and a programmer or broadcaster purchases the right to include the show on one of its networks.[122] Programmers then license to video distributors (e.g., AT&T) the right to include the network in one or more packages to sell to the distributors' subscribers.[123] Distributors include multi-channel video programming distributors (MVPDs) and online video distributors (OVDs),[124] such as Netflix and Amazon, that do not offer live programming.[125]

Generally, programmers seek to have their networks carried by many distributors because "they make money by licensing their networks to video distributors and by selling air time for advertisements shown on their networks."[126] Video distributors rely on popular programming to attract customers. Programmers that carry a popular network with hit shows, such as *Game of Thrones*, and live sports, are more attractive to distributors, and thus provide them with increased bargaining leverage with distributors than their competitors do.[127] On the flip side, distributors with a large number of subscribers generally have more bargaining leverage and often pay programmers less per subscriber to carry their networks than distributors with

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122 Complaint at 8, United States v. AT&T, Inc., 916 F.3d 1029 (D.C. Cir. 2019) (No. 18-5214). Programmers also make their own contents (e.g. Disney).

123 *Id.*

124 They are also referred to as SVODs (subscription video on demand services). *Id.*, at 9.

125 Competitive Impact Statement at 4, United States v. Charter Commc'ns., Inc., No. 1:16-cv-00759-RCL (D.D.C. May 10, 2016).

126 Complaint at 8, United States v. AT&T, Inc., 916 F.3d 1029 (D.C. Cir. 2019) (No. 18-5214).

127 *Id.*, at 8-9.

fewer subscribers.[128] These negotiations are known as affiliate negotiations.[129] Programmers and distributors typically reach multi-year contracts under which distributors pay programmers "affiliate" fees for a bundle of networks owned by the programmer.[130] If a negotiation falls through, the distributor will lose the rights to display the programmer's content to its customers – referred to in the industry as a programming "blackout."[131] This is a similar concept to health plans having "holes" in their networks when a merged hospital decides to walk away from a deal with the insurance company.[132]

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128 *Id.* "When an MVPD considers the price it is willing to pay programmers to carry its networks, it generally takes into account the extent of potential subscriber losses if it did not carry those networks." *Id.* at 16.

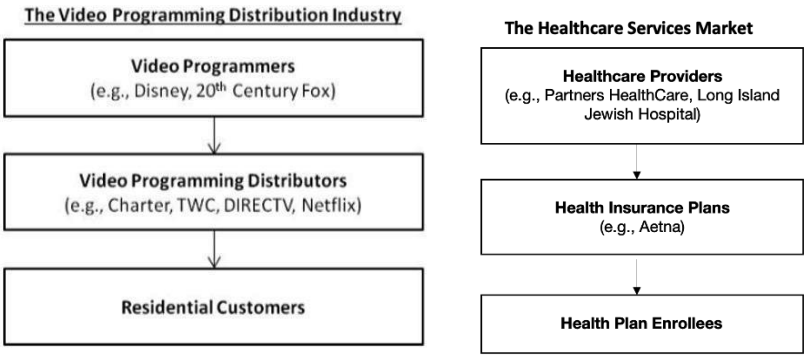
129 United States v. AT&T, Inc., 310 F. Supp. 3d 161, 170 (D.C.C. 2018), *aff'd*, 916 F.3d 1029 (D.C. Cir. 2019).

130 Complaint at 8, United States v. AT&T, Inc., 916 F.3d 1029 (D.C. Cir. 2019) (No. 18-5214).

131 United States v. AT&T, Inc., 310 F. Supp. 3d at 172.

132 *See supra* Part III.A. and accompanying texts.

Structural Similarities



Both video programming distributors and health insurance companies work as intermediaries to bundle the products/services from their respective suppliers in the upstream to consumers in the downstream market. Hospitals rely on being included in the insurance network to reach consumers, while video programmers rely on MVPDs and OVDs to distribute their content to consumers at home. In both markets, the parties are driven by similar incentives to negotiate – hospitals and video programmers want to be included in their respective intermediary's network or bundle to attract more customers, while health insurance companies and video programming distributors want "must have" products or services in their network. Both hospitals and video programmers can threaten their intermediaries with "holes" or "blackouts" in their networks, because it would be costly to health insurance companies and video programming distributors to not include their "must have" providers.[133]

Given these similarities, plaintiffs challenging a cross-market hospital merger can learn from the government's challenges in the video programming distribution industry.[134] The court's analysis of the government's theory in the AT&T/Time Warner ("TW") merger case is a cautionary tale that antitrust enforcers should heed when assessing the viability of a similar theory in the healthcare services setting.

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133 *See* United States v. AT&T, Inc., 310 F. Supp. 3d at 172, *aff'd*, 916 F.3d 1029 (D.C. Cir. 2019). ("On the distributor side, a blackout may lead a distributor to lose subscribers or may prevent the distributor from attracting new subscribers.").

134 Perry & Adler, *supra* note 34, at 500-501 (suggesting that plaintiffs might point to the structural similarities between the video programming distribution industry and the healthcare services market to block a merger, but ultimately concluding that courts will not be persuaded by this comparison).

AT&T/TW Merger Case

In the AT&T/TW merger, AT&T (distributor) decided to merge with TW (programmer) and the DOJ challenged the merger.[135] The DOJ claimed that the merger was likely to substantially lessen competition in the relevant markets by enabling AT&T to use TW's "must have" television content to either raise its rivals' video programming costs or, by way of a "blackout," drive those same rivals' customers to its subsidiary, DirecTV.[136] The DOJ presented economic evidence that the merger would disproportionately increase the bargaining leverage of the parties over its rivals but the court was unpersuaded because the model did not take into account the current affiliate long-term contracts that Turner – one of TW's popular network programmer – was engaged in at the time, and the rarity of "blackouts" in the industry.[137] Further, the rapidly changing landscape of the market with online streaming services like Hulu, Netflix, Sling TV,[138] combined with evidence that showed that distributors had successfully operated and continued to operate without the Turner networks,[139] persuaded the court to hold in favor of the defendants. The appellate court agreed with the district court. While acknowledging that the economic models used by the DOJ could assist in assessing the competitive effects, the higher court ruled that the models must be consistent with the real world.[140]

The government's theory in AT&T bears a strong resemblance to the "holes" theory that economists have raised in the cross-market hospital merger setting. However, there are some important differences between the two markets, which give the government a stronger case in the hospital context. Even though the defendants prevailed in the AT&T/TW merger, a key distinction between the market realities of the video programming distribution market and the healthcare services market is that the former is ripe with new entrants online (e.g. Hulu, Netflix, SlingTV), while the U.S. has continued to observe an upward trend in hospital mergers for nearly a

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135 Though this is a vertical merger case, the increased-bargaining leverage theory put forth by the DOJ is similar to the "common customers" or "holes" theory that economists have proposed in the cross-market hospital context and it would be useful to examine the AT&T case further to determine the factors and market conditions that courts look to.

136 United States v. AT&T, Inc., 310 F. Supp. 3d at 164.

137 *Id.*, at 172 (noting that "given the negative consequences for both sides from a blackout, 'the reality' is that virtually every bargaining impasse between a programmer and distributor is resolved after requiring either no blackout or a short-term blackout.") (citation omitted).

138 *Id.*, at 225-26.

139 *Id.*, at 202.

140 United States v. AT&T, Inc., 916 F.3d 1029 (D.C. Cir. 2019).

decade. Between 2010 and 2017, there were 778 hospital mergers,[141] with more independent hospitals merging with larger hospital systems. From 2010 to 2015, the number of hospital transactions announced grew 70 percent.[142] Further, the AT&T/TW merger was a vertical one, which courts are more reluctant to block because of the benefits of such transactions in lowering consumers' costs.[143]

Going forward, agencies should ensure that their empirical evidence takes into account the contracts that the merging parties have with health plans, as this was one of the factors that undermined the government's empirical theory in the AT&T/TW case.[144] Specifically, agencies should examine whether contracts between providers and health plans will expire shortly after the merger, or whether there are any provisions terminating the contract upon a merger. If so, the merging parties may gain bargaining leverage against insurance companies post-merger and demand higher reimbursement rates. This would implicate the bargaining concerns that the government raised in AT&T/TW. The court left open the question of whether it would find that the parties would have a greater bargaining leverage if TW's Turner had not entered into a long-term contract with its distributors.

Contractual Terms

Antitrust enforcers should also consider whether a merger consists of "must have" providers in health plans and whether there are existing all-or-nothing clauses in contracts with insurance companies requiring an insurer to contract with all of the hospital system's participating hospitals.[145] A hospital system with a must-have provider in one geographic market could force a health plan to accept its participating hospital in another geographic market – similar to the Sutter Health case *supra* – through an all-or-nothing clause, which could amount to an unlawful tying arrangement. If a merger does not

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141 Karyn Schwartz et al., *What We Knew About Provider* Consolidation, KAISAR FAMILY FOUNDATION (Sept. 2, 2020), https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/.

142 *Hospital Merger and Acquisition Activity up Sharply in 2015, According to Kaufman Hall Analysis*, KAUFFMAN HALL (Jan. 20, 2016), https://www.kaufmanhall.com/news/hospital-merger-and-acquisition-activity-sharply-2015-according-kaufman-hall-analysis.

143 *See* United States v. AT&T, Inc., 310 F. Supp. 3d at 193 ("Further complicating the Government's challenge is the recognition among academics, courts, and antitrust enforcement authorities alike that 'many vertical mergers create vertical integration efficiencies between purchasers and sellers.'"). Michael H. Riordan & Steven C. Salop, Evaluating Vertical Mergers: A Post–Chicago Approach, 63 ANTITRUST L.J. 513, 519 (1995)).

144 *Id.*, at 172.

145 *Provider Contracts*, THE SOURCE ON HEALTHCARE PRICE & COMPETITION, https://sourceonhealthcare.org/provider-contracts/ (last visited Feb.12, 2021).

involve a "must have" provider, it might not increase the merged firm's bargaining leverage when it is negotiating with an insurance company since the plan may have other rival providers it could choose to put in its network[146] unless other state laws apply.[147]

Agencies should also be wary of any anti-steering provisions[148] in the hospital system's pre-existing contracts with insurance companies. Post-merger, a hospital system could potentially preclude insurers from offering patients financial benefits to use less expensive healthcare services offered by the system's rivals in tied geographic markets, similar to the allegations against Sutter Health in Northern California.[149] Anti-steering clauses constrain a health plan from offering more generous coverage, such as reduced cost-sharing, for care obtained from a new market entrant or from a more distant provider.[150] Consumers may then be deprived of lower-cost alternatives to the providers in their plans and such provisions are evidenced to drive up patients' out-of-pocket healthcare costs.[151] Agencies could prevent the merging parties from including any steering restrictions in its contracts with insurance companies as a potential remedy, though structural remedies are preferred over behavioral.

Merging parties may claim efficiencies resulting from a merger, such as improved quality of care. Hospital mergers have many potential benefits, such as enhancing scale to absorb more financial risk and drive down costs

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146 King & Brown, *supra* note 14, 56 ("Must-have" providers generate significant market power for their health system.").

147 Certificates of Public Advantage are issued by states to hospitals and provide federal and state antitrust immunity to certain hospitals. *See Certificate of Public Advantage (COPA)*, NY DEP'T OF HEALTH https://www.health.ny.gov/health_care/medicaid/redesign/copa/#:~:text=Public%20Advantage%20(COPA)-,Certificate%20of%20Public%20Advantage%20(COPA),who%20might%20otherwise%20be%20competitors (last visited Feb. 21, 2021).

148 Provisions that prohibit insurers from steering consumers to lower cost services. *See e.g.*, Third Amended Complaint at 10-1, Sidibe v. Sutter Health, 51 F. Supp. 3d 870 (N.D. Cal. 2014) (No. C 12-04854), *rev'd*, 667 Fed. Appx 641 (9th Cir. 2016) (The anti-steering provision stated: "If Sutter Health or any provider learns that a payer . . . .does not actively encourage its members to use network participating providers [i.e., Sutter only providers] . . . Sutter shall have the right upon not less than thirty (30) days' written notice to terminate that payer's right to negotiated rates. In the event of such termination, the terminated payer shall pay for covered services rendered by providers at 100% of billed charges until such time as Sutter reasonable believes and notices that the payer does in fact actively encourage its members to use network participating providers.").

149 Norman PHO Advisory Opinion, Op. FTC 19 (Feb. 13, 2013) (finding that the physician-hospital organization merger did not appear to be limiting competition because, among other things, it did not "prevent payers from directing or incentivizing patients to choose certain providers… through 'anti-steering'… contractual clauses or provisions.").

150 Havighurst & Richman, *supra* note 32, at 879.

151 Competitive Impact Statement, United States v. Charlotte-Mecklenburg Hospital Authority 248 F.Supp. 3d 720 (W.D.N.C. 2018) (finding that Atrium abused its dominant position by forcing insurers to accept contract terms that restrict insurers from steering its consumers to Atrium's lower-cost competitors. "Deprived of any mechanism to reward low prices with more patient volume, insurers cannot create incentives for Atrium's rivals to compete on price [thereby] impeding [Atrium's] competitors' ability to attract patients by offering lower prices to insurers and their members." *Id.* (DOJ also noted that because of high provider prices, patients' out-of-pocket healthcare costs in the Charlotte area are among the highest in North Carolina).

and increase quality; improving capabilities to manage population health; streamlining costs; improving analytics by accessing more key health data; and bringing needed healthcare services to rural and disadvantaged areas.[152] However, courts are "skeptical about efficiencies defense in general and about its scope in particular."[153] Courts require merging parties to "clearly demonstrate that the proposed merger enhances rather than hinders competition because of increased efficiencies."[154]

An important antitrust principle is that all effects of a particular transaction must be analyzed and balanced to determine the net effect on consumers.[155] Enforcers and courts decide whether consolidation should be permitted based on whether the benefits of the merger significantly outweigh the harms.[156] Thus, merely showing that clinicians and providers have increased access to a common electronic medical records ("EMR") in a large system, for example, will not outweigh the harm from higher prices, unless the EMR is being used to create a large enough consumer benefit.[157]

Future Economic Studies

Section 6(b) of the FTC Act empowers the Commission to require an entity to file "special . . . reports or answers in writing to specific questions" to provide information about the entity's "organization, business, conduct, practices, management, and relation to other corporations, partnerships, and individuals."[158] This authority enables the agency to conduct wide-ranging studies that do not have a specific law enforcement purpose.[159] Pursuant to its Section 6(b) authority, the FTC's Bureau of Economics maintains a Merger Retrospective Program, which helps the agency determine, ex post, whether the agency has allowed too many potentially harmful mergers to

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152 Jeffrey W. Brennan, *Cross-Market Hospital Mergers: Economic Theory Challenged by Facts and Antitrust Law*, CPI ANTITRUST CHRON., May 2019, at 7.

153 *St. Luke's*, 778 F.3d at 790.

154 *Id.*

155 David M. Cutler & Fiona Scott Morton, *Hospital, Market Share, and Consolidation*, 310 JAMA 1964, 1969 (2013).

156 *Id.*

157 *Id.*

158 FTC Act § 6(b), 15 U.S.C. § 46(b). *See also A Brief Overview of the Federal Trade Commission's Investigative, Law Enforcement, and Rulemaking Authority*, FED. TRADE COMM'N., (rev. May, 2021) (noting that pre-complaint investigations are generally non-public. However, Commission policies may allow identification of investigations where the Commission determines the public interest warrants it or a merging party or target has disclosed the existence of the investigation) https://www.ftc.gov/about-ftc/what-we-do/enforcement-authority.

159 FTC Act § 6(b), 15 U.S.C. § 46(b). *See also*, *Brief Overview of the Federal Trade Commission's Investigative, Law Enforcement, and Rulemaking Authority*, FED. TRADE COMM'N., (rev. May, 2021)
https://www.ftc.gov/about-ftc/what-we-do/enforcement-authority.

proceed over the years and also observe the effectiveness of its analytical tools to review mergers.[160] As part of the program, in January of 2021, the FTC ordered six health insurance companies to provide information "that will allow the agency to study the effects of physician group and healthcare facility consolidation that occurred from 2015 through 2020."[161]

The FTC should expand this study to determine specifically, under what circumstances insurance companies look at one hospital as a substitute for another not just at the point of service to customers, and whether consumers differentially value services in a way that meaningfully affects competition.[162] The agency should also evaluate whether price increases are purely a result of better negotiation skills or whether health plans are forced to accept higher reimbursement rates due to the hospital's greater bargaining leverage and its status as a "must have" provider in a geographic market. If the rise in price is due to superior bargaining skills, it may not warrant antitrust concerns. But if the latter is true, the transaction warrants scrutiny from enforcers. The biggest limitation of the cross-market merger theory is that empirical evidence is still premature,[163] but with a closer examination by the FTC's Economics Bureau, the agency can gain more clarity as to when such transactions are anticompetitive.

V. CONCLUSION

With the uncertainty of the COVID-19 pandemic, affordable access to healthcare is more crucial than ever. Antitrust authorities must be vigilant about allowing mergers that harm competition from going through. Though empirical evidence of increased bargaining leverage resulting from a cross-market hospital merger is still in its early stages, the FTC and the DOJ could look to recent precedent from the video programming distribution market to guide their analysis. Nevertheless, more economic research is required to

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160 *See generally*, *Overview of the Merger Retrospective Program in the Bureau of Economics*, FED. TRADE COMM'N., https://www.ftc.gov/policy/studies/merger-retrospectives/overview (last visited Feb. 12, 2020).

161 Press Release, Fed. Trade Comm'n., FTC to Study the Impact of Physician Group and Healthcare Facility Mergers (Jan. 14, 2021) ("Six health insurance companies that received special orders from the FTC include: 1) Aetna Inc., 2) Anthem, Inc., 3) Florida Blue, 4) Cigna Corporation, 5) Health Care Service Corporation, and 6) United Healthcare. These orders seek patient-level commercial claims data for inpatient, outpatient, and physician services in 15 U.S. states from 2015 through 2020.") https://www.ftc.gov/news-events/press-releases/2021/01/ftc-study-impact-physician-group-healthcare-facility-mergers. *Id.*

162 Keith Brand & Ted Rosenbaum, *A Review of the Economic Literature on Cross-Market Health Care Mergers*, 82 ANTITRUST L.J. 533,549 (2019).

163 Argue & Stein, *supra* note 69, at 29 (concluding that the "initial empirical analysis of cross-market effects… must be refined" and that "[n]umerous plausible alternative explanations need to be accounted for to give greater credence to the findings."); *see also*, Perry & Adler, *supra* note 34, at 507 ("Economic evidence that some transactions may increase provider reimbursement rates in some contexts cannot, by itself, substitute for such a showing [that there is harm to the competitive process.]").

determine whether the increase in price is resulting from cross-market mergers or from the hospital's increased bargaining leverage.