The Never-Ending Quest for Clarity Amidst Uncertainty: Hospital M&A and Antitrust Scrutiny

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"More important than the quest for certainty is the quest for clarity."

– François Gautier[1]

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1. GINNY WEST, THE ART OF JOY: INSPIRATION AND PRACTICAL TOOLS TO CULTIVATE A LIFE FILLED WITH PASSION AND JOY 33 (2013) (ebook).

INTRODUCTION

The healthcare landscape is constantly changing, and with change comes uncertainty. Amidst uncertainty, the healthcare industry has re-established its convoluted nature by exasperating highly debated issues that have lingered on for decades, adding to the lack of clarity surrounding the industry as a whole. Similar to the lack of consistency in how healthcare, health care, or health-care is spelled,[2] varying opinions about hospital mergers and the uncertainty caused by antitrust laws create a miasma that continues to hover around the industry.[3]

Currently, hospitals across the nation participate in the largest wave of mergers since the 1990s with the idea that "[b]ig is going to be better. Small is not going to survive."[4] Considering the dynamic attributes and various forces pushing the healthcare market towards consolidation and integration, hospitals increasingly participate in mergers and acquisitions (M&A) with other medical practices.[5] Experts note that hospital transactions are so widespread that many are predicting the demise of the independent hospital.[6] In 2015 alone, the number of hospital transactions announced grew 18% compared to 2014 and 70% compared to 2010.[7]

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2. "Health care" is in the top 20% of the most searched words in the Merriam-Webster's online dictionary. *Healthcare Definition*, MERRIAM-WEBSTER, http://www.merriam-webster.com/dictionary/healthcare [https://perma.cc/CWL5-3QKT] (last visited Feb. 16, 2017); *see also* Michael Millenson, *"Healthcare" vs. "Health Care": The Definitive Word(s)*, THE DOCTOR WEIGHS IN (Aug. 29, 2010), http://thedoctorweighsin.com/healthcare-vs-health-care-the-definitive-words/ [https://perma.cc/A7CQ-99MQ] (discussing the various rationales for the correct spelling of health care).

3. *See* Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, N.Y. TIMES (Aug. 12, 2013), http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html.

4. Ann Twomey, *When It Comes to Hospitals: Is Bigger Better?*, OBSERVER (Apr. 15, 2015, 1:57 PM), http://observer.com/2015/04/when-it-comes-to-hospitals-is-bigger-better/ [https://perma.cc/5ULJ-GEAE].

5. *See id.*; *see also Balancing Act: Consolidation and Antitrust Issues in Health Care*, CAL. HEALTHCARE FOUND. (June 2015), http://chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20B/PDF%20BalancingConsolidationAntitrust.pdf [https://perma.cc/CZ9Y-989V].

6. Bill Woodson, *Behind Healthcare's M&A Boom*, FORTUNE, (Aug. 18, 2015, 11:05 AM), http://fortune.com/2015/08/18/healthcare-ma-aetna-anthem-cigna/ [https://perma.cc/QX3Z-G24N].

7. Kaufman, Hall & Associates, *Hospital Merger and Acquisition Activity Up Sharply in 2015, According to Kaufman Hall Analysis*, http://www.kaufmanhall.com/about/news/hospital-merger-and-acquisition-activity-up-sharply-in-2015-according-to-kaufman-hall-analysis [https://perma.cc/79E6-RZ84] (last visited Oct. 2, 2016) ("In 2015, 112 hospital transactions were announced compared with 95 transactions in 2014 and 66 in 2010. The pace of transactions was especially strong in the second half of 2015.").

Although critics say hospitals justify mergers in the same way as they did during the M&A boom of the 1990s,[8] these critics frequently link the current wave of mergers with the purpose of becoming more integrated and efficient to achieve the level of cost savings and improved quality that the United States and patients currently require.[9] However, the results from hospital consolidation remain uncertain because of the limited and mixed evidence about its impact on quality of care and price.[10] Part I of this Article discusses the recent surge in hospital M&A activity.[11] Part II brings some clarity by discussing the most frequently cited justification to this current wave of mergers—the Affordable Care Act (ACA).[12]

Concurrently, with the uncertainty surrounding the ever-changing healthcare landscape and the rising number of hospital transactions, the Federal Trade Commission (FTC) and Department of Justice (DOJ) (collectively, the Agencies) apply an increased level of scrutiny on modern healthcare transactions.[13]

While both public and private forces fuel the drive toward hospital consolidation, the Agencies enforce a myriad of roadblocks to hospital

8. Scott Gottlieb & Patrick Pilch, *The Urge to Merge in Healthcare: This Time, Will It be Different?*, MORNING CONSULT (Sept. 12, 2014), https://morningconsult.com/opinions/columns-hospital-mergers-the-urge-to-merge-in-healthcare-this-time-will-it-be-different/ [https://perma.cc/CXF7-E7UG].

9. *See id.*

10. *See* WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? 2–10 (Feb. 2006), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1 [https://perma.cc/77RU-DJVD]. Some studies show that increases in hospital M&A reduce competition and thereby raise prices, although others show that hospital consolidation is necessary to reduce costs and improve health care quality. *See, e.g.*, UNIVERSAL HEALTH CARE FOUND. OF CONN., HOSPITAL CONSOLIDATIONS AND CONVERSIONS 12 (2014), http://universalhealthct.org/images/publications/Hospital_Consolidations_and_Conversions.pdf [https://perma.cc/YNJ6-56FH] (noting that "the most comprehensive studies showed limited differences in outcomes between consolidated and non-consolidated hospital systems"); Gregory Curfman, M.D., *Everywhere, Hospitals Are Merging—But Why Should We Care?*, HARV. HEALTH PUBLICATIONS (Apr. 1, 2015, 5:00 PM), http://www.health.harvard.edu/blog/everywhere-hospitals-are-merging-but-why-should-you-care-201504017844 [https://perma.cc/Q864-C3EY].

11. *See infra* Part I.

12. *See infra* Part II.

13. Sandra M. DiVarco, *The Top Five Traps in Health Care M&A Transactions*, NAT'L. L. REV. (Oct. 14, 2011), http://www.natlawreview.com/article/top-five-traps-health-care-ma-transactions [https://perma.cc/K486-LAD6]. Recently, the Obama administration identified merger enforcement as one of its top priorities, and the FTC has also illustrated a newfound aggression in its antitrust enforcement efforts. *See id.*

mergers. Although hospital executives and the Agencies alike direct their actions towards the broad goal of improving health care, their independent actions are dissimilar and have uncertain results.[14] Beyond the uncertainty caused by the ACA and the dynamic healthcare industry, Part III focuses on antitrust law and its framework as applied to previous hospital mergers, illustrating how courts add more confusion to an already uncertain field by applying unclear antitrust laws.[15] Part IV attempts to bring some clarity by shedding light on the court's most recent analysis of a hospital merger.[16] Instead of applying the per se or "Rule of Reason" approach, this Article proposes that, in theory, courts now slide along the analytical continuum by using a quick look approach to scrutinize hospital mergers, which increases the amount of uncertainty and lack of clarity surrounding hospital M&A.

I. THE RECENT SURGE IN HOSPITAL M&A ACTIVITY

Consolidation has transformed nearly every U.S. industry—the health-care industry is no different.[17] After decades of attempting to deal with the causes and effects of hospital consolidation, this controversial trend continues to grow.[18] In 2015, 112 hospital transactions were announced,[19] which is an increase from the average of 88.4 hospital transactions announced each year from 2010 to 2014.[20] Furthermore, in the second quarter of 2015, the dollar volume of hospital transactions increased approximately $1.5 billion from the $542 million in the second quarter of 2014.[21] The hospital sector's deal volume also increased approximately

14. Ayla Ellison, *Should Hospitals Merge to Improve Care, Lower Costs?*, BECKER'S HOSP. REV. (Sep. 16, 2014), http://www.beckershospitalreview.com/hospital-transactions-and-valuation/should-hospitals-merge-to-improve-care-lower-costs.html [https://perma.cc/4QQT-5X3G].

15. *See infra* Part III.

16. *See infra* Part IV.

17. Mitch Morris, *Health Care Current: November 12, 2013 The Dilemma of M&A in Health Care*, DELOITTE (Nov. 12, 2013), http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/health-care-current-nov12-2013.html# [https://perma.cc/SC5T-XP2E].

18. *See id.*

19. *See* Kaufman, Hall & Associates, *supra* note 7. These transactions are occurring across a broad range of acute-care segments. In 2015, twenty-eight of the 112 transactions announced the acquiring entity was for-profit; in eighty-three transactions, the acquiring entity was not-for-profit; and in one transaction, a not-for-profit and for-profit organization jointly acquired an organization. *Id.*

20. There were sixty-six, eighty-eight, ninety-five, ninety-eight, and ninety-five announced hospital transactions in years 2010, 2011, 2012, 2013 and 2014, respectively. *Id.*

21. *See* PWC'S DEALS PRACTICE, Q2 2015 US HEALTH SERVICES DEALS INSIGHT 5 (Aug. 2015), https://www.pwc.com/us/en/healthcare/publications/assets/pwc-health-services-deals-insights-q2-2015.pdf [https://perma.cc/AXY4-N7D8].

38% between the second and third quarter of 2015.[22] Along with a huge growth in multi-hospital systems in which systems acquire individual hospitals, increases of mega-hospital-chain mergers are also prevalent.[23] As an example, the largest deal announced in 2015 was the merger of two non-profit, Catholic healthcare systems, which would form one of the largest non-profit healthcare systems in the country,[24] with a combined $17.6 billion in revenue.[25] Another notable hospital transaction announced in 2015 was Ventas, Inc.'s $1.75 billion bid on Ardent Health Services.[26] As these examples illustrate, hospital mergers are a big part of the industry and are making an even bigger splash compared to previous waves of hospital mergers.[27]

Generally, professionals projected that 2016 would bring great change in the healthcare industry.[28] But, as noted before, with change comes

22. *See* PWC'S DEAL PRACTICE, Q3 2015 US HEALTH SERVICES DEALS INSIGHT 5–6 (Nov. 2015), https://www.pwc.com/us/en/healthcare/publications/assets/pwc-health-services-deals-insights-q3-2015.pdf [https://perma.cc/W6DZ-F8YU].

23. *See* Ryan Mcaskill, *Hospital Sector Embraces Consolidation Over 'Mega-Mergers,'* REVCYCLE INTELLIGENCE (Nov. 21, 2014), http://revcycleintelligence.com/news/hospital-sector-embraces-consolidation-mega-mergers [https://perma.cc/W7Z9-FEHM] (noting the Affordable Care Act has influenced mergers, partnerships, affiliations, and alliances to effectively compete within the healthcare reform landscape).

24. *See, e.g.*, Gottlieb & Pilch, *supra* note 8.

25. *See id*. Providence Health & Services signed a letter of intent to merge with St. Joseph Health, which would include the combination of Providence's thirty-four hospitals and 475 physician clinics and other services with St. Joseph Health's sixteen hospitals, physician organizations, home health agencies, hospice care, outpatient services and community outreach services. Annie Zak, *What a Providence-St. Joseph Merger Would Mean for the Puget Sound Region*, BIZJOURNALS (Aug. 4, 2015, 2:37 PM), http://www.bizjournals.com/seattle/blog/health-care-inc/2015/08/what-a-providence-st-joseph-health-merger-would.html [https://perma.cc/Y42X-4RRB].

26. *Ventas to Acquire Ardent Health Systems for $1.75 Billion*, BUS. WIRE (Apr. 6, 2015, 6:33 AM) http://www.businesswire.com/news/home/20150406005245/en/Ventas-Acquire-Ardent-Health-Services-1.75-Billion [https://perma.cc/62LY-ZSQY].

27. The last time the United States saw this level of merger and acquisition activity among hospitals was in the 1990s when the annual average rate of hospital mergers doubled from twelve in the mid-1980s to twenty-four or more. Gottlieb & Pilch, *supra* note 8.

28. PWC'S HEALTH RESEARCH INST., TOP HEALTH INDUSTRY ISSUES OF 2016: THRIVING IN THE NEW HEALTH ECONOMY 2 (Dec. 2015), https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf [https://perma.cc/HZR5-TNCT]. For example, millions of American consumers will have their first video consults. Healthcare professionals will also begin to conduct e-visits with behavioral health patients and react to alerts from remote patient monitoring devices. Additionally, the way healthcare is paid for, delivered and accessed will progressively start to echo other industries. *Id.*

uncertainty.[29] Whether one believes hospital M&A is in spite of or because of the changes occurring in the healthcare landscape, what remains certain is that hospital M&A trends will continue to grow.[30] Although the true impact of hospital M&A remains uncertain,[31] observers cite healthcare pressures, predominately the Patient Protection and Affordable Care Act, as the main justification behind this recent wave of hospital M&A activity.[32]

II. UNCERTAINTY OF THE AFFORDABLE CARE ACT BRINGS CLARITY TO HOSPITAL M&A

Since Congress passed the ACA in 2010, the law has garnered a wide variety of political and legal debate.[33] Supporters of the ACA believe it "greatly expands access to healthcare and will over time lower government spending while boosting the economy."[34] In contrast, opponents believe the ACA harms the economy, adds to the deficit, and increases the price of healthcare.[35] Generally, the ACA mandates universal health care coverage for all U.S. citizens and makes hundreds of regulatory changes as an attempt

29. Uncertainty pervades and motivates every activity related to health care and has been acknowledged by scholars since the 1950s. While broadening mass media coverage has heightened public interest and confusion, uncertainty in health care has attracted increased attention because of several trends and events. *See* Paul K.J. Han, William M.P. Klein, & Beraj K. Arora, *Varieties of Uncertainty in Health Care: A Conceptual Taxonomy*, 31 MED. DECISION MAKING: AN INT'L J. OF THE SOC'Y FOR MED. DECISION MAKING 828, 828 (2011), http://doi.org/10.1177/0272989X11393976 [https://perma.cc/P9QE-AC3J].

30. *See id.* Rating agencies believe that hospital M&A activity will continue to increase because they expect that large for-profit hospitals will continue to have good access to credit markets, with an increased likelihood of debt-funded acquisitions, and they also expect that the largest hospital corporations will direct their cash flow towards acquisitions. *See, e.g.*, Richard Daly, *More Hospital M&A: Ratings Agencies*, HEALTHCARE FIN. MGMT. ASS'N (Jan. 6, 2016), https://www.hfma.org/Content.aspx?Id=45598 [https://perma.cc/VS82-U22X].

31. *See* Lawrence G. Goldberg, *Health Care Consolidation and the Changing Health Care Marketplace. A View of the Literature and Issues*, EMP. BENEFIT RES. INST. (Oct. 1999), https://www.ebri.org/pdf/briefspdf/1099ib.pdf [https://perma.cc/V6EV-JHLE] ("Hospitals claim that their primary motives are improving efficiency and the quality of care. The empirical evidence on this claim is mixed.").

32. *See* Melanie Evans, *Reform Update: ACA Will Accelerate Hospital Mergers, Moody's Says*, MODERN HEALTHCARE (Oct. 23, 2013), http://www.modernhealthcare.com/article/20131023/NEWS/310239966 [https://perma.cc/86PA-XF7E]; *see also* IRVING LEVIN ASSOCIATES, INC., THE HEALTH CARE ACQUISITION REPORT (Stephen M. Monroe & Sanford B. Steever, Ph.D. eds., 18th ed. 2012).

33. *Should Congress Repeal the Affordable Care Act?*, U.S. NEWS (July 10, 2012, 12:00 AM), http://www.usnews.com/debate-club/should-congress-repeal-the-affordable-care-act [https://perma.cc/8CBN-B35N].

34. *See id.*

35. *See id.*

to improve care for individuals, improve the health of populations, and reduce costs.[36]

Despite the lack of clarity surrounding the ACA, experts widely recognize the ACA as the key catalyst for the recent surge in hospital M&A.[37] Although hospital M&A is arguably an expected outcome of the healthcare industry—declining revenues, large stranded cost structures, and demographics—the ACA accelerated these issues.[38] Some of the ACA's changes involve competition for individual consumers and the move from fee-for-service to value-based reimbursement.[39] The ACA changes the old model by emphasizing patient care and efficiency.[40] With an eye towards the ACA's reimbursement reductions and shifting business model, which places more risk on hospitals by increasing the connection of payments to outcomes and value, hospitals feel major pressure to gain leverage by combining assets, staff, and resources.[41] Many believe the way to best prepare for the ACA's new mandated payment systems is through M&A.[42]

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36. *See generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); *see also* Robert King, *Economic Impact of Obamacare Hotly Debated*, WASH. EXAMINER (June 4, 2015, 5:00 AM), http://www.washingtonexaminer.com/economic-impact-of-obamacare-hotly-debated/article/2565578 [https://perma.cc/FL2Z-T6J6].

37. Health experts and empirical studies have widely recognized that tight clinical and financial integration facilitates accountable, coordinated care. *See, e.g.*, Daniel Casciato, *Mergers & Acquisitions: What's in Store for 2016*, IH EXECUTIVE (Jan. 1, 2016), http://www.ihexecutive.com/business/article/12145071/mergers-acquisitions-whats-in-store-for-2016 [https://perma.cc/8KJ6-EKER]; Alain C. Enthoven & Laura A. Tollen, *Competition in Health Care: It Takes Systems To Pursue Quality and Efficiency*, HEALTH AFF. (Sept. 7, 2005), http://content.healthaffairs.org/content/early/2005/09/07/hlthaff.w5.420.full.pdf+html [https://perma.cc/X5Q3-DCL5].

38. "The passage of the Affordable Care Act (ACA) accelerated a nationwide shift towards accountable, coordinated care to further the 'Triple Aim' of health care delivery: higher quality care, at lower costs, while improving population health." Brief of Amicus Curiae America's Essential Hospitals in Support of Reversal of the District Court at 2, Saint Alphonsus Medical Center-Nampa Inc. v. St. Luke's Health System, Ltd., 778 F.3d 775 (9th Cir. 2015) (No. 14-35173), 2014 WL 2958115; *see also* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Casciato, *supra* note 37.

39. *See* Casciato, *supra* note 37.

40. Roy Strom, *Hospital Mergers Get Caught Between Reform, Competition*, CHI. LAW. MAG. (Dec. 12, 2012), http://chicagolawyermagazine.com/Archives/2012/12/Hospital-Mergers.aspx [https://perma.cc/Q9CS-EU4R].

41. John Andrews, *Hospital Consolidation Rising*, HEALTHCARE FIN. NEWS (Mar. 11, 2013), http://www.healthcarefinancenews.com/news/hospital-consolidation-rising [https://perma.cc/T5GU-MUDV].

42. *See id.*

In any industry, a primary motivator to engage in M&A is the goal of reducing costs.[43] The healthcare industry is no different. In actuality, despite the lack of certainty surrounding the ACA, it seems clear that the ACA expressly incentivizes M&A activity. Experts widely accept that integration and coordination of care are the best ways to reduce fragmentation, increase efficiency, and thus reduce costs.[44] The ACA illustrates this by its attempt to create more efficient health care delivery systems that are entitled to significant monetary benefits over smaller, independent entities.[45] Moreover, the ACA seeks to increase cost efficiency in the delivery of health care services by promoting a patient-group centered, value-based reimbursement model.[46] For example, the ACA's accountable care organizations (ACOs), which are specialized collaborative ventures among healthcare providers, by their very nature influence hospital consolidation because if health care organizations create these networks of primary care doctors, specialists, and hospitals, they can utilize several income-enhancing provisions found in the ACA.[47] By allowing ACOs to participate in favorable provisions, such as the "Medicare Shared Savings Program," the ACA encourages hospital consolidation because hospitals can more efficiently manage a large number of enrolled patients in an economically feasible manner.[48]

With the ACA's new model of health care requiring hospitals to cover uninsured patients' expenses and deal with diminishing government

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43. This is typically done by combining two firms that were independently operating at lower than optimal efficiency levels. *See* ROBERT B. THOMPSON, MERGERS AND ACQUISITIONS: LAW AND FINANCE 11 (Wolter Kluwers Law & Bus. eds., 2d ed. 2014) (noting that synergy— the belief that the combination of two companies will produce greater economic efficiency then the operation of two independent firms—is a major financial incentive to mergers).

44. *See* Michael E. Porter & Thomas H. Lee, *The Strategy That Will Fix Health Care*, HARV. BUS. REV. (Oct. 2013), https://hbr.org/2013/10/the-strategy-that-will-fix-health-care [https://perma.cc/62LD-RRYF].

45. See The Patient Protection and Affordable Care Act and the Consequent Impact on Competition in Healthcare: Hearing Before the Subcomm. on Regulatory Reform, Commercial & Antitrust Law of the H. Comm. on the Judiciary, 113th Cong. 1 (2013) (statement of Thomas L. Greaney, Chester A. Myers Professor of Law and Dir. of the Center. for Health Law Studies, St. Louis Univ. School of Law).

46. James Ellis & Aaron Razavi, *3 Reasons Why Hospital Mergers are Advantageous*, HEALTHCARE FIN. NEWS (Feb. 8, 2012), http://www.healthcarefinancenews.com/blog/3-reasons-why-hospital-mergers-are-advantageous.

47. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, § 3022 (2010). Examples such as fee-for-services arrangements, Medicare reimbursements, and additional bonuses for meeting Section 3022 cost-cutting and quality-care criteria are unavailable to physicians and hospitals outside of the ACO network. Stephen E. Ronai, The Patient Protection and Affordable Care Act's Accountable Care Organization Program: New Healthcare Disputes and the Increased Need for ADR Services, 66-Oct. DISP. RESOL. J. 60, 63 (2011).

48. *See* Ronai, *supra* note 47.

reimbursements, hospitals justify their participation in M&A as a way to stay afloat in this new healthcare landscape.[49] The ACA also encourages hospital consolidation by extending the premiums paid for treatment in general hospitals, employing the purchasing power of the Medicare program, and reforming insurance law to eliminate many of the margins for competition between carriers.[50] Experts argue that the ACA eliminates many of the essential competition checks available in the healthcare system, and in relation to its support of consolidation, the ACA represents a concerted attempt to prevent competition.[51]

Whether critics believe that the ACA is a reaction to, and not a cause of, hospital consolidation,[52] or critics believe that hospital M&A is becoming more popular to keep up with the ACA's goals, amidst this uncertainty one thing remains clear: this tsunami like wave of hospital mergers is here to stay.[53] Additionally, regardless of whether we view hospital consolidation as a positive development in health care or an unintended consequence of the ACA,[54] consolidation will certainly raise the issue of competition and the application of antitrust law.[55]

III. ANTITRUST LAW AND HOSPITAL M&A

Antitrust law is the study of competition, and it is perhaps the least understood law of all.[56] Justice Scalia once famously quipped, "[i]n law school, I never understood [antitrust law]. I later found out, in reading the writings of those who do now understand it, that I should not have understood it because it did not make any sense then."[57] Antitrust law centers around

49. *See id.*

50. CHRISTOPHER M. POPE, HERITAGE FOUND., BACKGROUNDER NO. 2928, HOW THE AFFORDABLE CARE ACT FUELS HEALTH CARE MARKET CONSOLIDATION 1 (2014), http://thf_media.s3.amazonaws.com/2014/pdf/BG2928.pdf.

51. *See id.* at 2.

52. *See* Ellis & Razavi, *supra* note 46 (noting other arguments about the fact that hospitals are a part of a dynamic industry that has a fixed market share, major capital needs, and major needs to continue to provide care to patients in the community).

53. *See* Casciato, *supra* note 37.

54. *See* Joanne Kenen, *Getting the Facts on Hospital Mergers and Acquisitions*, ASS'N OF HEALTH CARE JOURNALISTS, http://healthjournalism.org/resources-tips-details.php?id=828#.VvQ69T-kXOo [https://perma.cc/EJ2A-KQQK] (last visited Feb. 17, 2017).

55. *See id.*

56. *See* RICHARD A. POSNER, ANTITRUST LAW 33–39 (2d ed. 2001).

57. *Scalia Confirmation Hearing Day 1*, C-SPAN (Aug. 5, 1986), http://www.c-span.org/video/?150300-1/scalia-confirmation-hearing-day-1 [https://perma.cc/3LBV-928F].

the primary principle that society is better off if markets behave competitively.[58] Thus, when the market deviates from the competitive ideal, antitrust laws play a big role.[59] Like the development of general antitrust law, as we gain new knowledge about the assumptions and dynamics of the healthcare marketplace, the law's application to hospital M&A constantly changed over time.[60] Broadly speaking, antitrust law seeks to promote fair competition on the merits, protect consumers, and protect competitor businesses from anti-competitive business practices; however, the common law character of antitrust led to unclear application and uncertain effects.[61]

A. Antitrust Law Applied to Hospital Mergers

As hospitals consolidate with the avowed purpose to keep up with the ACA's goals, the surge in M&A activity caught the attention of antitrust regulators.[62] The Agencies challenge transactions under Section 1 of the Sherman Act and Section 7 of the Clayton Act.[63] The Sherman Anti-trust Act of 1890 prohibits conspiracies in the restraint of trade that affect interstate commerce.[64] Section 7 of the Clayton Anti-Trust Act of 1914 prohibits mergers if they "lessen competition or tend to create a monopoly."[65] Consequently, the intentions of Section 7 of the Clayton Act and Section 1 of the Sherman Act differ, but the practical distinction between them is insignificant.[66] Under both, courts generally adjudicate claims under the same standards.[67]

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58. WILLIAM C. HOLMES & MELISSA MANGIARACINA, ANTITRUST LAW HANDBOOK § 6:7, Westlaw (database updated Nov. 2016).

59. *See id.* For example, antitrust law seeks to prevent the wrongful acquisition or preservation of monopoly power, the abuse of monopoly power to establish a new monopoly, and the concerted restraints of trade. Antitrust law also governs proposed mergers and acquisitions that are sufficiently large to constitute a threat to competition, furthering their goal of protecting consumers. *Id.* § 6:5.

60. *See generally id.*; *see, e.g.*, POSNER, *supra* note 56, at 195.

61. *See* POSNER, *supra* note 56, at 1.

62. *See* Thomas L. Greaney, *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*, 23 AM. J.L. & MED. 199 (1997).

63. *See* The Sherman Antitrust Act, 15 U.S.C. § 1 (2014); *see also* The Clayton Antitrust Act of 1914, 15 U.S.C. § 18 (1996).

64. 15 U.S.C. § 1 (2014).

65. Under the Clayton Act, a merger is invalid if it gives a few large firms control of a particular market, thus trying to reduce the risk of price-fixing and other forms of illegal collusion. 15 U.S.C. § 18.

66. *See* 15 U.S.C. §1 (2014); Jonathan B. Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 LAW & CONTEMP. PROBS. 93, 142–43 (1988).

67. *See, e.g.*, United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1283 (7th Cir. 1990). For the purpose of this Article, it is not essential to address the Sherman Act and Clayton Act separately. Additionally, "[b]ecause the vast majority of transactions are challenged

The analytical framework that courts apply to hospital mergers also applies to any other merger.[68] With that said, the evolution and change shown by recent developments in antitrust law has resulted in unclear guidelines and a world of uncertainty, especially when applied to hospitals.[69] The lack of certainty is demonstrated by antitrust law's decade-long shift from rigid per se rules of illegality to the Rule of Reason analysis.[70]

B. The Court's Early Success Using the Per Se Illegality Approach

Certain business practices are per se illegal under Section 1 of the Sherman Act.[71] Simply put, a per se violation requires no further inquiry into the practice's actual effect on the market or the intentions of those individuals who engage in the practice.[72] As a policy matter, the per se rule of illegality clarifies the law by promoting certainty for business planning and promoting judicial economy.[73]

In the past, courts applied per se illegality to mergers. This created a presumption of illegality for horizontal mergers in concentrated markets when, as a result of the merger, the resulting firm controls an undue market share and market share concentration significantly increases.[74] Courts believed the inherent likelihood of diminished competition was so great that they needed to enjoin the mergers unless evidence clearly demonstrated that there were no anticompetitive effects.[75]

Although per se illegality constantly transformed in cases during the 1990s, it has the benefit of creating a bright line standard to specific legal

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under both section 7 and section 1, any difference that may exist between these provisions is only relevant to mergers which are not subject to both section 7 and section 1. However, commentators have argued and at least one court has ruled that section 7 does not apply to mergers of nonprofit hospitals." David A. Ettinger & Mark L. Lasser, *An Introduction to Antitrust Merger Analysis* (Am. Health Law. Ass'n, 1997).

68. FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July 2004), https://www.justice.gov/atr/chapter-4-competition-law-hospitals [https://perma.cc/Z6R9-EJNR] [hereinafter IMPROVING HEALTH CARE].

69. *See* POSNER, *supra* note 56, at 1.

70. Abraham L. Wickelgren, *Determining the Optimal Antitrust Standard: How to Think About Per Se Versus Rule of Reason*, 85 S. CAL. L. REV. POSTSCRIPT 52 (2012).

71. *See* 15 U.S.C. §1 (2014).

72. *See* N. Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958).

73. *See id.*

74. *See* United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 363 (1963).

75. *See id*; United States v. Baker Hughes, 908 F.2d 981, 982 (D.C. Cir. 1990) (holding that showing of undue concentration in market for a particular product in a particular geographic area establishes presumption of illegality).

conduct.[76] This approach prevents defendants from introducing evidence that may establish a business justification, efficiency justification, or a procompetitive effect.[77] In *FTC v. University Health, Inc.*, the FTC challenged a proposed hospital merger by offering evidence of anticompetitive effects of the University Health, Inc. merger.[78] University Health, Inc. rebutted the FTC's evidence by arguing that the increased market share from the merger did not necessarily equal a lessening of competition because the acquired hospital was weak and not a meaningful competitor.[79] The court rejected this contention and held that the hospital's arguments against per se illegality were ineffective against the government's prima facie case.[80]

Regardless of how one categorizes many of these cases in principle, in decision-theory terms the per se illegality rule represents a conclusive presumption.[81] In earlier cases, the court tried to present the anticompetitive presumption as a rebuttable one because it recognized the determination of the competitive effects of a proposed merger as a matter of "probabilities, not certainties."[82] However, subsequent cases interpreted the clear showing

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76. *See Philadelphia Nat'l Bank*, 374 U.S. at 321 (discussing the Court's modification of the *per se* rule to make it look more like a quick look approach).

77. *See* Josh Wright, *The Guidelines Should Be Revised to Reject the PNB Structural Presumption*, TRUTH ON THE MARKET (Oct. 26, 2009), http://truthonthemarket.com/2009/10/26/the-guidelines-should-be-revised-to-reject-the-pnb-structural-presumption [https://perma.cc/2ML7-DEHU].

78. The district court rejected the FTC's motion for a preliminary injunction and, upon appeal, the Eleventh Circuit vacated and remanded the decision. *See* FTC v. Univ. Health, Inc., 938 F.2d 1206, 1206 (11th Cir. 1991).

79. *Id.* at 1220.

80. *See id*. The court said:

> [w]e are not prepared, on the strength of [the] language [in *General Dynamics*], to hold that the acquisition of a "weak company" is absolutely immune from § 7 scrutiny. Rather, we view *General Dynamics* as standing for the unremarkable proposition that a defendant may rebut the government's *prima facie* case by showing that the government's market share statistics overstate the acquired firm's ability to compete in the future and that, discounting the acquired firm's market share to take this into account, the merger would not substantially lessen competition. . . . The acquired firm's weakness, then, is one of many possible factors that a defendant may introduce to rebut the government's *prima facie* case. It is, however, "probably the weakest ground of all for justifying a merger." Therefore, to ensure that competition and consumers are protected, we will credit such a defense only in rare cases, when the defendant makes a substantial showing that the acquired firm's weakness, which cannot be resolved by any competitive means, would cause that firm's market share to reduce to a level that would undermine the government's *prima facie* case.

Id. at 1221.

81. *See* United States v. Socony-Vacuum Oil Co., Inc., 310 U.S. 150, 218 (1940) (discussing the seminal standard of per se illegality for price fixing); United States v. Trenton Potteries Co., 273 U.S. 392, 399 (1927).

82. Brown Shoe, Co. v. United States, 370 U.S. 294, 323 (1962); *see* United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 360 (1963) (holding that a firm with 30% share

rebuttal standard as placing a very high bar for demonstrating that presumptively unlawful mergers would not reduce competition, thus making the standard practically irrefutable.[83] As Justice Stewart famously stated in his dissent in *United States v. Von's Grocery*, "the sole consistency that . . . can be [found] is that, in [antitrust] litigation under [Section] 7, the Government always wins."[84]

In later cases, the courts replaced the clear showing standard with one that required the defendant to show only that "the prima facie case inaccurately predicts the relevant transaction's probable effect on future competition."[85] This appeared to reduce the burden of proof, but it remained unclear whether there was a meaningful analytical difference between lowering the burden of proof and lowering the burden of production.[86] In *United States v. Baker Hughes*, the court stated that in order to rebut a presumption of anticompetitive effects, a defendant must show that the prima facie case inaccurately predicts the relevant transaction's probable effect on future competition.[87]

This slight attempt of moving towards clarity still brought uncertainty. In *Baker*, the court suggested that a defendant can make the required showing by affirmatively demonstrating that a given transaction is unlikely to substantially reduce competition, or by discrediting the data underlying the initial presumption in the government's favor.[88] Because the government can carry its initial burden of production simply by presenting market concentration statistics using the Herfindahl-Hirschman Index,[89] the court noted that allowing the government to rest its case at that point would grossly inflate the role of statistics in actions brought under Section 7 of

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of the market was *per se* illegal). However, modern economic learning and empirical evidence does not support the notion that mergers that generate post-merger firm with greater than 30% share substantially lessen competition. *See* Wright, *supra* note 77.

83. In *United States v. Von's Grocery*, the Court held that a merger between the third and sixth largest grocery companies in Los Angeles, even though their combined sales only accounted for 7.5% of total sales in Los Angeles, was a violation of antitrust laws. *See* United States v. Von's Grocery Co., 384 U.S. 270, 272–77 (1966).

84. *Id.* at 301 (Stewart, J., dissenting).

85. United States v. Baker Hughes Inc., 908 F.2d 981, 991 (D.C. Cir. 1990).

86. *See* Steven C. Salop, *The Evolution and Vitality of Merger Presumptions: A Decision-Theoretic Approach*, 80 ANTITRUST L.J. 269, 275 (2015) (discussing the lack of clarity).

87. *See Baker Hughes*, 908 F.2d at 991.

88. *See id.* at 991–92.

89. *See id.* at 989.

the Sherman Act.[90] Ultimately, the court held that the showing of undue concentration in a market for a particular product in a particular geographic area establishes the presumption of illegality.[91] Thus, the lack of clarity prevailed when it came to the type of evidence that was needed for each of the dueling presumptions and continued to bring uncertainty to antitrust litigation.

Per se illegality—the most unyielding standard of review—has major defects, especially in the health-care industry.[92] When the courts took this hardline approach, critics argued that it was too easy for the government to prevail in these cases because almost any hospital merger would run afoul of concentration benchmarks used to assess the merger's competitive effects.[93] Additionally, when hospital mergers are at issue, the per se assumption that merging entities can control prices is not necessarily true.[94] Specifically, the per se illegality presumption—that merged hospitals will have automatic control of prices and will produce anticompetitive effects—fails because a hospital's largest source of revenue comes from government payers, who offer set prices to hospitals for their services.[95] Despite the uncertain fit, the underlying thought process of the per se illegality approach clearly aided the Agencies in their early success during litigation to stop hospital mergers.[96]

C. The Court's Declining Confidence Using the Rule of Reason Approach

Hospital mergers may create anticompetitive behavior, and at other times, encourage competition within the market. Understanding that bright-line tests put restraints on a party's freedom of action and may in fact defeat the Sherman Act's underlying purpose, courts turned to the Sherman Act's

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90. *Id.* at 986. There are also many important issues surrounding the market definition and defined geographic market that evolved. *See, e.g.*, *id.* at 982.

91. *See* Baker, *supra* note 66, at 142–43.

92. *See id.*

93. *See* Gloria J. Bazzoli et al., *Federal Antitrust Merger Enforcement Standards: A Good Fit for the Hospital Industry?*, 20 J. HEALTH POL. POL'Y & L. 137, 149 (1995); Fredric J. Entin et al., *Hospital Collaboration: The Need for an Appropriate Antitrust Policy*, 29 WAKE FOREST L. REV. 107, 115–16 (1994); David L. Glazer, *Clayton Act Scrutiny of Nonprofit Hospital Mergers: The Wrong Rx for Ailing Institutions*, 66 WASH. L. REV. 1041, 1055 (1991).

94. *See* United States v. Rockford Mem'l Corp. & Swedish Am. Corp., 898 F.2d 1278, 1283–1285 (7th Circ. 1990) (noting that higher market shares make it easier for firms in market to collude, and thereby force prices above competition levels).

95. *See* Entin, *supra* note 93, at 128.

96. Martin Gaynor & William B. Vogt, Competition Among Hospitals, 34 RAND J. ECON. 764, 764–65 (2003).

text to show its "generality and adaptability" in its application.[97] Thus, accepting the lack of clarity when dealing with hospitals, courts moved away from the per se illegality approach to a more flexible approach, the Rule of Reason. Under the Rule of Reason, the act of a merger is not illegal per se, but rather the legality of the merger depends upon the reasonableness—or lack thereof—of the predicted impact of the merger.[98] The Rule of Reason is a more holistic approach; it allows courts to gauge whether the restraint or merger is reasonable.[99] The Rule of Reason requires a determination of the particular facts of each case, possibly considering the intent of the conduct and the method used to obtain control over competition.[100] Courts expanded the Rule of Reason to balance the welfare-enhancing effects of consolidation, such as the creation of efficiencies, against welfare-reducing effects.[101]

Generally, a full Rule of Reason analysis evaluates the purpose and the effect of the allegedly anticompetitive behavior.[102] Although there are complexities within each step, especially when evaluating hospital mergers, the Rule of Reason can be broken down into three steps. [103] The first step is to determine whether the defendant has market power in a defined relevant market for goods or services, and whether the defendant has used that market power to adversely affect competition through increased prices or decreased output.[104] The market analysis question is the primary distinguishing factor between the Rule of Reason and the per se illegality analysis. In a Rule of Reason analysis, the practical result of the first

97. *See* Appalachian Coals, Inc. v. United States, 288 U.S. 344, 360 (1933) (emphasizing that the Sherman Act "set[s] up the essential standard of reasonableness").

98. Heather R. Spang et al., *Hospital Mergers and Savings for Consumers: Exploring New Evidence*, 20 HEALTH AFF. 150, 150 (2001), http://content.healthaffairs.org/content/20/4/150.long.

99. *See id.*

100. A good intention, however, will not evade scrutiny under § 1 of the Sherman Act if an unreasonable restraint is either its intent or effect. *See* Entin, *supra* note 93, at 128–29.

101. *See id.*

102. E. THOMAS SULLIVAN & HERBERT HOVENKAMP, ANTITRUST LAW, POLICY AND PROCEDURE: CASES, MATERIALS, PROBLEMS 125 (1984).

103. Hospital merger analysis raises a number of significant issues, including how best to define the geographic and product markets, assess the prospects for entry and the likelihood and magnitude of efficiencies, and determine the relevance of a hospital's institutional status (for-profit or nonprofit). *See* IMPROVING HEALTH CARE, *supra* note 68, at 20–29.

104. *See* Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 689 (1978) (noting that the temporary and limited loss of competition is outweighed by long term benefit of enhancing the marketability of the business itself).

requirement is that defendants usually prevail because plaintiffs must spend significant time, effort, and money to prove their case.[105] If the plaintiff meets these requirements, the second step of the Rule of Reason shifts the burden to the defendant to prove the challenged merger has procompetitive justifications.[106] Although the type of evidence required to meet the burden is unclear, if the defendant meets this burden, the third step of the analysis shifts the burden back to the plaintiff. The plaintiff must prove the merger is not reasonably necessary to attain the procompetitive justifications or that a less anticompetitive alternative may be used to attain the procompetitive justification.[107]

Even though courts previously had success in preventing hospital mergers, the lack of certainty surrounding the healthcare industry and the lack of clarity when applying antitrust laws to hospitals caused significant change to antitrust enforcement regarding mergers in the healthcare area.[108] From the 1990s to early 2000s, courts increasingly accepted various justifications, like potential cost savings, as a sufficient basis for allowing hospital mergers.[109] Between 1994 and 2000, there were approximately nine hundred hospital mergers and only seven litigated antitrust challenges; the Agencies lost every single challenge, which revealed the courts' confusion about how to handle hospital antitrust cases.[110]

During this wave, the FTC struggled to meet the definitions embedded in antitrust law, and judges were reluctant to enforce antitrust principles on certain hospital transactions. For example, in *FTC v. Butterworth Health*,

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105. *See* Thomas A. Piraino, Jr., *Reconciling the Per Se and Rule of Reason Approaches to Antitrust Analysis*, 64 S. CAL. L. REV. 685, 691 (1991) (explaining that plaintiffs face a "significant disadvantage" and are often deterred from filing valid claims).

106. *See* United States v. Visa U.S.A., Inc., 344 F.3d 229, 238 (2d Cir. 2003) (describing the steps of the rule of reason analysis).

107. *See id.*

108. *See* FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1303 (W.D. Mich.1996); United States v. Mercy Health Servs., 902 F. Supp. 968, 989 (N.D. Iowa 1995), vacated as moot, 107 F.3d 632, 637 (8th Cir. 1997); FTC v. Freeman Hosp., 911 F. Supp. 1213, 1228 (W.D. Mo. 1995), aff'd, 69 F.3d 260, 273 (8th Cir. 1995).

109. *See* Spang et al., *supra* note 98.

110. Gaynor & Vogt, *supra* note 96, at 764–65. The seven cases were: California v. Sutter Health Sys., 84 F. Supp. 2d 1057, 1085–1086 (N.D. Cal. 2000), aff'd mem., 217 F.3d 846 (9th Cir. 2000), revised, 130 F. Supp. 2d 1109 (N.D. Cal. 2001); FTC v. Tenet Healthcare Corp., 17 F. Supp. 2d 937, 948–49 (E.D. Mo. 1998), rev'd, 186 F.3d 1045, 1055 (8th Cir. 1999); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 149 (E.D.N.Y. 1997); FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1302–04 (W.D. Mich. 1996), aff'd, 121 F.3d 708 (6th Cir. 1997); United States v. Mercy Health Servs., 902 F. Supp. 968, 989 (N.D. Iowa 1995), vacated as moot 107 F.3d 632, 637 (8th Cir. 1997); FTC v. Freeman Hosp., 911 F. Supp. 1213, 1228 (W.D. Mo. 1995), aff'd, 69 F.3d 260, 273 (8th Cir. 1995); In re Adventist Health Sys., 117 F.T.C. 224, 315 (1994). State antitrust enforcers without either Agency's involvement brought one of the seven cases. See Sutter Health Sys., 84 F. Supp. 2d at 1057.

the court denied the FTC's motion for an injunction and allowed Butterworth Health to merge with Blodgett Memorial Medical Center despite finding that the merger created a surviving entity with near-monopoly status in two relevant markets.[111] Setting aside controversy surrounding the market definition issue, the opinion opened new avenues in antitrust analysis of hospital mergers as a basis for overcoming the presumption of illegality.[112] Although the court dismissed consumer surveys that had questionable reliability, the court ultimately held that the defendants successfully rebutted the FTC's prima facie case and additional evidence of likely harm.[113]

This revolutionary case showed how the lack of clarity troubled courts when evaluating hospital mergers. The courts' antitrust analysis shifted towards permitting open-ended inquiry into the competitive consequences of mergers unaided by meaningful presumptive rules.[114] In *Butterworth*, the court considered the nonprofit status of the hospitals, the community commitment undertaken by the merged entity, and the efficiencies resulting from the merger to determine that the proposed merger was not likely to cause anticompetitive effects.[115] The court claimed that there was a plausible basis in the record for each conclusion; however, scholars later questioned the court's factual premise for each factor.[116]

Eroding the impact of previously used legal doctrine, the decision in this case made the outcome of litigation highly uncertain.[117] Lacking sound economic and policy research, observers criticized antitrust laws on the grounds that they relied too heavily on presumptions, rules, and norms based on neoclassical theory.[118] The court's Rule of Reason analysis represented its uncertainty as a whole, and showed the lack of clarity embedded in antitrust law and its application to hospitals. The never-ending pursuit of

111. *See Butterworth Health Corp.*, 946 F. Supp. at 1300–01.

112. The district court agreed with the FTC's relevant product and geographic markets and provided a helpful step forward in refining hospital merger analysis by identifying two product markets: (1) the general acute care inpatient hospital services market; and (2) a market consisting of primary care impatient hospital services. *Id.* at 1290; *see id.* at 1300. For example, the Court balanced the nonprofit status of the merged hospital and the parties' prospective commitments. *Id.* at 1296–97.

113. *See id.* at 1302.

114. *See* Greaney, *supra* note 62, at 214.

115. *See Butterworth Health Corp*., 946 F. Supp. at 1302.

116. *See* Greaney, *supra* note 62, at 214.

117. *Id.* at 192, 214 (explaining the uncertainty when litigating antitrust hospital merger cases, hence the title *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*).

118. *See* Spang et al., *supra* note 98, at 150.

clarity in an industry of uncertainty continued, especially because guidelines lacked substance and empirical evidence demonstrating the hospital sector's imperfect market remained scarce.[119]

IV. THE QUEST FOR CLARITY

As the healthcare industry confronts a range of new and different pressures from previous years, hospitals continue to look towards the self-help remedy of M&A as means to spur growth, improve care, cut costs, and strengthen their competitive position.[120] Meanwhile, in keeping with the explosive growth of regulatory oversight of business activities in the past decade, the Agencies continue to scrutinize the effects of hospital M&A.[121] Considering the Agencies' series of failed attempts in challenging hospital mergers in the mid-1990s to early 2000s, the Agencies realized that the template for trying hospital mergers no longer works.[122]

Accordingly, the Agencies began to make changes. In 2002, the FTC established a new merger litigation task force to reinvigorate the FTC's hospital merger program.[123] The task force screens targets, selects the best cases, and develops strategies by taking a hard look at which strategies worked and which did not in prior hospital cases.[124] In 2010, the Agencies also revised their horizontal merger guidelines, signaling the FTC's move to a more flexible fact-based approach that deemphasizes the complicated, theoretical task of the relevant market definition.[125] Although its intent

119. *See id.* at 157.

120. *See id.* at 150.

121. *See* Timothy J. Muris, Chairman, Fed. Trade Comm'n, Everything Old is New Again: Healthcare and Competition in the 21st Century, Remarks Before the Seventh Annual Competition in Healthcare Forum, at 19–20 (Nov. 7, 2002), https://www.ftc.gov/sites/default/files/documents/public_statements/everything-old-new-again-health-care-and-competition-21st-century/murishealthcarespeech0211.pdf [https://perma.cc/2MH3-XG3Q].

122. The federal courts throughout the United States repeatedly rejected the FTC attempts to block hospital mergers. For example, the Eighth Circuit denied two FTC challenges on grounds that the FTC failed to meet its burden of establishing the relevant geographic market because the FTC's alleged geographic markets were too narrow. *See* FTC v. Tenet Health Care Corp., 186 F.3d 1045, 1053–54 (8th Cir. 1999); FTC v. Freeman Hosp., 69 F.3d 260, 268–72 (8th Cir. 1995).

123. *See* Press Release, Fed. Trade Comm'n, Federal Trade Commission Announces Formation of Merger Litigation Task Force (Aug. 28, 2002), https://www.ftc.gov/news-events/press-releases/2002/08/federal-trade-commission-announces-formation-merger-litigation [https://perma.cc/26XN-JX96].

124. *See id.*

125. The 2010 update modified the 1992 Horizontal Merger Guidelines that describe the factors used by the Agencies in analyzing "horizontal" mergers among competitors. *See* DEP'T OF JUSTICE & FED. TRADE COMM'N, 1992 HORIZONTAL MERGER GUIDELINES (Aug. 19, 2010), https://www.justice.gov/atr/horizontal-merger-guidelines-08192010 [https://perma.cc/4CF2-ZQEY].

was likely different, the FTC's changes created even more uncertainty for hospitals attempting to predict whether the FTC will claim that a merger violates Section 7, and added to the court's confusion when applying the law.[126]

The role of antitrust law in monitoring the healthcare industry faces increasing uncertainty, and perhaps diminishing returns.[127] Experts continue to criticize the antitrust environment, while the United States places unprecedented reliance on competition to reduce costs and assure quality in our convoluted health care system.[128] As a result, the dependence on antitrust enforcement in the healthcare industry has never been greater as providers increasingly undertake M&A and other forms of consolidation to integrate care and achieve greater efficiency, thereby creating concerns of lessening competition.[129]

Earlier in history, when courts applied the principles of per se illegality, courts represented themselves as have having a deep understanding of the healthcare industry and stopped hospital mergers dead in their tracks.[130] As time progressed, pressures changed and evidence began to confuse courts when they applied its rigid approach.[131] Next, courts began to apply the Rule of Reason, opening floodgates to various counterarguments and allowing potentially anticompetitive hospital transactions because of their avowed benefits.[132] As the threat of hospital M&A increased, the Agencies began retrospective studies of consummated hospital mergers as an attempt to emphasize the importance of relying on real-world empirical evidence, instead of hunches, guesswork, and theoretical predictions.[133] The result of these studies aided the FTC to successfully challenge the consummated acquisition of High Park Hospital by Evanston Northwestern Hospital, which portended a reboot of healthcare merger enforcement.[134]

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126. *See*, Carl Shapiro, *The 2010 Horizontal Merger Guidelines From Hedgehog to Fox in Forty Years*, 77 ANTITRUST L.J. 49, 55–60 (2010) (explaining why the FTC originally believed the 2010 guidelines would create more, rather than less, judicial certainty).

127. Robert F. Leibenluft, *Antitrust and Provider Collaborations: Where We've Been and What Should Be Done Now*, 4 J. HEALTH POL. POL'Y & L. 845, 871 (2015).

128. *See id.* at 872.

129. *See id.*

130. *See* Wickelgren, *supra* note 70, at 52.

131. *See id.* at 54.

132. *See generally* FTC v. Ind. Fed'n of Dentists, 476 U.S. 447, 457–58 (1986) (discussing the two analytical approaches).

133. *See, e.g.*, Cal. Dental Ass'n v. FTC, 526 U.S. 756, 776–81 (1991).

134. *See* Press Release, Fed. Trade Comm'n, Commission Rules that Evanston Northwestern Healthcare Corp.s Acquisition of Highland Park Hospital Was Anticompetitive

A. The Move Along the Continuum—The Quick Look

Since the Northern District of Illinois issued its decision in *Evanston* in 2008, the FTC has won five out of five litigated hospital merger challenges.[135] Additionally, signals from the Agencies are clear: they will continue to challenge hospital mergers and are ready to defend their position in court.[136] But where does this newfound confidence and its related successes come from? Rather than taking a strict categorical approach applying per se illegality or the Rule of Reason, courts are moving along the analytical continuum by using a quick look approach to facilitate the Agencies' efforts to stop hospital mergers.

The quick look is not a new category of analysis.[137] Instead, it is an approach that courts are using to move away from reliance upon fixed categories and more towards a continuum.[138] Courts typically apply the quick look approach in situations when they can easily ascertain the substantial likelihood of anticompetitive effects.[139] The quick look is advantageous in situations where actors take anticompetitive steps and proffer no plausible justification,

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(Aug. 6, 2007), https://www.ftc.gov/news-events/press-releases/2007/08/commission-rules-evanston-northwestern-healthcare-corps [https://perma.cc/3V3J-T9JD] (holding that the evidence presented by complaint counsel "demonstrate[ed] that the transaction enabled the merged firm to exercise market power and that the resulting anticompetitive effects were not offset by merger-specific efficiencies."); *see also In re* Evanston Nw. Healthcare Corp., No. 9315, slip op. at 90 (F.T.C. Aug. 6, 2007), https://www.ftc.gov/sites/default/files/documents/cases/2007/08/070806opinion.pdf [https://perma.cc/USZ4-SFLK] (imposing "an injunctive remedy that requires respondent to establish separate and independent negotiating teams" instead of mandating divestiture).

135. *In re* Evanston Nw. Corp. Antitrust Litig., 268 F.R.D. 56, 87 (N.D. Ill. 2008) (denying the hospital's motion to dismiss the FTC's complaint). The FTC's wins include three mergers that were preliminarily enjoined by a federal court. *See* FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003 (2013); FTC v. ProMedica Health Sys., Inc., 749 F.3d 559, 573 (6th Cir. 2014); FTC v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1095 (N.D. Ill. 2012).

136. Nathan Hawthorne & Kelly Signs, *Notable Trends in Merger Review: Inside the HSR Annual Report*, FED. TRADE COMM'N (Aug. 12, 2015, 2:38 PM), https://www.ftc.gov/news-events/blogs/competition-matters/2015/08/notable-trends-merger-review-inside-hsr-annual-report [https://perma.cc/M4CA-TKXK].

137. *See* Polygram Holding, Inc. v. FTC, 416 F.3d 29, 35 (D.C. Cir. 2005) (noting that the court is not moving from a dichotomy to a trichotomy).

138. In *California Dental Ass'n v. FTC*, Justice Ginsburg added that the "quick look" is not a new category of analysis that is an intermediate position between "per se" condemnation and a full-blown "rule of reason" analysis and further noted that the Supreme Court has not moved from a "dichotomy" to a "trichotomy," but instead, has backed away from any reliance upon fixed categories and has moved towards a continuum. Polygram Holding, Inc. v. FTC, 416 F.3d 29, 35 (D.C. Cir. 2005) (citing *Cal. Dental Ass'n*, 526 U.S. at 779).

139. Notably, the quick look analysis applies when an "observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have any anticompetitive effect on customers and markets." *Cal. Dental Ass'n*, 526 U.S. at 770.

or only very weak justifications, for their conduct.[140] Unlike the per se illegality and Rule of Reason analysis,[141] the logic and value of taking a quick look saves time and money by not requiring a full market analysis.[142]

The quick look analysis is similar in nature to the Rule of Reason; however, it is much more advantageous for the Agencies in hospital merger cases. Generally, under the quick look approach the plaintiff alleges that the defendant violated antitrust laws.[143] A plaintiff can do this without defining the relevant market, showing market power, or proving actual anticompetitive effects, which promotes implicit bias from the court. Then, the defendant has the opportunity to prove a plausible explanation, but such explanation is subject to scrutiny by the court.[144] Compared to the Rule of Reason, the quick look decreases the amount of detail and analysis the court requires when forming a conclusion but still has the appearance of giving defendants the opportunity to justify their behavior.[145] To shed light on the court's recent approach to enjoin hospital mergers, the following

140. *See id.*

141. The per se illegality analysis requires courts to generalize about the utility of a challenged practice and reduces the cost of decision-making but correspondingly raises the total cost of error that may have negative effects on the health-care industry. *See, e.g.*, Arizona v. Maricopa Cnty. Med. Soc., 457 U.S. 332, 344 (1982) (citing Cont'l T.V., Inc., v. GTE Sylvania, 433 U.S. 36, 50 (1977)). The Rule of Reason analysis requires an exhaustive inquiry into all the myriad factors and increases litigation costs. *See* Frank H. Easterbrook, *The Limits of Antitrust*, 63 TEX. L. REV. 1, 12–13 (1984) ("When everything is relevant, nothing is dispositive. . . . Litigation costs are the product of vague rules combined with high stakes, and nowhere is that combination more deadly than in antitrust litigation under the Rule of Reason."); Donald F. Turner, *The Durability, Relevance, and Future of American Antitrust Policy*, 75 CALIF. L. REV. 797, 800 (1987).

142. Catherine Verschedlen, *Is the Quick-Look Antitrust Analysis in Polygram Holding Inherently Suspect?*, 32 J. CORP. L. 447, 464 (2007).

143. *Id.* at 452.

144. "If the defendant does offer such an explanation, then the Commission 'must address the justification' in one of two ways. First, the Commission may explain why it can confidently conclude, without adducing evidence, that the restraint very likely harmed consumers. Alternatively, the Commission may provide the tribunal with sufficient evidence to show that anticompetitive effects are in fact likely. If the Commission succeeds in either way, then the evidentiary burden shifts to the defendant to show the restraint in fact does not harm consumers or has 'procompetitive virtues' that outweigh its burden upon consumers." Polygram Holding, Inc. v. FTC, 416 F.3d 29, 36 (D.C. Cir. 2005) (quoting *In re* PolyGram Holding, 136 F.T.C. 310 (2003)).

145. *See id.*

compares the quick look approach used in *Polygram, Inc. v. FTC* to the most recent hospital merger case, *FTC v. St. Luke's Health System, Ltd*.[146]

B. Courts Are Taking a Quick Look at Hospital Mergers

In *St. Luke's Health System*, the FTC, State of Idaho, and local hospitals brought an action against two health care providers alleging that the providers' merger violated antitrust laws.[147] According to the joint complaint, the combination of St. Luke's and Saltzer would give the combined entity the market power to demand higher prices for health care services provided by primary care physicians in Nampa, Idaho, and surrounding areas, ultimately leading to higher costs for health care consumers.[148] Even though the "district court expressly noted the troubled state of the U.S. health care system, found that St. Luke's and Saltzer genuinely intended to move toward a better health care system, and expressed its belief that the merger would improve patient outcomes if left intact," the court still held that the acquisition violated antitrust laws, and ordered St. Luke's to fully divest itself of Saltzer's physicians and assets.[149] An appeal followed, and the Ninth Circuit reviewed the district court's findings of fact for clear error and conclusions of law de novo.[150]

The court's analysis in *St. Luke's* resembled the court's analysis in *Polygram*. First, under the quick look approach, the court determines whether it is obvious from the nature of the challenged conduct that it will likely harm consumers.[151] In *Polygram*, instead of referring to the inherent nature of the actual conduct, the court looked at the similarity of the conduct to another practice that the FTC recognized as per se illegal.[152] If the conduct appears likely to restrict competition and decrease output absent an efficiency justification, it is presumed unreasonable and deemed inherently suspect.[153]

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146. *Compare id.* at 32 (holding that the FTC was correct in following the analytical path that it established in *In Re Massachusetts Board of Optometry* dubbed as the "quick look" analysis); *with* St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 785 (9th Cir. 2015).

147. *St. Luke's Health Sys.*, 778 F.3d at 781.

148. *See id.* at 782 (noting that the district court consolidated the FTC and the State of Idaho complaint that was filed in March 2013 with the complaint filed by a private hospital in the District Court of Idaho in November 2012).

149. *See id.*

150. *See id.*

151. *PolyGram Holding, Inc.*, 416 F.3d at 35.

152. *See id.* at 37 (explaining that "the rebuttable presumption of illegality arises not necessarily from anything 'inherent' in a business practice but from the close family resemblance between the suspect practice and another practice that already stands convicted in the court of consumer welfare").

153. *See id.* at 35–36.

In *St. Luke's*, the court said the plaintiff must first establish a prima facie case that a merger is anticompetitive.[154] Instead of evaluating and weighing all the data equally, the court viewed this transaction with a bias that the merger was inherently suspect. For example, the court held that the plaintiffs proved Nampa was the relevant market because 68% of Nampa residents get their primary care from providers who are located in Nampa.[155] The court also gave weight to the plaintiffs' expert witness who said commercial health plans need to include Nampa primary care physicians (PCP) in their networks to offer a competitive product.[156] Conversely, the court did not consider the defendants' undisputed evidence from a natural experiment that concluded consumers could and would obtain PCP services outside of Nampa in the event of anticompetitive prices.[157]

On appeal, St. Luke's argued that the district court erred by considering only the current behavior of Nampa consumers.[158] While the court agreed that the geographic market definition involves prospective analysis, the Ninth Circuit held there was no clear error in the district court's determination.[159] The district court considered the mere probabilities provided by the plaintiffs, and basically ignored the defendants' statistical evidence and avowed certainties opposing the anticompetitive effects of the merger.[160]

The court's analysis and biased reasoning, paired with the standard of review, illustrates the quick look approach courts are starting to use. For example, in *St. Luke's*, the district court found no evidence of potential anticompetitive price increases in the market.[161] Instead, the district court found that anticompetitive effects were likely based on hypothetical price increases for ancillary services, and not adult PCP services.[162] The Ninth Circuit stated, "The problem with this conclusion is that the district court made no findings about St. Luke's market power in the ancillary services

154. *St. Luke's Health Sys., Ltd.*, 778 F.3d at 783.

155. Brief of Appellants at 18, St. Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 782 (9th Cir. 2015) (No. 14-35173), https://www.ftc.gov/system/files/documents/cases/140612briefofappellants.pdf [https://perma.cc/CH2B-6M76].

156. *Id.*

157. The natural experiment occurred when Micron, a major regional employer, put a tiered network structure in place that caused its employees to pay more to see Saltzer and St. Luke's PCPs, which resulted in substantial numbers of Micron employees obtaining PCP services from providers outside of Nampa. *See id.* at 18–19.

158. *St. Luke's Health Sys., Ltd.*, 778 F.3d at 785.

159. *See id.*

160. *See id.*

161. *See* Brief of Appellants, *supra* note 155, at 36.

162. *St. Luke's Health Sys., Ltd.*, 778 F.3d at 787.

market. Absent such a finding, it is difficult to conclude that the merged entity could easily demand anticompetitive prices for such services."[163] The court then stated, "wholly aside from these conceptual difficulties, the factual underpinnings of the district court's conclusion are suspect."[164] Thus, despite the fact that the defendant provided a large amount of the evidence, in theory, the court took a quick look by concluding that the merger would likely harm consumers without adducing evidence of these effects.[165] Analogous to the quick look approach, the court found that the high level of Herfindahl-Hirshman Index (HHI) established the prima facie case and pointed to arbitrary evidence of anticompetitive effects, despite being outside of the defined market, to shift the evidentiary burden.[166]

Although the parties presented evidence and testimony in support of both sides, the court ostensibly applied the inherently suspect categorization to the St. Luke Hospital merger to create a rebuttable presumption of illegality.[167] Under the quick look approach, unless the defendant then comes forward with a plausible and legally cognizable competitive justification for the restraint, the court summarily condemns it.[168]

Once the burden shifts under the quick look approach, the defendant must produce evidence that the transaction will in fact produce procompetitive effects.[169] In *St. Luke's*, the district court found that the merger was designed to, and would succeed in, promoting the procompetitive goal of integrated healthcare.[170] The court also noted that the transaction was intentionally structured to maximize consumer benefits and would succeed at improving

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163. *Id.*

164. *Id.*

165. *See Polygram Holding, Inc.*, 416 F.3d at 36.

166. The Herfindahl-Hirschman Index (HHI) is a commonly accepted measure of market concentration, calculated by squaring the market share of each firm competing in a market, and then summing the resulting numbers. *See Herfindahl-Hirschman Index*, U.S. DEPT. OF JUSTICE (July 29, 2015), https://www.justice.gov/atr/herfindahl-hirschman-index [https://perma.cc/V7VL-EUGM]. The Supreme Court has cautioned that statistics reflecting market concentration are not conclusive indicators of anticompetitive effects. *See* United States v. Gen. Dynamics, 415 U.S. 486, 498 (1974).

167. *See* Brief of Appellants, *supra* note 155, at 19.

168. A proper justification had to illustrate "why practices that are competitively suspect as a general matter may not be expected to have adverse consequences in the context of the particular market in question; or they may consist of reasons why the practices are likely to have beneficial effects." *Polygram Holding, Inc.*, 416 F.3d at 29.

169. Kenneth G. Starling, *Increasing the FTC's Burden: Quick Look Verse Full Rule of Reason*, CORPS., SEC. & ANTITRUST PRAC. GROUP (The Federalist Soc'y, Washington, D.C.), Aug. 1, 1999, http://www.fed-soc.org/publications/detail/increasing-the-ftcs-burden-quick-look-versus-full-rule-of-reason [https://perma.cc/QC8F-6ERF].

170. *See* Brief of Appellants, *supra* note 155, at 46. The defendants explained that there is no dispute in academic literature or in federal policy that integration in health care benefits consumers by giving rise to higher-quality and higher-value care. *Id.*

patient outcomes.[171] Instead of balancing the benefits of the merger against the likelihood of anticompetitive effects to determine whether the transaction was valid, the court simply disregarded the undisputed benefits by deeming them not "merger-specific."[172]

Although the justifications provided in *Polygram* were different,[173] the court in *St. Luke's* took the same vague approach after it decided the defendants failed to proffer a "cognizable" justification and subsequently ceased its analysis.[174] After disregarding evidence demonstrating that the efficiencies benefiting patients and physicians were not "merger-specific," the court's analysis rested almost exclusively on aspirational generalities about physicians and made no effort to determine, on the evidence, whether the hospitals could achieve the benefits otherwise.[175] In both cases, the courts showed great bias against the claimed efficiencies. In *St. Luke's*, the court held that a transaction that lessens competition or creates monopolies is not excused from antitrust law simply because the transaction can improve its operations.[176]

Instead of objectively looking at the facts and evidence of the case to weigh the anticompetitive effects with the justifications provided by the plaintiff, the court in *St. Luke's* made a policy judgment resembling the quick look analysis used in *Polygram*. The court failed to apply the main goal of antitrust law—to enhance consumer welfare—and approached the case with a bias presuming the merger's anticompetitive effects despite opposing evidence. The court's bias in *St. Luke's* resembles the per se

171. St. Luke's argued that the merger would benefit patients by creating a team of employed physicians with access the electronic medical records system that St. Luke's used. *Id.*

172. *See* St. Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys., 778 F.3d 775, 789–91 (9th Cir. 2015).

173. Polygram's proffered justification was that the moratoriums increased the three recordings' long-term profitability and enhanced the Three Tenors Brand, thus preventing free riding from the market of the joint recording. PolyGram Holding, Inc. v. FTC., 416 F.3d 29, 37 (D.C. Cir. 2005). Although the court may have had to engage in more searching analysis of the market circumstances and that there was in fact a harm to competition, the FTC noted that the showing requires neither proof of actual anticompetitive effect nor full market analysis. *Id.* at 33.

174. *St. Luke's Health Sys., Ltd.*, 778 F.3d at 791–92.

175. *Id*. at 791; *see also* Brief of Appellants, *supra* note 155, at 48.

176. In *Polygram*, the court noted that a restraint cannot be justified solely on the ground that it increases the profitability of the enterprise that introduces the new product, regardless of whether that enterprise is a joint venture or a solo pledge. *See Polygram Holding, Inc.*, 416 F.3d at 38; *see also St. Luke's Health Sys., Ltd.*, 778 F.3d at 792.

illegality analysis requiring a showing of mere possibility or resemblance to anticompetitive behavior.[177] Although the court moved along the continuum towards the Rule of Reason by allowing St. Luke's to provide a case of rebuttal, the court set a high standard by requiring St. Luke's to produce convincing proof of significant and merger-specific benefits to successfully rebut the presumption of illegality.[178]

The fact that the court required a higher standard of proof for showing efficiencies than for showing anticompetitive effects enabled the court to give a quick look at the evidence without really considering its weight before coming to a conclusion. Additionally, the Court practically ignored the demonstration of actual procompetitive effects before validating the mere speculations provided by the plaintiff. This oversight of efficiencies and bias during the balancing step equates to the court applying a quick look approach when analyzing hospital merger cases.[179] Whether the Ninth Circuit's recent approach resulted from political pressures or newfound expertise with hospital mergers, applying this analysis with an eye towards the biased notion of a hospital merger's illegality may produce profound effects by foreclosing innovation in the healthcare market that may increase efficiency and reduce costs.[180]

Accordingly, hospitals face a growing need to demonstrate and explain how their mergers or acquisitions are procompetitive and will benefit consumers. Even though the Agencies may use anticipatory broad concepts, hospitals may not use broad evidence of procompetitive effects through efficiencies.[181] Instead, hospitals must prepare sharper-focused, well-

177. *See* discussion *supra* Part III.B (describing the per se illegality approach applied by courts).

178. *St. Luke's Health Sys., Ltd.*, 778 F.3d at 791–92.

179. Judge Easterbrook once explained that a court should err on the side of allowing conduct because the market will typically self-correct any anticompetitive effects, while a judgment erroneously prohibiting precompetitive behavior will create significant and long-term societal costs. He further noted that "wisdom lags far behind the market" and firms must be allowed to experiment with innovative practices. Easterbrook, *supra* note 141, at 2–7.

180. It is practically impossible for a health care system operating in a mid-sized market to merge where the scale necessary to form an integrated delivery system entails a substantial market share. It is even more difficult now because the court reasoned that there is no case in which the benefits of integrated care could be deemed "merger-specific" due to the theoretical possibility that independent physicians could simply work together as a "committed team." *See* Brief of Appellants, *supra* note 155, at 52.

181. *See FTC Scores a Big Victory Challenge to Hospital-Physician Practice Deal*, ADVISORY BD. (Feb. 17, 2015, 10:06 AM), https://www.advisory.com/daily-briefing/2015/02/17/ftc-scores-a-big-victory [https://perma.cc/MU2N-WTMJ] (quoting an attorney that said, "[j]ust stating that you're merging to better patient outcomes to achieve the goals of the [ACA]—that you somehow intend to gain cost efficiencies without providing the flesh to that argument—[is] not going to work under antitrust laws").

developed evidence of procompetitive effects and document their intentions properly when structuring a merger. If their transaction is challenged, they need evidence to push the court's analysis along the continuum towards a full Rule of Reason analysis, rather than allowing the court to use a quick look approach that leans towards per se illegality. Contemplating the court's recent quick look approach, it is crucial that hospitals perform considerable due diligence to evaluate transaction costs, benefits, and risks before considering M&A.

CONCLUSION

The healthcare industry is full of uncertainty. Considering the political debate and uncertainty surrounding the future of U.S. health care, it will likely remain this way for a long time. There is a lack of empirical evidence, and the studies that do exist show conflicting evidence of the ACA's effect on hospital mergers and the overall effect of hospital M&A. Moreover, courts continue to add to the uncertainty. Despite the Agencies' attempts, antitrust regulation is increasingly convoluted and misunderstood. The waves of hospital mergers and ensuing litigation have created uncertain outcomes that frustrate the industry.

It is important to understand the evolution of the courts' approach when analyzing hospital mergers. Courts no longer analyze hospital mergers categorically using per se illegality or the Rule of Reason, but instead slide along the analytical continuum using a quick look approach to scrutinize hospital M&A. Effectively, courts focus only on the possible anticompetitive considerations of hospital mergers, while ignoring evidence of the widely accepted wisdom in healthcare that integration and coordination are the best ways to reduce fragmentation, increase efficiency, and thus reduce costs. While the never-ending quest for clarity amidst uncertainty continues, one thing remains clear—hospital antitrust challenges will continue to add to the uncertainty of the healthcare industry.