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Shifting Antitrust Laws and Regulations in the Wake of Hospital Mergers: Taking the Focus Off of Elective Markets and Centering Health Care

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TAKING THE FOCUS OFF OF ELECTIVE MARKETS AND CENTERING HEALTH CARE

INTRODUCTION

Imagine you are a woman living in middle America and you have felt unwell for some time. You decide that it is time to see a gynecologist.[1] There is no clinic in your area, so you go to your local hospital. Unbeknownst to you, your local hospital has merged with a Catholic hospital and is now governed by canon law.[2] Your local hospital is thus unable to provide many reproductive health services and no longer has a gynecologist on call. You learn that the closest gynecologist is two counties away; the trip would cost you $150. You have one young child and make $700 per month. After saving for months, you are able to cover your bills, find child-care, and make the three-hour trip. You arrive for your appointment and undergo a preliminary cervical cancer screening; you then take the three-hour trip home to wait for the results. The results come back abnormal and your doctor schedules a follow-up appointment. This time, however, you are not able to save enough for the trip, so you miss your follow-up appointment. More time passes before you can return to the

[1] Hypothetical based on the testimony and quotes from women surveyed in nine Alabama counties. *It Should Not Happen: Alabama's Failure to Prevent Cervical Cancer Death in the Black Belt*, HUMAN RTS. WATCH (Nov. 29, 2018), https://www.hrw.org/report/2018/11/29/it-should-not-happen/alabamas-failure-prevent-cervical-cancer-death-black-belt [https://perma.cc/8BUH-MNH2] [hereinafter *Cancer Death in the Black Belt*].

[2] Canon law refers to "codified law governing a church." *Canon Law*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/canon%20law [https://perma.cc/5U47-QF29].

doctor, and what was once highly treatable cancer[3] has now progressed and your likelihood of survival has plummeted.[4]

Unfortunately, this hypothetical scenario may not be too far afield from reality for many patients. The rise in hospital mergers in the late 1990s resulted in a decline of the number of hospitals.[5] This wave of mergers happened under the rationale that hospitals were more efficient post-merger because smaller hospitals needed support from large systems.[6] Today hospitals continue merging and continue to justify these mergers by citing increased efficiency.[7] However, this justification ignores that quality care often requires accessible hospitals, both in terms of geography[8] and range of care.[9] When hospitals combine, two questions emerge: (1) where the consolidated location will be, and (2) what the new joint policies will be.[10] Therefore, not only are hospital mergers causing would-be patients to travel much farther than they would have

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[3] If caught early and there is no sign the cancer has spread outside the cervix or uterus, there is a 92% survival rate. However, if gone untreated, and the cancer is allowed to progress and spread to distant parts of the body, the survival rate plummets to 17%. *Survival Rates for Cervical Cancer*, AM. CANCER ASS'N (Feb. 2, 2021), https://www.cancer.org/cancer/cervical-cancer/detection-diagnosis-staging/survival.html [https://perma.cc/6WJQ-M7JJ].

[4] *See supra* text accompanying note 1.

[5] CHRISTINE KHAIKIN ET AL., MERGERWATCH, WHEN HOSPITALS MERGE: UPDATING STATE OVERSIGHT TO PROTECT ACCESS TO CARE 11 (2016), https://www.hpae.org/wp-content/uploads/2016/10/WHM-CONreport_epub_1-42.pdf [https://perma.cc/KXJ4-SBVS].

[6] *Id.* at 10.

[7] There are many who say that the Affordable Care Act (ACA) is to blame for this recent wave of mergers, due to its emphasis on consolidation. While an investigation of this potential explanation is important to fully understand hospital mergers, the fact remains that they happened before the ACA and have continued to happen since. For this reason, the scope of this note will be limited to the anti-trust legislation that is in place and needs to be amended to adequately oversee and regulate future mergers. *Id.*

[8] It is important to note that the COVID-19 pandemic has further brought to light the disparities in COVID-19 treatment options offered to patients by hospitals in lower income and affluent communities. Brian M. Rosenthal et al., *Why Surviving the Virus Might Come Down to Which Hospital Admits You*, N.Y. TIMES, (Dec. 25, 2020) https://www.nytimes.com/2020/07/01/nyregion/Coronavirus-hospitals.html [https://perma.cc/YY6E-SQ2L]. However, this does not impact the long-standing issues in accessing reproductive health care. Moreover, due to COVID-19, the frequency of hospital mergers has either been "continuing at previous levels or actually picking up momentum," making the remainder of this note only more relevant and timelier. Larry Gage, *What COVID-19 Means for the Future of Health Mergers*, LAW360 (July 1, 2020, 4:56 PM), https://www.law360.com/articles/1287931/what-covid-19-means-for-the-future-of-health-mergers [https://perma.cc/LL6V-QH47]. Therefore, this note will not focus its discussion on the impact that COVID-19 has had on access to treatment or the prevalence of hospital mergers.

[9] Charlotte Kelly et al., *Are Differences in Travel Time or Distance to Healthcare for Adults in Global North Countries Associated with an Impact on Health Outcomes? A Systematic Review*, 6 BJM OPEN 1, 1 (2016); Paola Bertoli & Veronica Grembi, *The Life-Saving Effect of Hospital Proximity*, 26 HEALTH ECON. 78, 78 (2017).

[10] *See* Lois Uttley et al., *Merging Catholic and Non-Sectarian Hospitals: New York State Models for Addressing the Ethical Challenge*, 17 NYSBA HEALTH L.J. 38, 38–39 (2012).

otherwise, but when patients arrive at one of these hospitals, their medical options are limited.[11]

This limitation is most clearly seen when secular and Catholic hospitals merge.[12] Catholic hospitals are governed by religious institutions, such as the Catholic Church.[13] Catholic hospitals are directly overseen by the local Bishop or Archbishop.[14] As Catholic institutions, these hospitals do not provide certain methods of reproductive healthcare, including contraceptives, sterilizations, and abortions.[15] As a result, reproductive care is often eliminated or severely restricted post-merger, even if the secular institution had once provided these services.[16]

There are many who believe that healthcare should be conceived as, and protected as, a human right.[17] Despite the potential merits of this argument, healthcare in the United States is currently subjected to free-market regulations. Under the current system, healthcare, namely reproductive healthcare, must be made more accessible within the confines of the current antitrust structure.

Despite the seemingly unique business model of hospitals, centered on necessity and proximity, hospital mergers are governed by the same body of antitrust law which governs all mergers and acquisitions.[18] In the United States, antitrust law is comprised primarily of the Sherman Antitrust Act (Sherman Act) and the Clayton Antitrust Act (Clayton Act), with

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[11] Steven Porter, *House Subcommittee Takes Dim View of Healthcare Consolidation*, HEALTHLEADERS (Mar. 8, 2019), https://www.healthleadersmedia.com/strategy/house-subcommittee-takes-dim-view-healthcare-consolidation [https://perma.cc/8743-WZ4W]; Dunc Williams & George H. Pink, *Rural Hospital Mergers and Acquisitions: 2005–2016*, NC RURAL HEALTH RES. PROGRAM (Nov. 1, 2018), https://www.ruralhealthresearch.org/assets/2183-8443/110118-rural-hospital-mergers-acquisitions-ppt.pdf [https://perma.cc/SV8G-BEUM].

[12] *See* KHAIKIN ET AL., *supra* note 5, at 11.

[13] *Id.* at 11–12. This note will exclusively address issues that arise from Catholic-owned institutions.

[14] Michael D. Belsley, *The Vatican Merger Defense—Should Two Catholic Hospitals Seeking to Merge be Considered a Single Entity for Purposes of Antitrust Merger Analysis?*, 90 NW. U. L. REV. 720, 751–52, 759 (1996).

[15] *See* KHAIKIN ET AL., *supra* note 5, at 11, 17.

[16] *See* Uttley et al., *supra* note 10, at 39–40.

[17] *See* Mary Gerisch, *Health Care as a Human Right*, AM. BAR ASS'N, https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-health care-in-the-united-states/health-care-as-a-human-right/ [https://perma.cc/392E-YY2K]; Jocelyn Kiley, *Most Continue to Say Ensuring Health Care Coverage is Government's Responsibility*, PEW RES. CTR. (Oct. 3, 2018), https://www.pewresearch.org/fact-tank/2018/10/03/most-continue-to-say-ensuring-health-care-coverage-is-governments-responsibility/ [https://perma.cc/LX2Y-2ZBV]; *Human Rights and Health*, WORLD HEALTH ORG. (Dec. 29, 2017), https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health [https://perma.cc/Z2W6-LCNN].

[18] *See* Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 MERCER L. REV. 1087, 1088 (1996); David L. Glazer, Comment, *Clayton Act Scrutiny of Nonprofit Hospital Mergers: The Wrong Rx For Ailing Institutions*, 66 WASH. L. REV. 1041, 1042 (1991); *see also* 15 U.S.C. §§ 1, 18.

the Federal Trade Commission (FTC) guidelines providing additional support. The Sherman Act forbids "all contracts, combinations, and conspiracies that unreasonably restrain interstate and foreign trade."[19] The Sherman Act also outlaws interstate monopolies, which occur when one firm[20] "controls the market for a product or service" and has secured that market power through "anticompetitive conduct."[21]

When hospitals violate The Sherman Act, the FTC is empowered to bring a civil action.[22] Section 1 of the Sherman Act outlaws "conspiracies in the restraint of trade that *affect* interstate commerce," and the burden of proof initially lies with the government to show that a proposed hospital merger will affect interstate commerce.[23] Under this standard, the FTC must first make a prima facie case showing that "the merger would lead to undue concentration in the product market in the geographical area" at issue.[24] One this is accomplished, the burden shifts to the defendants, the merging entities, to rebut the presumption.[25] If the defendants accomplish this, the FTC has the burden of showing the anticompetitive effects of the merger.[26]

Congress passed the Clayton Act in 1914 and extensively amended it in 1950.[27] Under this act, the government "challenges those mergers" that have a demonstrably high likelihood of raising prices for consumers.[28] The burden of proof under the Clayton Act arises from Section 7, which outlaws mergers that "*lessen* competition, or *tend* to create a monopoly."[29] Therefore, to claim a violation of the Clayton Act, the government must only show an intent to lessen competition, or a possibility of lessening competition. Although there is little difference in proving that a merger will affect or tends to affect the free market, theoretically the burden of proof

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[19] U.S. DEP'T OF JUSTICE, ANTITRUST ENFORCEMENT AND THE CONSUMER § 2, https://www.justice.gov/atr/file/800691/download [https://perma.cc/Z252-3R6C].

[20] The term firm describes any organization subject to The Sherman and Clayton antitrust acts, including healthcare firms. *Id.*

[21] *Id.*

[22] The Supreme Court has held that when the Sherman act is violated, the FTC Act is also violated. In this way, the FTC can bring civil action against "the same kinds of activities that violate the Sherman Act." *The Antitrust Laws*, FED. TRADE COMMISSION, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws [https://perma.cc/V6CM-DJCF] [hereinafter *Antitrust Laws*].

[23] Ross E. Bautista, *The Never-Ending Quest for Clarity Amidst Uncertainty: Hospital M&A and Antitrust Scrutiny*, 54 SAN DIEGO L. REV. 149, 158, 161 (2017) (emphasis added); *see also* The Sherman Act, 15 U.S.C. § 1.

[24] FTC v. ProMedica Health Sys., No. 3:11 CV 47, 2011 U.S. Dist. LEXIS 33434, at *144 (N.D. Ohio Mar. 29, 2011).

[25] *Id.*

[26] *Id.*

[27] *See* U.S. DEP'T OF JUSTICE, *supra* note 19; *see also* 15 U.S.C. § 18.

[28] *Id.*

[29] *See* Bautista, *supra* note 23, at 158 (emphasis added) (quoting 15 U.S.C. § 18).

that must be met under the Sherman Act is higher than under the Clayton Act.[30] This distinction is important, as these two acts together allow the government to challenge both anticompetitive and likely anticompetitive conduct.

In addition to the Sherman Act and the Clayton Act, the FTC provides guidelines to evaluate potential mergers and which courts can take into consideration when hearing a case. The Federal Trade Commission Act was passed in 1914.[31] It outlawed "unfair methods of competition" and created the FTC "to police violations of the [a]ct."[32] Since its formation, the FTC has promogulated multiple versions of guidelines, the most recent of which were published in 2010.[33] *The FTC 2010 Guidelines for Horizontal Mergers* (FTC Guidelines) state that analysis of competitive market alternatives is always necessary when there is concern over a potential merger.[34] To ensure that there are competitive market alternatives in the wake of a merger, the DOJ and the FTC must first define the market in order to understand the type of commerce that would be affected, and where, geographically, the proposed merger would occur.[35] Second, the DOJ and the FTC identify the market participants, and analyze the market shares and concentration.[36] Market definition is therefore predicated on "demand substitution factors" or the ability, and willingness, of consumers to substitute one product or service for another in the event of price increases.[37] Thus, the guidelines supplement the burden of proof requirements of the Sherman Act and the Clayton Act by requiring specific types of market analyses to show that the merger does not constrain the free market.

When the government sues to prevent hospital mergers, hospitals often rely on an affirmative defense of increased

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[30] *Id.*

[31] *See Antitrust Laws*, *supra* note 22.

[32] *See* U.S. DEP'T OF JUSTICE, *supra* note 19.

[33] Craig A. Waldman, *What You Need to Know About the Revisions to the Merger Guidelines*, INSIGHTS (Apr. 2010), https://www.jonesday.com/en/insights/2010/04/what-you-need-to-know-about-the-revisions-to-the-merger-guidelines [https://perma.cc/XJT8-BWPA].

[34] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 2, 7 (2010) [hereinafter HORIZONTAL MERGER GUIDELINES] (The Department of Justice (DOJ) and the Federal Trade Commission (FTC) are responsible for identifying if a proposed merger presents anticompetitive concerns.); *Premerger Notification and the Merger Review Process*, FED. TRADE COMMISSION, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/mergers/premerger-notification-merger-review [https://perma.cc/E8AD-DMRA] (Under the Hart-Scott-Rodino Act, the parties interested in merging must file a notice of a proposed deal with the DOJ and the FTC. One of these two agencies will review the merger.).

[35] *See* HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 7.

[36] *Id.*

[37] *Id.*

efficiency.[38] This affirmative defense is essentially the same as the justifications claimed for merging, which are that smaller hospitals need support from large healthcare systems, and that they operate more efficiently post-merger.[39] Thus far, it has been a successful defense. From "1994 [to] 2000, there were approximately nine hundred hospital mergers and only seven litigated antitrust challenges;" of those seven, the merging hospitals prevailed every time.[40] However, since 2000, in cases such as *Saint Alphonsus Med. Ctr. - Nampa, Inc. v. Saint Luke's Health Sys.*,[41] courts have started to reign in this defense and now require hospitals to make a specific showing that the added efficiencies are procompetitive[42] and will benefit consumers.[43] Still, one of the strengths of this affirmative defense most detrimental to preserving access to care is that it does not require drawing out the quality and variety of services provided.

In the wake of the ambiguity around evaluation of potential hospital mergers, this note seeks to clarify the standards necessary to meet the burden of proof under the Sherman Act and the Clayton Act, as applied to hospital mergers, in order to facilitate uniform court analysis. Part I demonstrates, through an analysis of access to reproductive care, how the legal shortcomings in merger oversight create immense hurdles for individuals seeking health care. Part II provides background on the current mechanisms of statutory oversight and their shortcomings. Part III examines current methods of agency oversight of mergers, namely, the FTC. Finally, Part IV remedies the current lack of oversight by proposing amendments to the Sherman Act, Clayton Act, and the FTC Guidelines, such that each includes specific language for hospitals and health care centers. Together this analysis will comprehensively account for the unique qualities of hospitals and the need to mitigate the number of market and care constraining mergers, while also providing courts with clear statutory guidance upon which to evaluate cases dealing with hospital mergers.[44]

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[38] *See* Bautista, *supra* note 23, at 164–65, 174–75.

[39] *See* KHAIKIN ET AL., *supra* note 5, at 10.

[40] *See* Bautista, *supra* note 23, at 164.

[41] Saint Alphonsus Med. Ctr.–Nampa, Inc. v. Saint Luke's Health Sys., 778 F.3d 775 (9th Cir. 2015).

[42] "'[P]rocompetitive benefit' refers to an agreement's favorable competitive consequences, without taking account of its anticompetitive harm." FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS 3 (2000).

[43] *See* Bautista, *supra* note 23, at 174–75; *see also Saint Alphonsus Med.*, 778 F.3d at 790.

[44] This note will not be addressing the best interpretation for the court to take. Though it is an important factor, the scope of this note is limited to the idea that the

I. THE NEXUS BETWEEN THE LACK OF MERGER OVERSIGHT AND THE LACK OF CARE OPTIONS

Health care is not a typical service or commodity—it is often not elective, and receiving care is heavily dependent on an individual's geographic proximity to a health care facility.[45] Thus, access to health care must be considered in light of an individual's reasonable financial and logistical confines.

A. When Secular and Catholic Hospitals Merge: Fundamental Differences in Governing Structures

Catholic hospitals are governed by the Catholic religious doctrine. The Pope serves as the head of the Catholic Church. Directly below him are Bishops and then Cardinal Bishops.[46] The Catholic hierarchy then includes individual Churches and institutions, such as Catholic hospitals.[47] It is important to note that the Vatican does not directly own any Catholic hospitals. Instead, the Church's "congregations, institutes, and societies" own and oversee the Catholic hospitals.[48] However, since each of these religious orders are within the control of the Pope, the Vatican retains effective control over the hospitals.[49] Thus, Catholic hospitals not owned by the Vatican are nevertheless directly overseen by the local Bishop or Archbishop and are therefore governed by canon law.[50]

When any two hospitals merge, two issues develop: (1) where the consolidated location will be, and (2) what the new joint policies will be for the merged hospital.[51] Not only can hospital mergers cause would-be patients to travel much farther for care, but medical options within merged hospitals can be limited.[52] These limitations are most clearly seen when secular and Catholic hospitals merge. Since the Catholic Church

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current statutes and regulations are so lacking that they must be revamped prior to tackling how to interpret the new provisions.

[45] *See Cancer Death in the Black Belt*, *supra* note 1.

[46] *See* Belsley, *supra* note 14, at 748–50 ("[T]he pope alone selects [which bishops] will serve as cardinal bishops. Cardinal bishops have three major functions: (1) provide for the election of the Pope; (2) serve as special advisors to the Pope; and (3) assist the Pope by serving as special papal officers charged with the daily care of the Catholic Church.").

[47] *Id.*

[48] *Id.* at 752.

[49] *See id.*

[50] *Id.* at 751–52, 758–59.

[51] *See, e.g.*, Uttley et al., *supra* note 10, at 39–41.

[52] *See* DUNC WILLIAMS JR., ET AL., NC RURAL HEALTH RES. PROGRAM, RURAL HOSPITAL MERGERS FROM 2005 THROUGH 2016 1 (2018), https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/08/Rural-Hospital-Mergers.pdf [https://perma.cc/HE85-7R9M]; *see also* KHAIKIN ET AL., *supra* note 5, at 11.

oversees and owns Catholic hospitals, the *Ethical and Religious Directives for Catholic Health Care Services*[53] governs Catholic hospitals' operations.[54] To adhere to these teachings, Catholic hospitals do not offer certain medical services, including but not limited to, voluntary sterilizations, contraceptives, and abortions.[55] As a result of this new affiliation with the Church, secular hospitals that merge with Catholic hospitals often eliminate or severely restrict reproductive care post-merger, even if the secular institution had once provided the services.[56]

B. How Secular and Catholic Mergers Limit and Restrict the Reproductive Care Options Available

The *Ethical and Religious Directives for Catholic Health Care Services* prevent Catholic health care facilities, including hospitals, from providing a range of reproductive health services.[57] These services include: "abortions, elective sterilizations, contraceptive services and supplies, most forms of assisted reproduction, comprehensive AIDS prevention . . . and 'morning-after' pills,"[58] including for rape victims.[59] Compliance with these rules necessarily restricts the scope of care that patients are able to receive at these hospitals. Moreover, patients often do not realize that the hospital is Catholic and do not know that they may be denied health care.[60] One woman went to a Catholic hospital in Oregon to give birth and asked to be sterilized after she delivered her child.[61] The requested sterilization was not performed and the doctors failed to tell the woman that it had not been performed.[62] The woman found out

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[53] "The *Ethical and Religious Directives for Catholic Health Care Services* are directives promogulated by the United States Conference of Catholic Bishops to govern Catholic health care facilities." They are the standards which Catholic hospitals, clinics and managed care organizations must adhere to. Hayley Penan & Amy Chen, *The Ethical & Religious Directives: What the 2018 Update Means for Catholic Hospital Mergers*, NAT'L HEALTH L. PROGRAM (Jan. 2, 2019), https://healthlaw.org/resource/the-ethical-religious-directives-what-the-2018-update-means-for-catholic-hospital-mergers/ [https://perma.cc/T77X-KN45].

[54] *See* Belsley, *supra* note 14, at 758.

[55] *Id.*; *see also* KHAIKIN ET AL., *supra* note 5, at 26.

[56] *See* Uttley et al., *supra* note 10, at 38; KHAIKIN ET AL., *supra* note 5, at 11–12.

[57] *Hospital Mergers: The Threat to Reproductive Health Services*, ACLU, https://www.aclu.org/other/hospital-mergers-threat-reproductive-health-services#comment-0 [https://perma.cc/5XF5-6UX6] [hereinafter *Hospital Mergers*].

[58] *Id.* (Morning after pills "prevent implantation of a fertilized egg.").

[59] *Id.*

[60] *Id.*

[61] *Id.*

[62] *Id.*

that she had not been sterilized when she was later confronted with an "unwanted pregnancy."[63]

This story is not unique[64] and illustrates how hospital mergers not only limit the spectrum of care offered but can cause physical and psychological harm to patients.[65]

C. The Place for Health Care as a Right in the United States

In addition to the issues posed by Catholic religious doctrine governing the range of services provided in Catholic hospitals, the fact that health care is not considered a "right" under United States law means that patients are not inherently protected from gaps in coverage that result from mergers. [66] Antitrust law is, therefore, the main legal mechanism by which a full range of care can be preserved in the face of hospital mergers.

In the United States, health care is not a constitutional right.[67] Congress has, however, enacted multiple statutes that use health insurance as a path to provide health care to certain groups of people.[68] Moreover, the concept of health care as a right is not foreign to the United States; Franklin Delano Roosevelt drafted the second bill of rights, which included a right to health care.[69] This bill of rights effectively served as the basis for the United Nation's (U.N.) Universal Declaration of Human Rights, including Article 25, the essential right to health.[70] The United States adopted these international standards, as did all other U.N. member nations.[71] Regardless, the United States has been careful to avoid referring to health care as a right. The United States' 2015 report to the U.N. refers to "health measures" not

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[63] *Id.*

[64] "Catholics for a Free Choice, which has done much of the groundbreaking research on this subject, has documented a number of these cases" *Id.*

[65] *Id.*

[66] KATHLEEN S. SWENDIMAN, CONG. RESEARCH SERV., R40846, HEALTH CARE: CONSTITUTIONAL RIGHTS AND LEGISLATIVE POWERS 1 (2012).

[67] *Id.* at 1.

[68] *Id.* at 10 (programs include: Medicare, Medicaid, and the Children's Health Insurance Program).

[69] Mary Gerisch, *Health Care as a Human Right*, ABA, https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-health care-in-the-united-states/health-care-as-a-human-right [https://perma.cc/ULY8-TCCC]. Second Bill of Rights, also called the Economic Bill of Rights, was part of Franklin Delano Roosevelt's 1944 State of the Union address. This second bill of rights was therefore not proposed to amend the constitution but instead to challenge Congress to aspire to these goals while legislating. *Historic Documents: The Economic Bill of Rights*, US HIST., https://www.ushistory.org/documents/economic_bill_of_rights.htm [https://perma.cc/3PKV-Z2TU].

[70] *See* Gerisch, *supra* note 69.

[71] This treaty was signed by the United States but not ratified by congress. *Id.*

"health rights."[72] This complex dichotomy between pioneering the concept of health rights, while at the same time refraining from adapting those same concepts, complicates health care policy in the United States.

Despite this complex history, public opinion is shifting toward conceptualizing health care as a government-ensured right. In 2018, 60 percent of people living in the United States believed that the federal government has a responsibility to ensure all those in the United States have health care coverage.[73] This ideal is also within the health care goals set forth by the World Health Organization (WHO), which include accessibility.[74] The WHO health care goals can serve as a blueprint in the event that the United States formally reconceived of health care as a human right. In the interim, health care currently remains constricted by the free market framework of antitrust and as such, antitrust laws must evolve to adequately protect access to health care, namely reproductive health care.

The regulation of hospital mergers must evolve with an eye toward access to care. The loss of care options after secular and Catholic hospitals merge exemplifies the failures of antirust regulation to consider the distinct governing structures of secular and Catholic hospitals. Moreover, because the United States does not currently view health care as a human right, antitrust law remains the best mechanism through which to properly regulate hospital mergers.

II. HISTORY OF THE CURRENT STATUTORY MERGER OVERSIGHT SYSTEM

There are two main levels though which regulators and courts evaluate mergers and their effects on competition. The first level is statutory oversight, primarily through the Sherman Act and Clayton Act and judicial enforcement of these acts. Statutory authority can be further analyzed by: (1) each act's respective

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[72] *Id.*

[73] Amanda Mull, *What It Means for Health Care to Be a Human Right*, ATLANTIC (June 24, 2019), https://www.theatlantic.com/health/archive/2019/06/health-care-human-right/592357/ [https://perma.cc/7JS6-Y2ZM]; *see also* Jocelyn Kiley, *Most Continue to Say Ensuring Health Care Coverage Is Government's Responsibility*, PEW RES. CTR. (Oct. 3, 2018), https://www.pewresearch.org/fact-tank/2018/10/03/most-continue-to-say-ensuring-health-care-coverage-is-governments-responsibility/ [https://perma.cc/39M4-LFY2].

[74] *Human Rights and Health*, WORLD HEALTH ORG. (Dec. 29, 2017), https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health [https://perma.cc/58UB-PN9K].

statutory history;[75] (2) the burdens of proof laid out in each act;[76] (3) the analytic approaches courts take in interpreting each act, including "The Rule of Reason"[77] and the affirmative defense merging entities often invoke.[78] The second level of evaluation is agency oversight through the FTC and its guidelines.[79]

A. History of the Sherman and Clayton Acts

Congress enacted The Sherman Act in 1890 as a response to the lack of federal regulation of trusts.[80] A trust under the act is defined as stockholders of multiple companies transferring their shares to one group of trustees.[81] "In exchange, the stockholders receive[] a . . . specified share of the consolidated earnings of the jointly managed companies."[82] Accordingly, these trustees uniformly run the individual companies, in effect operating as a monopoly.[83] Interstate monopolies occur when "one firm controls the market for a product or service" and gains that market power through "anticompetitive conduct."[84]

Prior to the passage of the act, trusts were only regulated by state law.[85] Because they were state laws, these regulations were limited to matters of intrastate commerce.[86] Congress then enacted the Sherman Act by invoking its constitutional power to regulate interstate commerce.[87] The Sherman Act thus renders combinations of "trust[s] or otherwise that [are] in restraint of trade or commerce among the several states, or with foreign nations," illegal.[88]

The act, however, was "loosely worded" and neglected to define key terms, rendering it weak in practice.[89] The Act was essentially dismantled by *United States v. E. C. Knight Company*.[90]

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[75] *See* David L. Glazer, Comment, *Clayton Act Scrutiny of Nonprofit Hospital Mergers: The Wrong Rx For Ailing Institutions*, 66 WASH. L. REV. 1041, 1045–47 (1991); *see also Sherman Anti-Trust Act* (1890), OURDOCUMENTS, http://www.ourdocuments.gov/doc.php?doc=51 [https://perma.cc/RE3D-8WSV]; *Clayton Antitrust Act*, ENCYCLOPEDIA BRITANNICA, https://www.britannica.com/event/Clayton-Antitrust-Act [https://perma.cc/9ZK4-JD3S].

[76] *See* Bautista, *supra* note 23, at 163–64; 15 U.S.C. §§ 1, 18.

[77] *See* Bautista, *supra* note 23, at 163 (discussion on "The Rule of Reason").

[78] *See* FTC v. ProMedica Health Sys., NO. 3:11 CV 47, 2011 U.S. Dist. LEXIS 33434, at *92-*113 (N.D. Ohio Mar. 29, 2011).

[79] *See* Bautista, *supra* note 23, at 164; HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 1–2.

[80] *See Sherman Anti-Trust Act*, *supra* note 75.

[81] *Id.*

[82] *Id.*

[83] *Id.*

[84] *See* U.S. DEP'T OF JUSTICE *supra* note 19.

[85] *See Sherman Anti-Trust Act*, *supra* note 75.

[86] *Id.*

[87] *Id.*

[88] *Id.*

[89] *Id.*

[90] *Id.*; *see also* United States v. E. C. Knight Co., 15 S. Ct. 249 (1895).

Decided in 1895, the case was brought against four defendant sugar refinery or trade companies, which allegedly combined and conspired to restrict trade. Despite the companies' control over the manufacture and sale of refined sugar,[91] the Court ruled that no monopoly had been formed.[92] Despite the temporary setback, President Theodore Roosevelt was able to successfully use the Sherman Act to break up monopolies.[93] Since then, courts have upheld the Sherman Act's power to dissolve trusts.[94]

In 1914, as a response to President Woodrow Wilson's request that Congress revise existing antitrust legislation, Congress passed the Clayton Act to strengthen the Sherman Act and clearly define prohibited activities.[95] The Clayton Act defined illegal business practices as any practice that facilitates, or results from, a monopoly.[96] Importantly two sections of the Clayton Act were amended in 1936 and 1950.[97] In 1936, the Robinson-Patman Act was passed, strengthening the enforcement capacity of Section 2 of the Clayton Act, which deals with customer discrimination by price or otherwise.[98] The Celler-Kefauver Act was passed in 1950, amending

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[91] *E.C. Knight Co.*, 15 S. Ct. at 251 ("[I]n March 1892, the American Sugar Refining Company entered into contracts (on different dates) with the stockholders of each of the Philadelphia corporations named whereby it purchased their stock, paying therefore by transfers of stock in its company; that the American Sugar Refining Company thus obtained possession of the Philadelphia refineries and their business . . . . ").

[92] *Id.* at 254–55.

[93] *See Sherman Anti-Trust Act*, *supra* note 75. President Roosevelt's first success using the Sherman Act was the dismantling of the Northern Securities Corporation in 1902. This corporation was a holding company with one board of trustees that controlled many separate railroads from Chicago to the Pacific Northwest. On appeal the Supreme Court ruled 5–4 that the Northern Securities Corporation violated the Sherman Act. *The Sherman Act*, THEODORE ROOSEVELT CTR. AT DICK. ST. U., https://www.theodorerooseveltcenter.org/Learn-About-TR/TR-Encyclopedia/Capitalism-and-Labor/The-Sherman-Act.aspx#:~:text=After%20losing%20in%20the%20lower,trust%2Dbusting%20during%20Roosevelt's%20presidency [https://perma.cc/29JS-5PEL].

[94] *See Sherman Anti-Trust Act*, *supra* note 75. *See generally* Minnesota v. Northern Sec. Co., 194 U.S. 48 (1904) (this case, together with United States v. Microsoft, worked to cement the power of the Sherman Act in breaking up trusts); United States v. Microsoft Corp., 253 F.3d 34 (D.C. Cir. 2001) (this major case further cemented the power of the Sherman Act as used by courts to dissolve trusts).

[95] *See Clayton Antitrust Act*, *supra* note 75; Glazer, *supra* note 75, at 1046.

[96] *See Clayton Antitrust Act*, *supra* note 75; *See* 15 U.S.C. § 18.

[97] *See* sources cited *supra* note 96.

[98] Price discrimination generally defined is a "selling strategy that charges customers different prices for the same product or service based on what the seller thinks they can get the customer to agree to." This is generally the maximum price possible at which to make the sale. Alexandra Twin, *Price Discrimination: What is Price Discrimination?*, INVESTOPEDIA (Mar. 14, 2021), https://www.investopedia.com/terms/p/price_discrimination.asp [https://perma.cc/YVL4-26ZB]. There are three degrees of price discrimination, however for the scope of this note it is unnecessary to delve into each. *See* Corporate Financial Institute, *What is Price Discrimination?*, https://corporatefinanceinstitute.com/resources/knowledge/strategy/price-discrimination/ [https://perma.cc/2XBQ-NFR2]. An example of price discrimination is when a movie theater charges $15.00 USD for a general admission ticket but charges senior citizens $8.00 USD for the same ticket. Investopedia, *What Are Some Examples of Industries That Practice Price Discrimination?*, SECTORS & INDUSTRIES

and strengthening Section 7 of the Clayton Act to forbid one firm from purchasing another firm's stocks or assets when that purchase would lessen competition.[99] Importantly, the Celler-Kefauver Act also extends the reach of antitrust laws to "all forms of mergers . . . [that] would substantially lessen competition and tend to create a monopoly."[100] This marked an important shift away from the previous legislative measures, which only restricted horizontal mergers,[101] and towards a restriction on conglomerate mergers.[102]

B. The Tests to Meet the Burden of Proof Under the Sherman and Clayton Acts

Antitrust laws in the United States regulate all businesses and prohibit unreasonable restraints of trade.[103] There is not, however, any specific statutory language that applies to the unique markets that hospitals occupy.[104] The services provided by hospitals are often emergency or nonelective procedures for which patients likely do not have the opportunity to compare prices and "shop for" the best option. The current tests the government must satisfy to meet the statutory burden of proof contained in the Sherman and Clayton Acts do not require courts to account for these particularities when it comes to regulating hospital mergers.[105]

The Sherman Act's burden of proof scheme is created by Section 1, which outlaws mergers that restrict trade if they are found by the FTC or DOJ[106] to actually affect interstate commerce.[107] Violations of the Sherman Act generally result in civil action,[108] or in limited cases, criminal actions.[109] The agencies[110] tasked with enforcing the Sherman Act each focus their efforts on distinct areas

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ANALYSIS, https://www.investopedia.com/ask/answers/051515/what-are-some-examples-industries-practice-price-discrimination.asp [https://perma.cc/BJ3A-5YZF].

[99] *See* sources cited *supra* note 98.

[100] *See* sources cited *supra* note 98; Glazer, *supra* note 75, at 1047.

[101] Horizontal mergers are defined as mergers "involving firms that produce the same goods [or services]." *See Clayton Antitrust Act*, *supra* note 75.

[102] Conglomerate mergers are defined as mergers involving firms in different industries. *Id.*

[103] *See Antitrust Laws supra* note 22.

[104] *See generally* 15 U.S.C. §§ 1–7; 15 U.S.C. §§ 12–27.

[105] *See* sources cited *supra* note 104.

[106] *See* Bautista, *supra* note 23, at 151 (defining "The Agencies" to comprise the FTC and the DOJ).

[107] *See* Bautista, *supra* note 23, at 158; *see also* 15 U.S.C. § 1.

[108] *See Antitrust Laws supra* note 22.

[109] Criminal felony charges are limited to when there is an "intentional and clear" violation and are brought by the Department of Justice. Criminal penalties include up to 10 years in prison. Additionally, the Sherman Act also provides a private right of action. *Id.*

[110] The FTC and the DOJ; *The Enforcers*, FED. TRADE COMM'N, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/enforcers [https://perma.cc/9P93-J4VH].

of business.[111] For instance, violations of the Sherman Act in the health care industry are investigated by the FTC.[112]

The Clayton Act does not carry criminal charges; the government may bring actions for civil penalties against mergers that have a high likelihood of raising prices for consumers.[113] Section 7, which outlaws mergers that the FTC or DOJ finds "lessen competition or tend to create a monopoly," establishes the standard government must comply with to meet the burden of proof.[114] This standard to meet the burden of proof is theoretically lower than the standard established by the Sherman Act. The Sherman Act requires demonstration of an actual effect, whereas the Clayton Act only requires a showing that the merger has a strong tendency to limit free competition.[115] In practice however, methods of demonstrating an actual effect on competition and a tendency to affect competition are often largely the same, rendering the strength of each burden practically equal.[116]

From these burdens of proof, the courts initially followed the Rule of Reason Test to determine if a proposed merger would violate either the Sherman Act or the Clayton Act.[117] Under the Rule of Reason, the merger is not illegal per se, instead its legality depends on reasonableness of the merger.[118] The Rule of Reason test hinges on market power analysis and allows courts to weigh the stated purpose of the proposed merger against the effects of the allegedly anticompetitive behavior to determine if the merger is reasonable.[119] Historically, this test has, however, generated more confusion than clarity.

The Sixth Circuit case *FTC v. Butterworth Health* exemplifies this uncertainty.[120] In *Butterworth Health*, the court allowed the hospital to rebut the FTC's prima facie case by showing that its merger resulted in consumer savings.[121] The hospitals presented evidence of economic studies, expert witness testifying that the prices would not become anticompetitive, and

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111 *Id.*

112 *Id.*

113 Importantly, the Clayton Act additionally allows private rights of action. *See* U.S. DEP'T OF JUSTICE, *supra* note 19; *Antitrust Laws supra* note 22.

114 *See* Bautista, *supra* note 23, at 158; *see also* 15 U.S.C. §§ 12–27.

115 *See* Bautista, *supra* note 23, at 158. *Compare* 15 U.S.C. §§ 1–7, *with* 15 U.S.C. §§ 12–27.

116 *See* Bautista, *supra* note 23, at 158.

117 *Id.* at 162–63.

118 *Id.* at 163.

119 *Id.* at 163.

120 FTC v. Butterworth Health Corp., No. 96-2440, 1997 U.S. App. LEXIS 17422 (6th Cir. July 8, 1997).

121 *Id.* at *5–8; *see* Bautista, *supra* note 23, at 165.

a "Community Commitment" statement meant to indicate the intent of the hospitals to remain competitive.[122] Critics of this decision argue that the economic and policy research was subpar and the court instead based its analysis "presumptions, rules and norms based on neoclassical theory."[123] This uncertainty, derived from the lack of clear factors, was rampant in the late 1990's and early 2000's and resulted in the FTC struggling to meet "the definitions embedded in antitrust law" when litigating hospital mergers.[124] Perhaps as a result of this uncertainty, courts no longer employ the Rule of Reason test and have yet to clearly commit to another test.[125]

C. A Key Affirmative Defense for Merging Institutions: Increased Efficiency and Lower Patient Costs

When the FTC or DOJ bring suits against hospital mergers under either the Sherman or the Clayton Act, hospitals often present an affirmative defense of increased financial efficiency. This justification developed during the reign of the Rule of Reason test yet remains a common and powerful affirmative defense.[126] Healthcare firms claim that merging will allow them to operate with increased financial efficiency, which will translate into lower prices for consumers.[127] The risk is that in certain circumstances, the efficiency justification can hide the true result of merger: higher costs, reduced options, and a lesser quality of care.[128]

Regardless, in the realm of hospital mergers, efficiency, specifically lower consumer cost, as an affirmative defense has been fairly successful.[129] From the years 1994 to 2000, nine hundred hospital mergers occurred.[130] Of these nine hundred mergers, the FTC and the DOJ only challenged seven.[131] Of those

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[122] The FTC criticized this "Community Statement" stating that it was "both temporary and illusory." Butterworth Health Corp., 1997 U.S. App. LEXIS 17422, *6-*7.

[123] *See* Bautista, *supra* note 23, at 164–65.

[124] *Id.* at 164.

[125] *See* Bautista, *supra* note 23, at 175.

[126] *Id.* at 163; U.S. DEP'T OF JUSTICE, *supra* note 19, at 4; Porter, *supra* note 11, at 2–3.

[127] *See* Porter, *supra* note 11, at 2–3.

[128] *See* FED. TRADE COMM'N: BUREAU OF COMPETITION, COMPETITION COUNTS: HOW CONSUMERS WIN WHEN BUSINESSES COMPETE 1, 4 (2015).

[129] *See* Bautista, *supra* note 23, at 164.

[130] *Id.*

[131] *Id.*; All seven challenged mergers claimed increased efficiency as an affirmative defense. FTC v. Tenet Health Care Corp., 186 F.3d 1045, 1054–55 (8th Cir. 1999); United States v. Mercy Health Servs., 107 F.3d 632, 635 (8th Cir. 1997); California v. Sutter Health Sys., 130 F. Supp. 2d 1109,1113–14 (N.D. Cal. 2001); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121,146–49 (E.D.N.Y. 1997); FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1300–02 (W.D. Mich. 1996); FTC v. Freeman Hosp., 911 F. Supp. 1213, 1224 (W.D. Mo. 1995); *In re* Adventist Health Sys., 1994 F.T.C. LEXIS 54, 59–64 (1994).

seven, the merging hospitals prevailed every time.[132] Importantly, in 2000, courts began requiring that merging hospitals show what particular efficiencies will be achieved by the instant merger.[133] Despite this reigning in, the affirmative defense continues to be used by merging hospitals[134] and if successful remains a powerful affirmative defense. Accordingly, it should be further restructured, rather than abrogated, to be in line with any regulatory amendments to hospital merger oversight.

Since their inception, antitrust laws have been obfuscated, first by not having the power needed to regulate monopolies, then by not having clarity of application. This lack of clarity, derived from the tests through which to evaluate the burden of proof, eroded the power of the FTC and DOJ to regulate mergers and gave greater strength to hospitals affirmative defenses. Despite this history, growth in antitrust must continue as it remains the best mechanism for regulating hospital mergers.

III. CURRENT AGENCY OVERSIGHT: THE NARROW CONSTRUCTION OF A MARKET WITHIN THE FTC GUIDELINES

The FTC publishes guidelines that outline the rules firms must follow when seeking to merge.[135] The current guidelines for horizontal mergers were published in 2010 and clearly outline the steps which the firms must take prior to and in the course of merging.[136] Additionally, the FTC Guidelines provide essential definitions for terms not adequately defined by the Sherman Act or the Clayton Act.[137] Importantly for hospital mergers, the FTC Guidelines define both a product market[138] and a geographic market.[139] These market definitions are predicated on "demand

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[132] A commonly accepted justification during this period was cost savings. *See* Bautista, *supra* note 23, at 164; Heather R. Spang et al., *Hospital Mergers and Savings for Consumers: Exploring New Evidence*, 20 HEALTH AFF. 150, 151 (2001).

[133] *See* Saint Alphonsus Med. Ctr.–Nampa, Inc. v. Saint Luke's Health Sys., 778 F.3d 775, 790–91 (9th Cir. 2015); FTC v. ProMedica Health Sys., No. 3:11 CV 47, 2011 U.S. Dist. LEXIS 33434, at *92–113 (N.D. Ohio Mar. 29, 2011).

[134] ProMedica Health Sys., 2011 LEXIS 33434, at *92–113.

[135] *See generally* HORIZONTAL MERGER GUIDELINES, *supra* note 34.

[136] *Id.* at 1–2.

[137] *Id.* at 7–15.

[138] "[A] product market in an antitrust investigation consists of all goods or services that buyers view as close substitutes." Product market analysis can therefore be applied to services such as health care. *Markets*, FED. TRADE COMMISSION, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/mergers/markets [https://perma.cc/ERF7-DVQQ]; *see also* HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 8–13.

[139] "A geographic market in an antitrust investigation is that area where customers would likely turn to buy the goods or services in the product market." *See Markets*, *supra* note 138; *see also* HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 13–15.

substitution factors," meaning the "ability and willingness" of consumers to substitute one product or service for another in the event of price increases.[140] The guidelines state that an analysis of competitive market alternatives is always necessary when investigating a potential merger.[141] Understanding the market is crucial to understanding whether anticompetitive activity is taking place and if that activity falls within the regulatory scheme of the Sherman and Clayton Acts as enforced by the FTC.

A. Defining a Product Market

When two firms that sell the same product or service propose a merger, the FTC must define a product market for that shared product or service.[142] In defining that product or service market, the FTC must evaluate the importance of preserving the competition between the two firms.[143] To determine if a product or service is shared and is likely to be interchangeable with a product or service sold by one of the merging firms, the FTC employs the hypothetical monopolist test.[144] This test requires that a product market contain enough substitute products or services so that the substitutes have enough market power to balance out the influence the proposed merger would have.[145] The likelihood that a hypothetical monopolist would raise prices depends on how likely customers are to substitute the monopolist's product or service for another similar product or service, and on the profit generated by the monopolist's products.[146]

When analyzing customers' likely responses to higher prices, the FTC may take into account "any reasonably available and reasonably reliable evidence."[147] Notably, this evidence includes objective information about both the characteristics of the product or service in question and the cost to the consumer of

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[140] *Id.* at 7.

[141] *See* HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 7–8.

[142] *See* HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 8–13; *Markets*, *supra* note 138.

[143] *See* HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 8.

[144] *See id.* at 8-10.

[145] *See* HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 9 ("The hypothetical monopolist test requires that a product market contain enough substitute products so that it could be subject to post-merger exercise of market power significantly exceeding that existing absent the merger."); *Markets*, *supra* note 138.

[146] This financial evaluation consists of gathering information about the "the costs and delays of switching products, especially switching from products in the candidate market to products outside the candidate market." Additionally, the profit analysis focuses on changes in sales when there has been an overall price increase for a given product. For example, "the percentage of sales lost by one product in the candidate market . . . that is recaptured by other products in the candidate market." Accordingly, "a higher recapture percentage mak[es] a price increase more profitable for the hypothetical monopolist." *See* HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 11; *Markets*, *supra* note 138.

[147] *See* HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 11.

changing products or services.[148] Illustrating the centrality of product characteristics is the FTC investigation of a "merger between two ready-mix concrete suppliers."[149] The FTC discovered that "customers believed that asphalt and other building materials were not good substitutes for ready-mix concrete."[150] In line with this discovery, "the product market was limited to ready-mix concrete."[151] This finding contributed to the eventual finding that anticompetitive behavior could result from the merger.[152]

However, the ease through which services can be secured (or substituted, using the FTC's product market definition) and the likelihood that an individual will receive care is in large part due to how far one must travel to get it.[153] Therefore, the geographic market must also be defined.

B. Defining a Geographic Market

If geography limits customers' desire or capacity to substitute products, or limits suppliers' desire or capacity to serve certain customers, then the market will be geographically constrained.[154] Thus, both consumer and supplier locations will affect the geographic market.[155] Geographic markets based on consumer location are defined by the locations of targeted customers, focusing on possible consumer discrimination by the hypothetical monopolist,[156] whereas geographic markets based on supplier location are defined as "the region from which sales are made."[157] Key factors that the FTC uses to define the scope of a geographic market, either based on the supplier's or consumer's location, are: the cost of transportation, language, reputation, and service availability.[158]

In analyzing consumer-based geographic markets, the FTC will define the market based on the locations of targeted customers.[159] Typically, the FTC employs a consumer-based geographic market when the suppliers deliver their products or services to the

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148 *See Markets*, *supra* note 138.

149 *Id.*

150 *Id.* (ready mix concrete is "pliable when freshly mixed and [is] superior [to asphalt] in strength and permanence after it hardens").

151 *Id.*

152 The companies agreed to settle and divest. FTC, *Cemex S.A. de C.V., In the Matter of*, CASES AND PROCEEDINGS (Aug. 19, 2005), https://www.ftc.gov/enforcement/cases-proceedings/0510007/cemex-sa-de-cv-matter [https://perma.cc/R3B9-EJBE].

153 *Id.*; *see also Cancer Death in the Black Belt*, *supra* note 1.

154 *See* HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 13.

155 *Id.*

156 *Id.* at 14.

157 *Id.* at 13.

158 *Id.*

159 *Id.* at 14.

customers' location.[160] Since hospitals do not deliver to their patients and patients retain the right to travel, it is unlikely that a consumer-based geographic market definition is the most accurate model to define the market when challenging a hospital merger.

Alternatively, the FTC utilizes geographic markets based on supplier location when customers receive food or services at the suppliers' locations, therefore making it the best suited type of geographic market definition for health care centers.[161] In 2014 there were 17.2 million hospital visits for surgery.[162] Physical access to a hospital is crucial to receiving this type of care. Like the methods employed by the FTC to define a product market, the FTC may consider evidence that is "reasonably available and reliable" to gauge what the likely consumer reaction would be to a price increase in a supplier-based geographic market.[163]

Importantly, the FTC Guidelines factors in cost and hardship the supplier incurs moving the product, along with the necessity for suppliers to be "near consumers to provide [their] service," when engaging in market analysis.[164] These considerations are crucial in defining a market for hospital mergers, though it is clear that the FTC must enact additional regulatory clauses in order to properly address the issues surrounding hospital mergers. The current guidelines should not be used as the comprehensive scheme that is necessary to adequately regulate hospital mergers.

IV. PROTECTING ACCESS TO COMPREHENSIVE HEALTH CARE WHEN HOSPITALS MERGE: A STATUTORY SOLUTION

This note proposes additional provisions to the Sherman Act, the Clayton Act, and the FTC Guidelines. These provisions detail hospital-specific criterion, clarifying the burden of proof in order to aid courts and guide their analysis when a proposed hospital merger is before them.

The burdens of proof derived from the Sherman Act and the Clayton Act provide a clear baseline that a merger must meet to be permissible. Each statute must therefore be amended to create space for the unique considerations' attendant to

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160 *Id.*

161 *Id.* at 13.

162 This number includes both surgery visits in hospital owned-ambulatory settings (57.8%) and inpatient visits to hospitals (42.2%). Claudia A. Steiner et al., *Surgeries in Hospital-Based Ambulatory Surgery and Hospital Inpatient Settings, 2014*, HEALTH COST AND UTILIZATION PROJECT (July 2020), https://www.hcup-us.ahrq.gov/reports/statbriefs/sb223-Ambulatory-Inpatient-Surgeries-2014.jsp?utm_source=ahrq&utm_medium=en1&utm_term=&utm_content=1&utm_campaign=ahrq_en5_23_2017 [https://perma.cc/TEK9-DSGF].

163 *See* HORIZONTAL MERGER GUIDELINES, *supra* note 34, at 14.

164 *Id.*

hospital mergers. Due to the interaction between the federal statutes and the FTC Guidelines, the FTC Guidelines must also be amended to include specific provisions for hospital mergers.

A. Proposed Amendment to the Sherman Act

The Sherman Act currently states that "[e]very contract, combination in the form of trust or otherwise, or conspiracy" that restricts interstate or international trade is illegal.[165] It then goes on to proscribe punishments for any violations.[166] It is important to note that there are exceptions which apply to certain industries listed within 7 U.S.C. § 608b,[167] 7 U.S.C. § 671,[168] 7 U.S.C. § 852.[169] The drafters thus have contextually indicated that there are certain vital industries which require a more specialized approach and should not be governed by this generally applicable law.[170]

This note does not propose to exempt hospital mergers from the Sherman Act. Instead, it proposes an industry specific accommodation based on the premise that the act's generally applicable methods of monitoring are not sufficient for monitoring hospital mergers. Unlike the omitted industries, hospital mergers do not need to be exempted from the act to be properly governed; they simply need a tailored burden of proof to provide additional guidelines to courts that are evaluating prospective hospital mergers. The most appropriate place to include these additional measures is within 15 U.S.C. § 1.

Under this proposed amendment, § 1 of 15 U.S.C. will be comprised of paragraphs (a) and (b), with paragraph (a) amended to include subparagraph (1). Accordingly, subparagraph (1), will provide the following language: proposed combinations, mergers, or contracts between two or more hospitals, clinics, or health care centers, must clearly, with verifiable data,[171] state the individual

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165 15 U.S.C. § 1.

166 *Id.*

167 The exemption includes: "marketing agreements [entered into by the Secretary of Agriculture] with processors, producers, associations of producers, and others engaged in the handling of any agricultural commodity or product thereof . . . " 7 U.S.C. § 608b.

168 The exemption includes: arbitrations, meetings, and awards entered into with "producers or organizations . . . of milk or its products" and the Secretary of Agriculture. 7 U.S.C. § 671.

169 The exemption includes: "marketing agreements [from the Secretary of Agriculture] with manufacturers and others engaged in the handling of anti-hog-cholera serum and hog-cholera virus." 7 U.S.C. § 852.

170 *See* 7 U.S.C. §§ 608b, 671, 852.

171 This data should include a statement of the Herfindahl–Hirschman Index (HHI) for the individual services. The HHI is an already accepted method of measuring market concentration and the acceptable ranges of market concertation are within the Horizontal guidelines. It is calculated by "squaring the market share of each firm competing in the market and then summing the resulting numbers." Importantly, "[t]he HHI increases both

services, inclusive of departments, individual procedures or consultations, that will be lost and, or expanded, as a result of the combinations, mergers, or contracts. Any proposal which would restrict or interfere with the average person in the affected community's reasonable ability to receive a full spectrum of medical treatment and consultation is hereby declared to be illegal.

The inclusion of language such as "clinics" and "health care centers" encompasses institutions that do not fall within the definition of hospital but offer the same array of services as a hospital. The amendment includes mandatory review when any "departments, individual procedures or consultations" are discontinued or expanded, avoiding a potential pitfall whereby regulators only review facilities when they are being opened. Additionally, the statement of "reasonable ability" will require courts to consider fiscal and geographic limitations a merging hospital may face. Lastly, regarding the range of health care that cannot be infringed upon, "full spectrum" will be defined within the Sherman Act as all health care services previously available to patients seeking care within a specified geographic market. This will focus the definition of "full spectrum" on market analysis and protect against the discontinuance of reproductive health services post-merger. Finally, the word "consultation" protects informational rights of those seeking reproductive health care.

Importantly, the proposed amendment allows the judiciary to address the circumstantial variances that occur from case to case and protect the existing affirmative defense of efficiency. The efficiency defense is invoked by merging hospitals to claim that a hospital will not have the fiscal resources to remain operative if the merger is prohibited, therefore eliminating all care options in the geographic area. Proposed Section (a)(1) therefore protects against closures due to fiscal shortages while ensuring that a patient's access to care is not restricted by the merger.

B. Proposed Amendment to the Clayton Act

The Clayton Act is understood to supplement the Sherman Act. Therefore, its burden of proof must be amended to affirm the proposed addition to the Sherman Act. The first two paragraphs of 15 U.S.C. § 18 within the Clayton Act, 15 U.S.C. § 12, currently state which actions are within the statute.[172] The subsequent four paragraphs of the statute detail the

as the number of firms in the market decreases and as the disparity in size between those firms increases." *Herfindahl-Hirschman Index*, U.S. DEP'T OF JUST., https://www.justice.gov/atr/herfindahl-hirschman-index [https://perma.cc/2UMF-YD25].

[172] 15 U.S.C. § 18.

exceptions.[173] Notably, the fourth paragraph exempts "any common carrier"[174] who is attempting to build, acquire, or extend "branches[175] or short lines."[176] At the time the Clayton Act was passed, the railroads were excluded as they were already strictly regulated by the Interstate Commerce Commission (ICC).[177] Healthcare, however, is not regulated by one agency, and should not be similarly excluded.[178] Healthcare thus requires explicit antitrust regulation. Accordingly, the amendment will not be an exception, but will instead expand the current burden of proof.

The proposed addition to 15 U.S.C. § 18 is paragraph (b), which will be located immediately after the first two existing paragraphs. Paragraph (b) will read as follows: And, when relevant, proposed combinations, mergers, contracts, or purchases of shares related to hospitals, clinics or health care centers must clearly, with verifiable data,[179] state the individual services, inclusive of departments, individual procedures or consultations, that could be lost and, or expanded, as a result of the combinations, mergers, contracts. Any proposal which could restrict or interfere with, in all possible affected communities, the average person's reasonable ability to receive a full spectrum of medical treatment and consultation is hereby declared to substantially lessen competition or tend to create a monopoly.

The proposed amendment does not radically change the core of the statute. It does not alter the existing burden of proof, but rather augments it through a series of additional criteria which must be satisfied for the burden to be met. Proposed § 18(b) will

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[173] *Id.*

[174] 15 U.S.C. § 18. A "common carrier" is defined as "[a] commercial enterprise that holds itself out to the public as offering to transport freight or passengers for a fee. A common carrier is generally required by law to transport freight or passengers without refusal if the approved fare or charge is paid.—Also termed *public carrier*." *Carrier*, BLACK'S LAW DICTIONARY (11th ed. 2019).

[175] A "branch line" is "a secondary line," usually referring to a railroad. *Branch Line*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/branch%20line [https://perma.cc/7WK8-S3TQ].

[176] 15 U.S.C.S. § 18. A "short line" is defined as "a transportation system (such as a railroad) operating over a relatively short distance." *Short Line*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/short%20line [https://perma.cc/CGC2-Z5JV].

[177] *See* William James Goodling, *U.S. Railroad Antitrust Immunity: Clarification, Discussion and Evaluation*, 1 OR. UNDERGRADUATE RES. J. 6, 6–8 (2011), https://scholarsbank.uoregon.edu/xmlui/bitstream/handle/1794/23369/OURJ_2011_WGoodling.pdf?sequence=1&isAllowed=y#:~:text=The%20railroad%20industry%20was%20exempted,and%20avoid%20market%20power%20abuse [https://perma.cc/694L-HN8F].

[178] *Guide to Healthcare Compliance Resources and Agencies*, TECHTARGET (May 2015), https://searchhealthit.techtarget.com/essentialguide/Guide-to-healthcare-compliance-resources-and-agencies [https://perma.cc/6GPL-HJCZ].

[179] *See* sources cited *supra* note 171.

further the original goal of the Clayton Act which was to supplement and clarify ambiguities in the Sherman Act.[180]

Within the amendment to the Clayton Act, the crucial difference is the replacement of "would" and "will" with more open language, "could." This lingual shift ensures that mergers with merely a high *likelihood* of affecting markets will fall within the scope of this regulation. Specifically, stating that services "could be lost" and proposals that "could restrict or interfere" with an individual's practical access health care, empowers the FTC to investigate a merger that may only have a high likelihood of restricting access to care. Additionally, "could be lost" and "could restrict or interfere" should not be interpreted to allow mergers that would limit reproductive care in a given geographic market.

Importantly, in the United States, health care is not a human right, but rather is controlled by the free market.[181] Within the confines of a market-based view of health care, it is imperative that antitrust laws be drafted to view restricting reproductive health care as a restriction on the free market, and step in to protect access to care. This is consistent with the text of the Clayton Act which outlaws actions that "may" substantially lessen competition or "tend to create a monopoly."[182] Therefore, the amendment will provide more guidance to courts' ruling on hospital mergers, without altering the overall posture of the Clayton Act.

C. Proposed Provisions to Include in the FTC Guidelines

Just as the amendments to the Sherman Act and the Clayton Act must mirror each other to create a cohesive body of regulatory law, the FTC Guidelines must also be revised to ensure that there is clarity as to the proposed standard. Amending the FTC Guidelines will play a central role in monitoring hospital mergers. Not only are the FTC Guidelines periodically updated by the FTC,[183] but they are not created by congress, and thus are not subject to the same political process that sculpts legislation.[184] Additionally, these guidelines "are

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[180] *See Clayton Antitrust Act*, *supra* note 75; *see also* Glazer, *supra* note 75, at 1046.

[181] *See supra* Section I.C.

[182] 15 U.S.C. § 18.

[183] *See* Waldman, *supra* note 33.

[184] *Id.* ("United States federal antitrust agencies—the Department of Justice Antitrust Division and the Federal Trade Commission—released proposed revisions to the Horizontal Merger Guidelines."); *See* HORIZONTAL MERGER GUIDELINES, *supra* note 34.

often used as persuasive authority"[185] despite "not [being] binding on the courts."[186] This proposal will conform to the current structure of the FTC Guidelines and fit within the existing guidelines for definitions of markets.[187]

Currently the most recent version of the FTC guidelines, published in 2010, defines a market by defining the product market and the geographic market, each of which detail various tests and methods of definition.[188] Since a hospital's geographic market analysis could be based upon either the locations of its suppliers or consumers, both subparts will be amended.

Section 4.2.1, "Geographic Markets based on the Locations of Suppliers," will be amended to specifically include listing health care centers and hospitals as facilities for which geographic market analysis must be completed.[189] The term customer will also be expanded to expressly include those who could have received care from the care centers or hospitals. Additionally, the FTC and DOJ must now consider the reasonable access to health care as part of their analysis of consumer reactions to price increases.

Finally, Section 4.2.1 of the guidelines will now specify that the list of "reasonably available and reliable evidence" the FTC and DOJ may consider is not exhaustive.[190] Moreover, this list will be expanded such that when the FTC and DOJ are evaluating a proposed hospital merger the following must be considered: (1) how customers have shifted purchases in the past between different geographic locations in response to relative changes in price or other terms and conditions; (2) if there are alternative sites for patients to receive the care, and quality of care, they seek; (3) if there are alternate terms to the merger or alternate ways of combining which would allow the merger to proceed, while maintaining a prospective patient's range of full spectrum healthcare options; (4) the cost and difficulty of traveling to the hospital or health care center to receive treatment or counsel, for the duration of treatment, inclusive of follow-up appointments; (5) whether hospitals and care centers, need to be geographically near patients, to provide services or follow-up support.

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185 Chi. Bridge & Iron Co. N.V. v. FTC, 534 F.3d 410, 431 n.11 (5th Cir. 2008); Saint Alphonsus Med. Ctr. - Nampa, Inc. v. Saint Luke's Health Sys., 778 F.3d 775, 784 n.9 (9th Cir. 2015).

186 Olin Corp. v. FTC, 986 F.2d 1295,1300 (9th Cir. 1993).

187 *See generally* HORIZONTAL MERGER GUIDELINES, *supra* note 34.

188 *Id.* at 7–15.

189 *Id.* at 13

190 *Id.* at 14

Similarly, Section 4.2.2, "Geographic Markets Based on the Locations of Customers,"[191] will now include language specific to healthcare. The hypothetical monopolist test based on consumer location will now expressly require consideration of the location of prospective patients. Each reference to suppliers will now include "hospitals and care centers." All analysis relating to customers will now be expanded to include "prospective patients." Finally, analysis on competitors in the market will include not only reference to firms but to "hospitals and care centers" as well.

The proposed additions to Section 4.2.1 center on the importance of alternatives to the merger as proposed. This language will empower both the entities seeking to merge and the FTC seeking to protect consumers and patients. Throughout Sections 4.2.1 and 4.2.2, the direct statement of what applies to hospitals and care centers works to clarify what standards the court should apply. In total, the proposed amendments have the potential to protect consumers and patients, without sacrificing the ability of entities to merge, by streamlining the factors relied on by courts when evaluating mergers.

D. Mandating a Comprehensive Analysis of Alternatives When Mergers are Permitted to Proceed

The proposed additions to these guidelines demand an analysis of the impacts on prospective patients' ability to access and afford care and require that alternatives to the proposed merger be investigated. Importantly, the amendment to Section 4.2.1 of the guidelines demands a preemptive consideration of alternative forms the merger can take. Currently, there are some methods of protecting access to spectrum of care, however they are not enough.[192] These existing methods are discussed after the merger has been approved and are the product of advocacy groups working to retroactively address gaps in access to care.[193] Implementing the above amendments would instead require that access to care be considered by government agencies as part of the approval process.

The current methods allow the new Catholic-run hospitals to remain in compliance with their beliefs and refuse to provide certain reproductive health care services, while

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[191] *Id.* (emphasis omitted).

[192] *Hospital Mergers: Creative Solutions*, MERGERWATCH, http://www.mergerwatch.org/creative-solutions [https://perma.cc/E5ES-LE29].

[193] *See Hospital Mergers: Recent Cases*, MERGERWATCH, http://mergerwatch.squarespace.com/recent-cases/ [https://perma.cc/AR2T-KAKK].

ensuring that there is another center providing care.[194] This access to reproductive health care is accomplished by physically and economically detaching health care centers from the Catholic hospital.[195] There are two main models to achieve this, the hospital-within-a-hospital model and the hospital-beside-a-hospital model.[196] The hospital-within-a-hospital model occurs when the merged hospital takes on the religious restrictions followed by the Catholic-owned partner hospital and a new entity[197] is separately incorporated to provide reproductive health services.[198] This separate entity can be housed within a separate "suite or floor within the formerly secular hospital building."[199] This separate entity can be operated by a foundation, corporate entity or group, including a doctor's association.[200] If accepted by the bishop who oversees the region[201] in which this merger has occurred, this set-up allows for the entities to merge and benefit financially, while protecting access to many reproductive care services. Depending on their personal flexibility, a Bishop may agree to allow the separate entity to provide certain much-needed reproductive services,[202] although abortion remains the most likely to be prohibited under this adjustable arrangement.[203]

The second option, the hospital-beside-a-hospital model, "is a separately-incorporated ambulatory[204] surgery center" which is located within or near the hospital's land and is used to provide the services that cannot be offered within the hospital.[205] This option is less desirable than providing the services within the hospital building, but nonetheless provides a way for reproductive care to

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194 *See Hospital Mergers: Creative Solutions*, *supra* note 192.

195 *Id.*

196 *Id.*

197 The new entity can be incorporated under a different name. *See, e.g.*, *Hospital Mergers: Recent Cases*, *supra* note 193 (documenting the case of a "separately incorporated" center within a post-merger hospital in Troy, New York).

198 *See Hospital Mergers: Creative Solutions*, *supra* note 192.

199 *Id.*

200 *Id.*

201 *See* Ikemoto, *supra* note 18, at 1097 (there are some instances where the merger proceeds despite the bishop's opposition such as: the sale of Holy Cross health system Corporation's Utah division to Healthtrust and the affiliation of St. Elizabeth's Hospital with the University of Chicago Hospitals network).

202 *Id.*

203 *See Hospital Mergers: Creative Solutions*, *supra* note 192 (in New York State, "the Burdett Care Center is . . . [a] separately incorporated and licensed birthing center" which provides many reproductive care services however, "no abortions are allowed within the facility").

204 "Ambulatory care refers to medical services performed on an outpatient basis, without admission to a hospital or other facility . . . ." *Defining Ambulatory Care*, INST. FOR PATIENT-AND FAM.-CENTERED CARE, https://www.ipfcc.org/bestpractices/ambulatory-care/defining-ambulatory-care.html [https://perma.cc/R2E7-KXS5].

205 *See Hospital Mergers: Creative Solutions*, *supra* note 192.

be maintained when secular and Catholic hospitals merge.[206] In upstate New York, a recent merger between the secular Kingston Hospital with the Catholic-affiliated Benedictine Hospital implemented the separately-incorporated ambulatory surgery center model and established the Foxhall Center.[207] In this particular merger, the archdiocese of New York agreed to sign a memorandum expressly allowing Kingston Hospital to continue to provide only post-partum tube tying operations,[208] contraception and contraceptive counseling.[209] Foxhall Center was then created to provide abortions, tube tying operations that do not occur immediately after childbirth, and vasectomies.[210] These creative options allow room for negotiation in the case of secular and Catholic mergers, allowing the church to remain in accordance with The *Ethical and Religious Directives for Catholic Health Care Services* and ensure that full spectrum health care continues to be accessible.[211] Unfortunately, these two options are de facto practices driven by advocacy groups, rather than de jour requirements imposed by the federal government on hospitals seeking merger approval.

E. The Future of Increased Efficiency as an Affirmative Defense

The proposed amendments,' to the guidelines, require an analysis of alternative merger methods, such as the hospital-within-a-hospital and hospital-beside-a-hospital models, which also works to preserve the strength of the merging parties' affirmative defense of increased efficiency. Efficiencies are generally visible in at least one of the following four areas: "(1) the cost of capital; (2) shared inputs; (3) better use of fixed-cost assets (economies of scale); and (4) elimination of duplicative services."[212] Notably, the effect on the availability or quality of care is not a clear point of focus.[213] The proposed provisions to the Sherman Act and the Clayton Act work to restructure, but not eliminate, the power of the efficiency defense.

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[206] *Id.*

[207] *See* Uttley et al., *supra* note 10, at 39–40.

[208] This is medically referred to as "tubal ligations." *Tubal Ligation*, MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/tubal-ligation/about/pac-20388360 [https://perma.cc/8PTX-4TLR].

[209] *See* Uttley et al., *supra* note 10, at 40.

[210] *Id.*; Vasectomies "cut the supply of sperm [to the male's] semen" by cutting and tying the tubes which carry sperm. *Vasectomy*, MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/vasectomy/about/pac-20384580 [https://perma.cc/N9LA-HR4C].

[211] *See* Ikemoto, *supra* note 18, at 1094.

[212] *See* Belsley, *supra* note 14, at 722.

[213] *See* KHAIKIN ET AL., *supra* note 5, at 10.

The aim of the proposed amendments is to ensure greater protections for access to care. Thus, a merger should be allowed to go through if the hospital is insolvent and must merge to avoid shutting down. Preventing that merger would only generate a more severe gap in care. This financial argument is the rationale behind the increased efficiency defense. The clause in the amendment requiring an analysis of alternatives reserves space for allowing a merger if the only alternative is a full shut down.

CONCLUSION

Ultimately hospital mergers will continue to occur, however comprehensive regulation of mergers must be developed. While this note seeks to further regulate hospitals, it is couched within the confines of the current free market model. Creating clarity in the legislation and powers of the agencies provides courts, and merging entities, with indicators of when adhering to free market principles comes at the cost of market competition and human welfare. This note proposes that the change must begin in both the legislature and regulatory agencies in order to provide courts with mechanisms through which to analyze the validity of a contemplated merger. Reframing the current thresholds required to meet the burdens of proof, provides courts with an adequate frame of analysis for hospital mergers. The proposed amendments to the FTC Guidelines, while not regarded as binding on courts, will provide courts with additional guidance as to what standards must be met for the specific context of hospital mergers.[214] Amending the FTC Guidelines will also enable the FTC to preemptively protect full spectrum medical services as well as reduce community insecurity and legal unknowns that arise with each proposed merger. Hospital mergers cannot continue to occur at the expense of health care. The porous antitrust law must be overhauled to provide courts a clear method of reviewing and regulating these mergers.

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[214] Darren S. Tucker, *Seventeen Years Later: Thoughts on Revising the Horizontal Merger Guidelines*, ANTITRUST SOURCE, Oct. 2009, at 1, 4 n.24.

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