Hospital Mergers

and the Threat to Women's Reproductive Health Services

Using Antitrust Laws to Fight Back

NATIONAL WOMEN'S LAW CENTER

The National Women's Law Center is a non-profit organization that has been working since 1972 to advance and protect women's legal rights. The Center focuses on major policy areas of importance to women and their families, including employment, education, reproductive rights and health, family support and income security—with special attention given to the needs of low-income women. The Center is a tax-exempt organization under section 501(c)(3) of the Internal Revenue Code, and contributions to enable it to continue its work are tax deductible. Judith C. Appelbaum, author of this report, is Senior Counsel and Director of Legal Programs at the Center.

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Introduction and Summary

In communities all across the United States, mergers between competing hospitals are causing a reduction in the availability of women's reproductive health services. Driven by pressures to cut costs and consolidate resources, hospitals are increasingly turning to mergers and other forms of affiliation with one another, producing what commentators have dubbed a "merger mania." By one reckoning, nearly two in five of the nation's 5,200 non-federal hospitals were involved in merger and acquisition activity from 1994 through 1996. It is when these transactions involve both a religiously-affiliated institution and a secular one, as is increasingly the case, that reproductive health services are most often threatened.

Hospitals affiliated with the Catholic church, and some other religiously-affiliated institutions, bar the delivery of certain reproductive health services. The Ethical and Religious Directives governing Catholic health facilities specifically ban: abortion, contraceptive services and counseling (including HIV risk reduction counseling), sterilization procedures, infertility treatments, and the "morning-after" pill. When hospitals that are governed by such restrictions merge with others that are not, and then impose their policies against reproductive health services on facilities that previously provided them, patients lose. They lose because they are deprived of access to needed services or, at best, because they must bear additional costs, delays and health risks in order to obtain these services outside their local communities. These burdens fall most heavily on poor women and women in rural areas, but adversely affect many others as well.

Health care advocates and community activists seeking to preserve access to reproductive health services have begun to generate community pressure to challenge hospital mergers that threaten to reduce the availability of these services. On a few occasions, these efforts have either blocked the consummation of such mergers altogether or caused them to be restructured to ensure the continuing availability of needed services. There is one potentially powerful weapon, however, that has not yet been utilized toward this end: the antitrust laws.

The nation's federal and state antitrust laws are designed to preserve vigorous competition among rival providers of goods and services, in order to ensure that consumers can get the highest quality products and services at the lowest possible prices. Mergers between hospitals are governed by these laws, principally Section 7 of the Clayton Act, a federal law barring mergers and acquisitions that may substantially lessen competition.

Proposed mergers that are large enough — in general, where the transaction is valued at over $15 million — must be reported in advance to the federal antitrust enforcement authorities, the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC). A merger subject to this "pre-merger clearance" requirement is delayed a minimum of 30 days to allow the DOJ or FTC to review it and, if necessary, go to court to obtain an order halting the transaction. The proposed merger may be stopped if the court finds that it is likely to lead to substantially reduced competition in the relevant market. Both the DOJ and the FTC recently have been increasingly

One potentially powerful weapon has not yet been used to preserve diminishing services: the antitrust laws.

active in challenging mergers that threaten to harm consumers.

The antitrust laws thus can become an important set of tools for those concerned about the consequences of a hospital merger. These laws can be used to bring a halt to the transaction altogether, or to force the merging parties to agree to conditions that will prevent or lessen the harm it threatens — for example, by requiring that reproductive health services continue to be offered after the merger.

In order to acquaint antitrust newcomers with the relevant law, this Report explains the substantive requirements of the antitrust laws governing hospital mergers and outlines the ways to challenge a potentially harmful merger under those laws. The legal analysis provided here, as well as the background on the barriers women face in seeking reproductive health services, is also intended to be of use to federal and state officials charged with enforcing the antitrust laws.

Part One of this Report describes the nature and extent of the underlying problem — the diminishing availability of abortion and other women's reproductive health services, and the way in which mergers involving religiously-affiliated hospitals are exacerbating this problem. Significant analysis of the merger phenomenon has been undertaken by other organizations, such as Catholics for a Free Choice (CFFC), and this part of the Report draws heavily on the work of CFFC and others.

Part Two of the Report, "Using the Antitrust Laws," explains how the antitrust laws apply to a prospective hospital merger that threatens to eliminate women's reproductive health services. This part of the Report explains the factors that the antitrust enforcement authorities will consider in analyzing a merger that threatens to eliminate reproductive health services ("The Applicable Antitrust Principles"). This section also includes a brief discussion of other conduct that threatens reproductive health services, such as anticompetitive acts by HMOs or a hospital's denial of physician staff privileges, which might also be subject to antitrust challenge. Part Two then describes ways to mount a challenge under the antitrust laws ("How To Bring a Challenge"). It outlines how to approach the federal antitrust enforcement authorities, the Justice Department and Federal Trade Commission; discusses the role of state laws and law enforcement authorities such as the state Attorneys General; and, finally, explores the possibility of private suits.

As explained in Part Two of the Report, the most effective way to mount an antitrust challenge to a merger is to persuade a federal or state agency to take action to halt it before it is consummated. The agencies will be most interested in challenging a merger if it appears anticompetitive when subjected to their five-step analytic approach, drawn from the *Department of Justice and Federal Trade Commission Horizontal Merger Guidelines.* Briefly summarized, the analysis under the Guidelines looks at the following issues:

- **Adverse Competitive Effects**: would the merger be likely to increase the market power of the merged firm such that it could raise prices, suppress output, or otherwise lessen competition? The fact that the post-merger hospital will be governed by religious directives prohibiting certain services constitutes strong evidence that there will be a reduction of competition for those services.
- **Concentration of the Relevant Product and Geographic Markets**: will the market become more concentrated — that is, will the largest

firms in the market hold larger shares after the merger? There are three steps to answering this question: (1) defining the relevant product (or service) market, which in a hospital merger traditionally has been considered all inpatient acute care services, but which could be women's reproductive health services or a subset of them; (2) defining the relevant geographic market, which means identifying an area beyond which the merging parties' patients would not travel in order to escape the negative effects of the merger (such as a price increase or elimination of service); and (3) measuring concentration of the market before and after the merger, according to formulas laid out in the Guidelines.

- **Ease of Entry**: will it be easy for a new provider to come into the market after the merger and offer the affected product or service? If so, the merger is not likely to create or enhance market power and therefore would not be considered anticompetitive.
- **Efficiencies**: will the merger lead to significant efficiencies that will outweigh its anticompetitive effects? If so, it may not be challenged under the Guidelines — but the burden is on the merging parties to quantify the expected efficiencies and show that savings will be passed on to consumers.
- **Failing Firm**: is the merger the only way to prevent one of the merging parties from going out of business? If it is, this may provide a defense to a merger that is otherwise a violation of the Clayton Act — but this defense is rarely successful.

In general, a merger between the only two hospitals in a particular market, or two of three or four hospitals in the market, would raise a presumption of anticompetitive consequences. There is an exception, however, for small hospitals: when the acquired hospital has an average of fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients, the federal agencies generally will not challenge the merger, although a state Attorney General might be convinced to do so.

If the Department of Justice or the Federal Trade Commission can be persuaded that when subjected to this "Guidelines" analysis a merger is likely to substantially lessen competition, the agency may delay it temporarily or seek to reshape it or block it altogether. The DOJ (through its Antitrust Division) and FTC (through its Bureau of Competition) therefore should both be approached. The agencies actively encourage input from anyone with concerns about a merger, especially information from the customers of the merger parties.

A merger that appears to be anticompetitive under the federal Guidelines is likely to be vulnerable to state challenge as well. State Attorneys General have authority to challenge a merger under the Clayton Act, and also under state antitrust laws. While not all states have the interest or expertise needed to review and challenge a merger, some state Attorneys General have become increasingly active in merger enforcement in recent years.

The Report concludes that when a prospective hospital merger threatens to reduce the availability of women's reproductive health services in a particular geographic area, there may well be a solid basis for invoking the federal or state antitrust laws to attempt to block the transaction, or to secure adequate provision of the affected services. The strength of the challenge will depend on the specific facts of each case — including, for example, the number of

A merger is most vulnerable to challenge if it appears anti-competitive under the Department of Justice and Federal Trade Commission Horizontal Merger Guidelines.

hospitals and others providing relevant services in the area, and the ability of consumers (patients) to obtain these same services from providers other than the merging parties without increased expense or difficulty. As a general matter, however, the prospect of a government challenge to a merger before it is consummated is a powerful tool: it can quickly become a "deal-killer" and stop the transaction in its tracks or, at a minimum, prompt the merging parties to reshape the transaction.

The Report therefore suggests that when reports of a potentially harmful merger first surface, those concerned should promptly contact the Department of Justice and the Federal Trade Commission, as well as the appropriate state officials, while exploring the possibility of private litigation as well.

Two Appendices attached to the Report — a sample letter to the antitrust enforcement agencies (Appendix A) and suggested information to gather for presentation to them (Appendix B) — are included as practical tools, to assist advocates in making their case. A third Appendix, Appendix C, provides a list of the offices of the state Attorneys General in every state.

Part One

The Problem: Diminishing Access To Reproductive Health Services

I.

The Threat to Reproductive Health Services

Access to women's reproductive health services in the United States is seriously threatened. Abortion services in particular are becoming an increasingly scarce commodity in many parts of the country, legally guaranteed in theory but unavailable as a practical matter. For a woman forced to travel to a distant provider, this can mean significantly increased costs and risks to her health.

A. The Current Provider Shortage

The absence of a nearby abortion provider is clearly an important barrier to access, since the greater the distance a woman lives from a provider, the less likely she is to be able to use the provider's services.[1] This is a very real problem for many women in this country. In 1992, the most recent year for which national data is available, 84% of the counties in the United States had no abortion provider.[2] Nearly one-third of women of reproductive age lived in one of the counties where there was no abortion provider.[3] Moreover, the number of providers has been dropping precipitously in recent years; between 1982 and 1992 the number fell 18%, and the rate of decline has been accelerating.[4] The shortage of providers is most acute outside urban areas; in 1992, 94% of non-metropolitan areas had no abortion services, and 85% of non-metropolitan women lived in the unserved counties.[5] South Dakota and North Dakota each has only one provider in the entire state.[6]

The number of hospitals providing abortion services has seen a particularly steep decline.[7] Between 1977 and 1992, the number of hospital abortion providers in non-metropolitan counties fell by 78% — from 427 to a total of only 96 nationwide.[8] In 1992, of all of the country's short-term, general hospitals, only 16% provided abortion services.[9] And while only 7% of all abortions were performed in hospitals as of 1992,[10] the availability of hospital abortion services is vital for several reasons. Many abortion patients, such as diabetics and those with heart conditions, require overnight postoperative observation or emergency equipment that only a hospital can provide.[11] Other women may be unable to obtain services if their personal physicians insist on performing abortions only in a hospital.[12] For low-income women, hospital emergency rooms often are the only option.[13] Further, even when abortion services are available in a free-standing clinic, the clinic must be able

The number of hospitals providing abortion services in non-urban areas fell by 78% between 1977 and 1992, from 427 to 96 nationwide.

to transfer patients to a local hospital in emergencies.[14] Thus, for many women, the absence of nearby hospital-based abortion services can be significant even if a clinic or other provider is available.[15]

Hospitals are important providers of other reproductive health services as well. For example, surgical sterilization procedures such as tubal ligation are often provided in hospitals; indeed, many women choose postpartum tubal ligation because it is safer and less costly to have the sterilization procedure while in the hospital for childbirth than to undergo two separate hospitalizations. In addition, hospital emergency rooms routinely provide emergency postcoital contraceptives (the "morning-after pill") to rape victims.

B. The Harm to Patients

Lack of access to a nearby provider can impose significant costs and other burdens on women seeking reproductive health services. For those seeking an abortion, these burdens are often compounded by legal obstacles such as mandatory waiting periods[16] and restrictions on public funding.[17] When a woman has to travel to a distant provider, she may incur expenses not only for transportation, but also for lodging (if the distance is too great for a day trip or where there is a waiting period), lost wages, and child care.[18] The delay entailed in such travel — especially where there are waiting periods and other restrictions, or time is needed to raise the necessary funds[19] — can be significant. Some clinics schedule abortions only one or two days a week; compliance with a mandatory 24-hour waiting period for an abortion at such a clinic can translate into a significant delay.[20]

These delays can be harmful not only to the patient's pocketbook but also to her health and well-being. Abortion is considered "semi-urgent" care: the risk of complications increases with gestation, abortion becomes impossible if it is delayed too long, and most women who have chosen to terminate their pregnancies want to do so as early as possible.[21] A survey of women who underwent abortions in Tennessee, a state with a mandatory waiting period, found that 59% of the women experienced one or more problems due to the delay.[22]

As the American Medical Association's Council on Scientific Affairs summarized:

> *Fewer providers mean that women have to travel increased distances, which may increase the cost of the procedure and delay pregnancy termination, thereby increasing the health risks to the woman. . . . Anything that delays the procedure increases the costs incurred . . . and increases the health risks associated with the procedure.*[23]

2.

The Impact of the Hospital Merger Wave

The barriers to access outlined above are being exacerbated by a wave of mergers and consolidations among rival hospitals. Following is a description of this trend, including the increasingly common phenomenon of mergers between secular and religiously-affiliated hospitals; the nature of the religious restrictions on reproductive health services that come into play in these transactions; and what happens when such mergers are completed.

A. Hospital Merger Mania

The hospital industry is experiencing an unprecedented wave of mergers, acquisitions, and other forms of consoli-

dation. *Modern Healthcare* magazine, which tracks hospital mergers, reported 235 such transactions involving 768 hospitals in 1996, a large increase over previous years.[24] The authors reported that nearly 40% of the nation's 5,200 nonfederal hospitals were involved in merger and acquisition activity from 1994 through 1996.[25]

The reasons for this trend include an industry belief that hospitals must be larger in order to reduce costs and enhance their market power.[26] As managed care reduces and shortens hospital stays, hospital owners see mergers as offering a way to reduce excess capacity, enhance efficiencies, increase access to capital for new equipment, and exercise more control over how much a hospital pays for supplies and what it charges for services.[27]

Religiously-affiliated hospitals are by no means immune from these pressures, and they too are being swept along in the merger wave.[28] Indeed, consultants in the health care industry are advising Catholic hospitals to consolidate with other facilities in order to help obtain access to capital and to enhance their competitive position.[29] As a 1997 *Wall Street Journal* article concluded, religiously-affiliated institutions can be just as aggressive as their for-profit rivals when fighting to gain market share, and as a consequence, "a Catholic hospital merger mania is spreading."[30]

Until recently, Catholic health institutions tended to consolidate by aligning themselves with one another, rarely "marrying outside the church."[31] This has changed, however, as market pressures and the need for patient volume have led to an increasing number of affiliations between Catholic and non-Catholic institutions.[32] In a study of hospital consolidation agreements between 1990 and 1995, Catholics for a Free Choice (CFFC) identified 57 mergers and affiliations between Catholic and non-Catholic hospitals, in 27 states.[33] In an update of its study, CFFC has catalogued another 38 completed consolidations between Catholic and non-Catholic hospitals in 1996 and 1997, with 20 more pending completion as of January 1998.[34] A report released by the Kaiser Family Foundation in November 1997 counted 131 affiliations involving one or more Catholic hospitals or health systems between 1990 and 1996, representing 18% of all hospital affiliations, and nearly 80% of these transactions were between Catholic hospitals and non-Catholic providers.[35]

The Catholic health care system is no small factor in the nation's health care industry. Catholic hospitals account for about 10% of all U.S. hospitals, 12% of hospital beds, 16% of all hospital admissions, and 17% of surgical procedures nationwide.[36] According to the magazine of the Catholic Health Association of the United States, in 1996 there were over 600 Catholic hospitals with 140,000 beds, $40 billion in revenues, and assets of $44 billion, and in 19 states they had at least a 20% market share.[37] Moreover, in many rural areas, a Catholic hospital is the only hospital for many miles around.[38] In light of the significant role that Catholic hospitals play, Catholic hospital "merger mania" thus stands to have a major nationwide impact.

"A Catholic hospital merger mania is spreading." — The Wall Street Journal, Mar. 12, 1997

B. Religious Restrictions on Reproductive Health Services

In December 1994, the National Conference of Bishops issued its revised "Ethical and Religious Directives for Catholic Health Care Services," which provide "authoritative guidance" to Catholic health care institutions and professionals on standards of behavior that flow from church doctrine.[39] According to the Directives, "Catholic

health care services must adopt these directives as policy, require adherence to them within the institution as a condition of medical privileges and employment, and provide appropriate instruction regarding the directives for administration, medical and nursing staff and other personnel."[40]

Part 4 of the Directives, governing "Issues in Care for the Beginning of Life," is of particular relevance here. The Directives in Part 4 prohibit the following reproductive health care services: abortion,[41] contraceptive services or counseling (including counseling about the use of condoms by HIV-positive patients to prevent the transmission of AIDS),[42] sterilization procedures (such as tubal ligation),[43] and infertility treatments.[44] In addition, the abortion prohibition includes language barring the use of the "morning-after pill," even for victims of sexual assault who come to a hospital's emergency room for treatment.[45]

The Directives, or at least some portions of them, tend to be applied quite strictly. Of 18 Catholic hospitals responding to a survey in Pennsylvania in 1995, only three reported that they would perform an abortion even in an emergency.[46] In 1992, 14 Catholic hospitals in and around Chicago denied the morning-after pill to more than 1,000 women who had been raped, while 22 of 26 non-Catholic hospitals did offer it.[47]

While the Catholic church has the most specific set of restrictions governing its health care institutions, other religions also have restrictions on abortion that apply to their affiliated hospitals. For example, the Tennessee Baptist Convention, which owns Baptist Hospital in Nashville, has a policy of performing abortions only in cases where the life of the woman is in danger and in other very limited circumstances.[48] The Georgia Baptist Convention, which owns a health care system in Georgia that includes the Georgia Baptist Medical Center, also has a policy against abortion.[49]

C. The Impact on Reproductive Health Services When Religious and Secular Hospitals Merge

Mergers involving religiously-affiliated hospitals have produced a variety of outcomes for abortion and other reproductive health services, as summarized below.

■ **Merger consummated; reproductive health services eliminated**. In its analysis of 57 mergers between Catholic and non-Catholic hospitals between 1990 and 1995, Catholics for a Free Choice identified 10 that resulted in the complete elimination of reproductive health services (including all abortions), and another 12 that ended all abortions while allowing other reproductive health services (such as sterilizations) at the non-Catholic institution.[50] In its 1998 update, CFFC found that reproductive health services were discontinued in at least half of the 1996-97 completed mergers it identified, and that the Directives were expected to be applied in 15 of the 20 mergers pending as of January 1998.[51]

In one notable example from the 1995 CFFC report, the Quad Cities area of Iowa and Illinois, with a population of 325,000, was left without any abortion provider in a 50-mile radius after a Catholic and a non-Catholic hospital merged and abortion procedures were discontinued in 1994.[52] The Kaiser Family Foundation Report, which included the Quad Cities merger as one of its case studies, noted three years later that the only abortion provider in the area was still a clinic located 50 miles away and not accessible by public transportation. Indicating

some of the difficulties this situation has posed for local women in the community, the report found that without a local abortion provider there was evidence of "unmet needs for treatment of post-abortion complications, particularly among low-income women seeking services at community health centers, where physicians tend to be anti-abortion."[53]

Baptist church restrictions can come into play in the same way. As part of a 1995 joint venture between Columbia/HCA and the Georgia Baptist Health Care System, which is owned by the Georgia Baptist Convention, Columbia agreed not to perform "elective" abortions in any of its 18 hospitals and other facilities in Georgia. Although this transaction eventually fell through, the willingness of the giant, merger-prone Columbia to agree to such a restriction is significant.[54]

■ **Merger plans abandoned**. In some cases, proposed mergers have been abandoned as a result of differences over abortion and other reproductive health services. In Portland, Maine, a local pro-choice coalition and other health care activists headed off a merger among three hospitals, including a Catholic hospital that sought to eliminate all the services banned by the Directives, through an intense effort to educate the local community about the potential loss of reproductive health care services for thousands of area residents.[55] A proposed partnership between a Catholic and a non-Catholic hospital in Brunswick, New Jersey, was abandoned after local pro-choice groups lobbied the secular hospital's board to continue to operate independently of Catholic restrictions on reproductive health services.[56] A planned merger between the only two hospitals in Kenosha, Wisconsin also collapsed over the desire of the Catholic owner of one of the hospitals to retain control of the merged entity and its "values."[57] A Maryland-based Catholic health system participated in a proposal to buy South Carolina's Hilton Head Island Hospital, but dropped out when the other partners decided to continue offering tubal ligations.[58] Other mergers have been stopped by church officials concerned about the risk that Catholic policies would be violated.[59]

■ **Merger completed under special conditions making services available**. In some cases, the parties to proposed mergers have agreed to various arrangements that have allowed the mergers to go forward while preserving the availability of reproductive health services. *This set of outcomes is of particular significance here, because it suggests that in a legal challenge to a merger, including one brought under the antitrust laws, the goal can be to reach an agreement guaranteeing that needed services will continue to be made available after the merger, as an alternative to outright cancellation of the merger plans.*

Catholics for a Free Choice identified several transactions between 1990 and 1995 that permitted reproductive health services to continue at a legally autonomous, separately-funded facility located on-site (*i.e.*, on the premises of the non-Catholic merger party) or nearby, others that permitted reproductive health services to continue off-site at an independent facility endowed as part of the merger agreement, and one that provided a means of subsidizing the patients' costs of traveling to alternative providers.[60] Among those cited by CFFC are these:

- When the two largest hospitals in West Palm Beach, Florida merged in 1994, the non-Catholic facility (Good Samaritan) created a separate corporate entity to perform tubal ligations and sterilizations on-site after the merger, as well as abortions necessary to save

In a legal challenge to a merger, including one under the antitrust laws, the goal can be to reach an agreement guaranteeing that needed services will continue to be made available, as an alternative to cancellation of the merger plans.

the woman's life. Physicians at the Catholic facility are permitted to make referrals to Good Samaritan.

- Two hospitals merging in Springfield, Ohio in 1994 agreed that the non-Catholic hospital's parent company would provide reproductive health services near the hospital but under auspices legally separate from the new consolidated entity.
- When Everett General Hospital in Washington state was taken over by Catholic-owned Providence Hospital in 1994, it transferred $500,000 of its endowment to the local Planned Parenthood affiliate to ensure that low-income women could still obtain abortion and sterilization, procedures that were then discontinued at General.
- When the only two hospitals in Great Falls, Montana — one Catholic and one secular — merged in 1995, the secular entity made arrangements to help subsidize the expenses of women required to travel outside of Great Falls for abortions, and the consolidated entity agreed to continue providing certain other reproductive health services that were available prior to the merger.
- Negotiations between a Catholic and non-Catholic hospital in Stanley, Wisconsin led to an agreement in 1994 that if the secular institution chooses to provide sterilization, it can establish a separate, freestanding facility in which to do so.

Arrangements allowing reproductive health services have been worked out in other cases as well, according to accounts in the press. Here are a few examples:

- A Catholic and a non-Catholic hospital in Port Jefferson, New York formed a joint venture instead of merging in 1996, and agreed that the secular institution would continue to offer in vitro fertilization, vasectomies and abortions.[61]
- When a Catholic hospital formed an alliance with another hospital in Baton Rouge, Louisiana in 1997, the agreement provided that the hospitals would remain separately owned and the secular hospital would continue to provide sterilization and fertility treatments.[62]
- When a Baptist and a Catholic hospital entered into a joint venture with a secular hospital in Murfreesboro, Tennessee in 1996, the Baptist hospital built a separate facility, with separate corporate ownership from the joint venture, to provide all gynecological and obstetric services that had previously been provided at the secular hospital.[63]

One approach that has been used to allow continuation of abortion and other reproductive health services is to structure a hospital affiliation in a partnership form that involves no asset transfer or joint ownership. For example, a Catholic hospital and a Lutheran hospital in Denver agreed in 1996 to be run by a new joint management organization while their assets remain separately owned, allowing abortions to continue to be performed at the Lutheran facility.[64]

Some of the creative arrangements that have been utilized to minimize the harmful consequences of a merger are less effective than others. An agree-

ment that involves the provision of services at a site that is completely separate from a hospital, or merely helps subsidize the cost of travel to a separate facility, is less than ideal, for several reasons. This approach will not help a woman who wishes to undergo a tubal ligation following childbirth if the local hospital where she intends to deliver, and where her physician has admitting privileges, is governed by the Catholic directives and refuses to perform sterilization procedures. Moreover, free-standing women's health clinics and their staff and patients are frequently the targets of anti-abortion violence and harassment, and there can never be a guarantee that a particular clinic will continue in operation indefinitely or continue to offer the services in question. Even the separate-facility approach, however, is preferable to accepting a merger that will cause some reproductive health services to disappear from the community altogether.[65]

In any event, these possible approaches to preserving needed services illustrate ways in which a merger challenge under the antitrust laws might be resolved in a manner that stops short of blocking the merger altogether. With this background, the applicability of the antitrust laws is the focus of the remainder of this Report.

Part Two

Using The Antitrust Laws

1. Introduction

Antitrust law is premised on the belief that vigorous competition among business enterprises will result in the lowest prices and best quality products and services for consumers. This concept is embodied at the federal level in the Sherman Antitrust Act,[66] which prohibits agreements in restraint of trade and monopolization, and the Clayton Act,[67] which specifically prohibits mergers and acquisitions that may substantially lessen competition or tend to create a monopoly.[68] These laws are enforced by the U.S. Department of Justice and the Federal Trade Commission. In addition, state Attorneys General have the authority to bring suit to challenge conduct that violates the federal and state antitrust laws, including anticompetitive mergers. In some circumstances, private parties also may sue to challenge an anticompetitive merger.[69]

This part of the Report explains how these laws apply to a prospective hospital merger that threatens to eliminate women's reproductive health services. It includes, first, an explanation of the way a proposed merger will be analyzed by government antitrust enforcers under Section 7 of the Clayton Act and the federal Merger Guidelines, as well as under the Sherman Act, along with a brief outline of conduct affecting reproductive health services, other than hospital mergers, that may raise antitrust concerns. That discussion is followed by a description of each of the ways in which concerned members of the affected community may challenge a merger (or other apparently anticompetitive conduct) — by enlisting the federal antitrust authorities or the relevant state officials, or filing a private suit.

2. The Applicable Antitrust Principles

A. Clayton Act Analysis (Federal Merger Guidelines)

When analyzing a proposed merger, the most relevant federal law is Section 7 of the Clayton Act, which prohibits stock or asset acquisitions that may substantially lessen competition or tend to create a monopoly.[70] This law applies to firms engaged in any activity that affects interstate commerce, which means that it covers not just mergers between entities in two different states, but also many mergers between entities in the same state.[71] And it has been interpreted to apply to nonprofit as well as for-profit entities.[72]

Two federal agencies are charged

Section 7 of the Clayton Act prohibits mergers where "in any line of commerce in any section of the country, the effect . . . may be substantially to lessen competition, or to tend to create a monopoly."

Merger review is undertaken before a merger is completed, in order to prevent competitive harm before it takes place.

with enforcing the Clayton Act: the U.S. Department of Justice (DOJ), and the Federal Trade Commission (FTC). Only one of these agencies will review a specific merger, and in the area of health care it is not possible to say in advance which one it will be.[73] The agency that reviews a specific hospital merger is the one that has the best knowledge of the particular geographic market(s) or hospitals involved. Usually, the choice of DOJ or FTC makes no difference: each agency has a health care division of attorneys and economists who specialize in hospital merger analysis, and the agencies share the basic analytical approach summarized below. Both agencies recently have been increasingly active in challenging mergers, especially in cases where there is evidence that a merger is likely to injure consumers. Indeed, several commentators have remarked on the revival that federal merger enforcement is experiencing.[74]

At the outset, it is important to note that merger review is usually a prophylactic measure, undertaken by the federal agencies before the merger is completed, in order to prevent competitive harm before it takes place. The language of the Clayton Act reflects this, prohibiting acquisitions that "*may* substantially lessen competition, or *tend to* create a monopoly" (emphasis added). This approach is bolstered by the Hart-Scott-Rodino Antitrust Improvements Act of 1976 ("HSR"),[75] which requires that most proposed mergers valued at over $15 million be first reported to the DOJ and FTC and then delayed a minimum of 30 days before being consummated.[76] Most proposed mergers are permitted to proceed to completion. However, if the reviewing agency decides further investigation is necessary, it can require the submission of additional information and delay the merger as much as several more months while it reviews the data.

Mergers that are subject to HSR (and not all hospital mergers are "big" enough to qualify) are automatically of the most interest to the federal authorities. These mergers also stand a better chance of being halted or modified by opponents, since HSR provides the time to develop a sound antitrust case and stops the merger until the parties have resolved the concerns it raises — by giving up the merger or agreeing to alter it — or the government either gives final clearance or goes to court to ask for an injunction preventing the merger from being consummated.

Hart-Scott-Rodino thus offers a major advantage to those concerned about a merger, by providing an opportunity to block or restructure the transaction before the anticompetitive effects actually take place. Parties challenging a merger that does not fall under the HSR guidelines — and therefore does not require premerger review — usually face the much greater challenge of remedying anticompetitive effects after the merger (although in some cases the government will investigate a non-HSR merger and the parties will voluntarily hold off on completing the transaction until the investigation is closed). Once the two entities are legally one, assets can be discarded or so thoroughly combined that recreating independent competitive entities can be virtually impossible. In the case of women's reproductive health services, there also may be an irretrievable loss of assets, such as the trained health care professionals who will leave a market where they can no longer practice and may not be easily or quickly enticed back in, even if a center providing such services were subsequently established.[77]

A government or private party plaintiff claiming that a proposed merger violates Section 7 of the Clayton Act need not demonstrate *with certainty* that a merger is intended to or will have anticompetitive consequences. The plaintiff only has to show that the

merger is *likely* to create or enhance the degree of market power that can lead to anticompetitive consequences. To prove that likelihood, a plaintiff must provide a detailed analysis of market structure before and (predicted) after the planned merger.

The most effective and resource-efficient way to mount an antitrust challenge to a merger is to persuade a federal or state agency to take action to halt it before it is consummated. The agencies will be interested in challenging a merger if it appears anticompetitive when subjected to their five-step analytic approach, which is drawn from the 1992 Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, as amended in 1997 ("Guidelines").[78] While the Guidelines do not have the force of precedent in a federal court, they distill the holdings of numerous antitrust cases and they outline the enforcement policies of the two federal agencies. A merger that appears to be anticompetitive under the Guidelines is likely to be vulnerable to state challenge as well.

The analysis under the Guidelines looks at the following issues:

- **Adverse Competitive Effects.** According to the Guidelines, the overarching question posed under the Clayton Act is whether the merger would be likely to increase the market power of the merged firm such that it could raise prices, suppress output, or otherwise lessen competition.

- **Concentration of the Relevant Product and Geographic Markets.** If the merger is likely to increase the concentration of the market — the market shares held by the market's largest firms — it is more likely to enhance market power or facilitate its exercise. To determine market concentration, it is necessary to define the relevant product market and geographic market, and then measure market concentration before and after the merger.

- **Ease of Entry.** If it would be easy for a new provider to come into the market after the merger and offer the affected product or service, the merger is not likely to create or enhance market power.

- **Efficiencies.** Even if a merger would be likely to create or enhance market power, it may not be challenged under the Guidelines if it will lead to significant efficiencies that would outweigh its anticompetitive effects.

- **Failing Firm.** Finally, if the merger is the only way to prevent one of the merging parties from going out of business, this may provide a defense to a merger that would otherwise violate the Clayton Act.

Each of these parts of the analysis, and its application to a hospital merger that will eliminate reproductive health services, is discussed below.

(1) Adverse Competitive Effects

The unifying theme of the Guidelines is that mergers should not be permitted to create or enhance market power or facilitate its exercise. "Market power" is defined primarily as "the ability to profitably maintain prices above competitive levels for a significant period of time, . . . the result [of which] is a transfer of wealth from buyers to sellers or a misallocation of resources."[79] The Guidelines note that "competition may also be lessened on dimensions other than price, such as product quality, service, or innovation."[80]

The Guidelines describe two ways in which a merger can diminish competition. The first is when the merger so reduces the total number of firms in a market that the remaining firms are able to collectively exercise market

power (*e.g.*, collude to raise price). The collusion can be tacit or express.[81] The second is through unilateral action — exertion of what can loosely be described as monopoly power that prevents consumers from finding substitutes for the product or service that is now controlled by the merged entity, and forces them to pay a higher price or do without.

Merger analysis under the Clayton Act thus poses this basic question: will this merger allow the firm to exercise market power — as reflected in its ability to raise prices or lessen competition on other dimensions such as product (or service) availability or quality — either on its own or in a conspiracy with its few remaining competitors? The fact that a post-merger hospital is to be governed by religious directives prohibiting certain reproductive health services constitutes strong evidence that there will be a reduction of competition for these services. Additional proof of the likelihood that services will be eliminated may be found in public pronouncements of hospital officials, merger planning documents, and the like.

The party challenging a merger must define the relevant product and geographic markets, and then assess the structure of the market and the change in structure the merger will bring about.

(2) Market Definition and Concentration Measurement

The basic question of market power cannot be answered without defining the relevant product and geographic markets, and then assessing the structure of the market and the change in structure the merger will bring about. The party challenging a merger must perform these analyses.

A. Product Market

Defining a relevant product market under the Guidelines requires identifying the product or group of products sold by the merging parties, and any reasonable substitutes that may exist. (Services are deemed to be "products.") The relevant product market consists of all firms that (1) produce or sell the same products or services as the merging firms; (2) produce or sell close substitutes for those products; or (3) could produce or sell those products or substitutes with relatively little effort and within a year's time.[82]

This approach to market definition focuses on the sellers' ability to raise prices (or otherwise reduce competition) profitably after the merger. If there are alternative products or suppliers to which consumers can turn in the face of a small price increase, and the existence of those products or suppliers would constrain the ability of the merged firms to raise prices, then those alternatives must be included in the definition of the relevant markets in which the competitive effects of the merger are being evaluated.

Women's reproductive health services could constitute a relevant antitrust product market under certain circumstances. Traditionally, hospital mergers are analyzed by looking at their effect on a broadly-defined product market — the provision of inpatient acute care services.[83] But product markets of a different scope (such as primary care inpatient services, rehabilitation services, psychiatric services, and outpatient surgery services) have been adopted in a few cases.[84]

When two hospitals merge, therefore, and certain reproductive health care services are eliminated, it should be possible to argue that *the relevant product market in which to assess the anticompetitive effects of the merger is women's reproductive health services provided in hospitals, or dependent upon hospital facilities for back-up.* To establish this product market, it would be necessary to demonstrate unique "supply side" and "demand side" characteristics that make substitution of other health care services impractical. Showing "demand" should not be difficult: patients, physicians and third-party pay-

ers can attest to the fact that women's need for these services cannot be satisfied by other types of health care.

A greater challenge lies in proving the "supply" side, since some components of the cluster of services comprising women's reproductive health services may not be dependent upon hospital access. For example, contraceptive counseling and services may continue to be available through physicians' offices after a hospital merger, allowing the merged entity to argue that there will be relatively little impact on the market if it no longer provided those services. But there is a danger in defining the product market too narrowly, to include only those services that are not available elsewhere, because if those services represent only a small part of the hospital's general acute care services the hospital might argue that the efficiencies to be gained by the merger will outweigh any harm to consumers. (See the discussion below of "efficiencies" arguments.)

Thus, it becomes important to demonstrate that a merger causing the elimination of a hospital provider of these services would have significant repercussions in the community. For example, it might be shown that physicians who could theoretically provide the services in their offices or a clinic setting would not do so without a nearby hospital to which patients could go when complications arise, or would not do so because they fear losing their privileges at a religiously-affiliated hospital if it became public that they provided services that are contrary to church directives. Physician testimony on these points would be very helpful.

B. Geographic Market

To define the geographic market it is necessary to identify an area beyond which the merging hospitals' patients would not travel in order to escape the negative effects of the merger (such as a price increase or the elimination of the service). Because people generally do not want to travel far to seek basic medical treatment, the geographic market for general acute care services offered in hospitals has often been defined as the county or metropolitan area where the hospital is situated.

There are two cautionary notes to this general rule of hospital competition as a local phenomenon. First, the geographic nature of competition can vary with the service offered.[85] The market for complex, specialized medical procedures such as cardiac surgery or cancer treatment can encompass whole states and regions, and may even be nationwide. If some or all women's reproductive health services are deemed more like complex surgery than primary care, their geographic market may be expanded. Second, there is a trend in recent hospital antitrust decisions to adopt broader geographic markets.[86] Courts appear to be increasingly receptive to the argument that changes in the health care system have made patients both more cost-sensitive and less physician-loyal, so that they are willing to travel further in order to save money.

To define the geographic market, the agencies and courts will consider various factors. First, they look to data showing the historical origin of the hospitals' patients, by hospital, zip code, and categories of medical treatment known as "DRGs" (Diagnostic Related Groups). Because such data only give a snapshot of past behavior, the agencies and courts are open to any fact-based argument that might help predict whether consumers would change their travel patterns after the merger. They will, for example, seek out the perceptions of consumers, managed care providers, hospital administrators (both in and outside the market), and physicians. They will attempt to define both "drive time" and physician loyalty in order to measure consumers' willing-

A successful challenge will require evidence that most women needing the threatened reproductive health services could not or would not travel long distances to obtain the services.

ness or ability to seek treatment at other locations. Consumers' willingness to travel will, in turn, be influenced by financial incentives provided by the health plan to which they subscribe and by the region in which they live: consumers in rural areas may be more likely to travel great distances for medical care than consumers in urban areas.

The broader the area defined as the geographic market, the harder it will be challenge a local merger, because it means a larger number of competing providers will be available in the market. *A successful challenge, therefore, will require evidence that most women needing reproductive health services could not or would not travel long distances to obtain these services, due to cost or the time-sensitive nature of the services* (as is the case, for example, with abortion, the morning-after pill, or postpartum tubal ligation), or other factors such as unfamiliarity with a more distant region. Obviously, the costs of such travel are likely to weigh most heavily on low-income women, and can include transportation, lodging, child care, and time lost from work. In the case of abortion, these costs are likely to be highest in states that have waiting periods necessitating two trips — for the initial consultation and again for the abortion — to a distant provider. Data on these factors should be developed to aid in definition of the geographic market.

c. Concentration Measurement

The next step in evaluating the legality of a merger is taken by a mathematical exercise to determine the market's "concentration" before and after the merger. Concentration is a key indicator of the potential competitive impact of a merger because as the number of firms in a market declines (*i.e.*, the market becomes significantly more "concentrated"), supply is controlled by fewer and larger firms and there is increased risk that one of them could exercise market power. (As discussed below, however, even where concentration is high, other factors — such as the ease of entry of new competitors — may make the exercise of market power unlikely.) *To measure concentration, the market shares of each of the merging firms and all their competitors in the relevant market are calculated,*[87] *and a comparison is made of the market's concentration before and after the merger.* "Concentration ratios" — which simply means the market shares held by the top two or four firms in the market — traditionally have been used in the case law to measure concentration. However, courts are increasingly turning to a more mathematically precise measure used by the federal agencies, known as the Herfindahl-Hirschman Index (HHI), which reflects the market shares of the top four firms as well as the composition of the rest of the market.[88] By either method, a merger between the only two hospitals in a particular market, or two of three or four hospitals in the market, would raise a presumption of anticompetitive effects.

There is one exception. The Department of Justice and FTC have carved out a "safety zone" for small hospital mergers: generally, when the acquired hospital has an average of fewer than 100 licensed beds and has an average daily inpatient census of fewer than 40 patients, the federal agencies will not challenge the merger.[89] Concerns about the acquisition of hospitals below or even slightly above this threshold should be brought before state authorities, who are not bound by this DOJ-FTC policy. While state authorities are likely to share the federal agencies' conclusion that hospitals below a certain size are too small to matter competitively in the acute care market, they may nevertheless be open to an argument that a small hospital is

a significant force in the market for women's reproductive health services, such that its elimination would harm competition.

(3) Ease of Entry

The third step in the analysis is to inquire whether it would be easy enough for other competitors to enter the market that the merger's presumptive anticompetitive effects would be deterred or counteracted.[90] When entry into a market is easy, even a firm with 100% of the market could not charge a monopoly price for very long, because the high price would attract others trying to earn monopoly profits as well, and soon price would be driven back to a competitive level.

To test the ease of entry, the Guidelines ask a three-part question: would competitors' entry be (1) timely (occur in under two years); (2) likely (profitable at premerger prices); and (3) sufficient (able to service enough of the market to provide consumers with a meaningful alternative to the merged firm)?

If the definition of the product market hinges on hospital access, a court is likely to conclude that potential competitors would face unacceptably high barriers to entering the market, and reject an "ease of entry" defense.[91] Statistics from the U.S. Department of Health and Human Services, state health agencies and other public sources are readily available to show that construction of a new hospital takes more than two years, is costly and, in today's health care market, is exceedingly unlikely.[92] Indeed, all predictions are for the number of hospitals to decrease precipitously in the next decade. Moreover, there should be statistical or at least anecdotal data available showing the significant cost and time it takes to assemble a hospital's trained professional staff. All this adds up to a conclusion that, in the hospital industry, entry barriers are very high indeed, and a merger that creates high market concentration may be presumed to lead to market power.

(4) Efficiencies

Even when a merger appears to threaten competition by further concentrating an already concentrated market, and those concerns are not eliminated by ease of entry or other market conditions, the merger may result in such substantial efficiency savings that could not be captured in any other way that, on balance, the transaction is not harmful to competition. The Guidelines provide that the federal agencies "will not challenge a merger if cognizable efficiencies are of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market."[93] "Cognizable efficiencies" are considered merger-specific efficiencies that enhance the merged firm's "ability and incentive to compete" and "do not result from anticompetitive reductions in output or service."[94]

Most mergers will result in at least some operating efficiencies for the merging parties, and where a hospital merger is challenged, the hospitals will undoubtedly offer specific examples of how the merger on the whole creates important efficiencies that will benefit the community.[95] Hospitals may also argue that the potential efficiencies of a merger will be large relative to the costs associated with the elimination of women's reproductive health services.[96] *The burden of proof, however, is on the merging parties to quantify the expected efficiencies and to show that they will outweigh the predicted anticompetitive effects. Moreover, some courts have held, and the reviewing agencies insist, that any savings from efficiencies will be passed on to consumers.*[97] In general, courts have been skeptical of efficiencies defenses, treating them as being inflated or too speculative.[98]

Most mergers that reduce the number of hospitals in a market from four to three, three to two, or two to one will present a case subject to challenge under the Guidelines.

(5) Failing Firms

In some cases, parties to a merger will argue that the merger would actually *preserve* competition by saving a firm that otherwise would fail. Competition would be harmed more if a failing firm exited the market, they will argue, than if its assets pass to a competitor and remain productive. This argument, drawing upon Supreme Court precedent,[99] is recognized by the Guidelines as a narrow defense to an otherwise objectionable merger.[100] The defense will be accepted only if: (1) failure is imminent; (2) the firm shows that it would be unable to reorganize in bankruptcy; (3) the party invoking the defense establishes that there are no alternative merger partners; and (4) the proponents of this defense demonstrate that "absent the acquisition, the assets of the failing firm would exit the relevant markets."[101]

This defense has rarely been successful. To date, the antitrust agencies and courts have resisted broadening the defense to include distressed industries, "flailing" (struggling) firms, or struggling units of financially healthy companies. However, failing firm and distressed industry issues can surface in the competitive effects, market power, and efficiencies stages of the analysis, and can tip the balance toward an endorsement of the proposed merger.

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To recap: To determine whether a given hospital merger raises antitrust concerns under the Clayton Act, a merger must be subjected to the Merger Guidelines' five-step analysis. Most mergers that reduce the number of hospitals in a market from four to three, three to two, or two to one will present a "Guidelines case," on the basis of concentration figures alone,[102] especially if there is obvious proof of intent to eliminate services, such as the Ethical and Religious Directives of the Catholic health care system. Further examination is necessary, however, to determine whether strong ease-of-entry or efficiencies arguments may be available to the hospitals defending the merger.

B. Sherman Act Merger Analysis

While Section 7 of the Clayton Act is the principal federal law governing anticompetitive mergers and acquisitions, a merger may be challenged under the Sherman Act as well, although such challenges are rare. An advantage of a Sherman Act challenge is that there is a body of Sherman Act case law holding that when former competitors reduce output, even if prices do not rise, an antitrust violation has occurred. This could be significant in a case challenging a hospital merger on the ground that it will eliminate the availability of reproductive health services — *i.e.*, an "output."[103]

To establish a violation of Section 1 of the Sherman Act, there must be proof of:

- a contract, combination or conspiracy;
- among two or more independent entities;
- that unreasonably restrains trade;
- in or affecting interstate or foreign commerce.

Three of these four elements can be easily satisfied: the first two will be found in the agreement to merge or form a joint venture. The fourth does not require that the merger itself have an effect on commerce, as long as the defendants' general business activities affect interstate commerce[104] — which should be easy to show from the hospitals' admitting patterns, supply orders and flow of insurance payments. The third element, however, incorporates the entire five-point merger review

process under the Clayton Act that is described above. Because the Sherman Act has been interpreted to bar only "unreasonable" restraints of trade,[105] all the factual circumstances of a case will be weighed before a decision can be reached about the merger's impact on competition.[106]

We are aware of only one merger case involving a Sherman Act challenge along these lines, but its facts bear a striking resemblance to those that would be presented in challenging a merger on the ground that it will make reproductive health services unavailable to a patient population. In *Nelson v. Monroe Regional Medical Center*, the plaintiffs alleged that the merger of the only two medical clinics in their city denied them access to health care, because they had previously been dropped by one of the clinics after bringing a malpractice suit against it, and when that clinic was acquired by the other, the acquiring clinic adopted the refusal to do business with the plaintiffs. Reversing the lower court's dismissal of the case, the court of appeals said:

> *Defendant argues that this injury, the denial of non-emergency medical services, is not the type the antitrust laws are intended to remedy. We are unable to agree. Monopolists are more likely to turn away prospective clients because they do not feel the same competitive pressure to serve all comers. That is why we recognized . . . that "injury from . . . lower output" was one of the "principal vices proscribed by the antitrust laws." . . . Alternatively, one could view the Clinic's refusal to treat [plaintiffs] as an infinite increase in the price it charges them for treatment . . . . In a market made non-competitive by a merger, it is the kind of "price increase" that is a central concern of the Sherman Act.*[107]

On this basis, a merger could be challenged under Section 1 of the Sherman Act if it similarly threatened to eliminate the only remaining provider of reproductive health services in the market.[108]

C. Conduct Other Than Hospital Mergers That May Raise Antitrust Concerns

In addition to mergers and affiliations between hospitals, there is other conduct in the health care industry that is potentially harmful to the availability of reproductive health services and that might be vulnerable to challenge under the antitrust laws. A few of these situations are briefly described below.

(1) Mergers Involving HMOs

One area of concern is mergers between two health maintenance organizations (HMOs) or between an HMO and a hospital, where one of the merging entities is governed by religious restrictions on abortion or other services. If such a merger gave a very broad enrollee base to an HMO that refused to reimburse for those services, a significant portion of the patient population could be denied access to them. This occurred when a Catholic-affiliated HMO covering Medicaid patients in New York City, Fidelis Care New York, took over a secular HMO with enrollees all across New York State in 1997, with the result that the plan's enrollee base tripled and enrollees lost coverage of abortion, contraceptive and sterilization services.[109]

An antitrust challenge to such a merger would have to pass through the same analytical grid as hospital-hospital mergers: anticompetitive effects, product and geographic market definition, calculation of market concentration, ease of entry, and assessment of efficiencies and "failing firm" arguments. To date, courts have held that HMOs

operate within a "health care financing market," which includes other forms of insurance and payment for health care.[110] As a result, the market concentration is likely to be too low to support a challenge to an HMO merger.

However, this situation is in flux, in part because health care financing is undergoing rapid change. Old notions of what package of services and benefits compete with what may shift in light of increasing HMO enrollment, disparities in patient volume, patient type and physician reimbursement. This may soon lead to a situation in which either the demand for HMO services or an HMO's control over supply of medical professionals becomes distinguishable from other forms of health care financing. In that case, an HMO-only health care financing market, and the imputation of undue market power to an individual HMO, would be supportable.

Developments in this area should be closely monitored. The federal antitrust agencies may be willing allies in a test case.[111]

(2) HMO (and Other Health Plan) Conduct

Another area of possible concern is a situation in which a health plan that denies coverage for certain services because of religious restrictions is able to "lock up" most of the health care providers in a particular specialty or geographic market. This would foreclose competition from other health plans because they would lack a critical mass of doctors with whom to contract.[112] The DOJ-FTC Health Care Policy Statements reflect a serious concern with lock ups.[113] The Statements provide the following "safe harbors" — *i.e.*, situations that the FTC and DOJ will not challenge as antitrust violations: a plan may empanel up to 30% of any specialty, on a non-exclusive contract basis, or empanel up to 20% of any specialty, on an exclusive contract basis.[114] This means that a health plan that uses exclusive contracts (with exclusivity based on real practice, not simply the terms of the contract) to empanel more than 20% of the doctors in a region may be engaged in a restraint of trade in violation of Section 1 of the Sherman Act.

To determine whether there is a Sherman Act violation, a full market power analysis must be undertaken: anticompetitive effects, product and geographic market definition, market concentration, ease of entry, assessment of efficiencies and failing firm defenses. There should be little difficulty establishing a market for providers of reproductive health services in a relatively small geographic area, since health care plans can force subscribers to travel only so far for covered services.[115] The key analytical issue here is ease of entry. If a high percentage of local specialty providers are contractually tied to a health plan by long-term exclusive contracts, then foreclosure of competition from alternative health plans and/or service providers is likely, and may be challenged as an anticompetitive restraint of trade or attempt to monopolize under Section 1 or 2 of the Sherman Act. Conversely, if physician association with a given plan is non-exclusive, or easy to revoke, any exercise of market power can be defeated. As usual in antitrust analysis, the factual details concerning market structure and operation will determine the strength of the case.

(3) Hospital Denial of Physician Staff Privileges

Antitrust concerns may also be raised where a religiously-affiliated hospital denies staff privileges to an area physician who provides services (outside the hospital) that are contrary to the hospital's religious principles.[116]

Hospitals routinely deny physicians and other health care professionals access to hospital resources. When staff privileges are denied solely on plausible grounds of maintaining quality of care, or the well-established right of a business to select its customers and associates, the conduct does not create an antitrust violation.[117] However, when privileges are denied as part of a plan to impair competition, antitrust issues are raised. Depending on the facts, the exclusionary effect of a denial of access may be challenged under Section 1 of the Sherman Act.

As noted earlier, a required element of a Sherman Act Section 1 claim is an agreement (conspiracy) between separate entities. Typically, staff privilege decisions are made jointly by a hospital and its medical staff. Courts differ from jurisdiction to jurisdiction on whether a hospital and its staff are considered separate entities and therefore legally capable of conspiring together.[118] However, most courts have held that, regardless of the ability of a hospital to conspire with its staff, the individual physician members of a medical staff can conspire with each other.[119] Thus, in most but not all jurisdictions, plaintiffs should be able to establish the conspiracy element.

The next issue is showing that the agreement to deny staff privileges advanced a restraint of trade. Success here is most likely if a plaintiff shows that the conspiracy originated or was implemented by the incumbent medical staff, some or all of whom stood to gain financially if their rivals could not use the hospital resources. On these grounds, a nurse anesthetist prevailed in an antitrust challenge to a hospital's policy of allowing only physician anesthesiologists to administer anesthesia in the hospital's operating rooms.[120] Similarly, the FTC alleged that a medical center's physicians had conspired, through the center's credentials committee, to suppress competition by denying a certified nurse-midwife's application for hospital privileges in order to protect the staff obstetricians' economic self-interest.[121]

If both quality-of-care and economic self-interest rationales are present, as they almost always are, the court will attempt to balance the competitive harm against the quality-of-care gain. Exclusion of an entire class of competitors is more likely to raise significant competitive issues than exclusion of only one or a few providers: quantity makes it easier to see an effect upon competition. In the balancing process, the court will inquire whether any less restrictive practice could have been employed.

Even with anticompetitive intent established, a plaintiff may have to show that the hospital has sufficient market power to restrain trade unreasonably by its staff privilege choices. The Supreme Court has sent mixed messages on this issue, in one case noting that hospitals have an "unquestioned right" to limit privileges, absent market power,[122] and in a second case declaring that market power questions can be skipped over when significant anticompetitive effects, such as a reduction of output, are obvious.[123]

In sum, a denial of physician staff privileges may be subjected to a Sherman Act challenge in certain circumstances.

3.
How To Bring A Challenge

The best way to attempt to stop a merger or force its restructuring under the antitrust laws is to enlist federal or state authorities to challenge it, in order to take advantage of their legal and economic expertise as well as their authority to put a planned merger on

The best approach is to enlist federal or state authorities to challenge a merger.

hold until the antitrust investigation is complete. This section discusses what the relevant federal and state agencies can do and how to approach them, as well as the possibility of private litigation. The sample letter and the list of types of information to gather attached as appendices to this Report provide specific guidance on how to present a case to the antitrust enforcement agencies.

The federal agencies can be contacted through:

Assistant Director for Health Care
Bureau of Competition
Federal Trade Commission
6th & Pennsylvania Ave., NW
Washington, DC 20580
Tel: 202-326-3688
Fax: 202-326-3384

Health Care Task Force
Antitrust Division
U.S. Department of Justice
325 7th Street, NW, Suite 400
Washington, DC 20530
Tel: 202-307-5799
Fax: 202-514-1517

A. The Federal Agencies: Federal Trade Commission and Department of Justice

Because the federal antitrust agencies carry the big stick of Hart-Scott-Rodino — that is, the ability to halt a transaction during the period of "pre-merger review," as discussed earlier — it is a good idea to go to them first, or at the same time as state officials are approached. It is best to approach both the FTC (through its Bureau of Competition) and the DOJ (through its Antitrust Division), as this improves the odds of prompting government action.[124] Since the FTC's Bureau of Competition and the DOJ's Antitrust Division will decide between themselves which agency will review a particular merger, any information a merger opponent gives to one agency will be shared with the other.

Senior officials of both the DOJ and the FTC have emphasized that the agencies actively encourage input from anyone with concerns about a merger under their jurisdiction, and that they generally find information from customers of the merger parties to be the most useful.[125] Parties with concerns about prospective mergers are urged to bring their concerns to the attention of investigators as early as possible, but the agencies have been known to re-examine the competitive effects of transactions, or the proposed relief, after the Hart-Scott-Rodino waiting period has expired and even after the reviewing agency has entered into a tentative settlement (proposed consent order) with the merger parties.[126] There is no required form or mechanism for submitting information to the agencies; it can be done initially through an informal dialogue or more formal presentation, and may develop into an ongoing working relationship with the agency staff responsible for reviewing the merger.[127]

The surest way to provoke the agency's interest is to present a "Guidelines" case — facts showing that, when subjected to the five-step analysis described earlier, it appears that the merger would substantially lessen competition. *The case will be even more persuasive if it suggests harm to other lines of health care services in addition to women's reproductive health services, since that would broaden and intensify the merger's anticompetitive effects.* The more data available to hand over (on geographic market, hospital concentration, plans to discontinue services, etc.) the better. If the agency is interested at that point, it will then use its own resources to develop the case.

B. State Antitrust Enforcement Authorities

The same approach and substantive arguments concerning the merger can be presented to the appropriate state antitrust enforcement agency. State Attorneys General have authority under the Clayton Act to bring suit as "parens patriae" on behalf of the state's citizens for an injunction to stop a merger that violates the federal antitrust laws[128] and for triple the monetary damages caused by such a merger, as well as for attorneys' fees and costs of suit.[129] Moreover, every state but Pennsylvania and Vermont has a state antitrust statute of general application, meaning a counterpart to

Section 1 and/or Section 2 of the Sherman Act, prohibiting agreements in restraint of trade and monopolization.[130] These laws can also be invoked to challenge mergers.[131] And 13 states have state statutory provisions relating specifically to mergers, although not all of them are as comprehensive as Section 7 of the Clayton Act.[132]

In addition, many states have enacted laws providing that a merger or other collaborative arrangement between health care providers will be treated as immune from state and federal antitrust laws if the parties can show that the consumer benefits of the proposed transaction will exceed any harm due to the likely reduction in competition. These statutes are not themselves antitrust laws, but they do offer another promising mechanism for challenging a merger with potentially anticompetitive consequences in the states.[133] The following states have enacted this kind of "regulatory statute" to facilitate cooperative endeavors or mergers between hospitals or other health care providers: Colorado,[134] Florida,[135] Georgia,[136] Idaho,[137] Kansas,[138] Maine,[139] Montana,[140] Nebraska,[141] New York,[142] North Carolina,[143] North Dakota,[144] Ohio,[145] Oregon,[146] South Carolina,[147] Tennessee,[148] Texas,[149] Washington[150] and Wisconsin.[151] These state laws vary considerably in the types of providers and activities covered, which state authorities are responsible for reviewing the transaction, the issues that must be addressed before approval is granted, and the nature and extent of post-approval monitoring or supervision by the state.[152]

These laws give state officials the authority to regulate a proposed transaction as a condition of allowing it to go forward, a power that can be useful in preserving the availability of reproductive health services. For example, Montana's antitrust immunity statute authorizes the Montana Department of Justice to approve a merger or other cooperative arrangement between competing health care facilities if the transaction would be likely to result in lower health care costs, or improve health care access or quality without any undue increase in health care costs.[153] It was this authority that enabled the state to impose conditions on the merger of Great Falls' only hospitals in 1995 to address concerns that services previously available at the non-Catholic hospital would not be offered after the merger.[154] As a condition of approving the merger, the state required that (1) the non-Catholic hospital agree to deed an office condominium to the local Planned Parenthood affiliate to produce revenue to pay the expenses of patients and physicians forced to travel outside of Great Falls for abortion services; and (2) the consolidated hospital agree to continue providing, without restriction, the following services offered prior to the merger: elective sterilizations, information and counseling on the morning-after pill for rape victims, and HIV risk reduction counseling.[155]

Most state-level merger reviews under the antitrust laws themselves will be conducted by attorneys in the office of the state's Attorney General (AG), who may or may not be antitrust experts.[156] No state has an analogue to the federal Hart-Scott-Rodino Act, requiring proposed mergers to be reported in advance and put on hold until completion of antitrust review. This means that states may be faced with having to move very quickly and with inadequate resources to investigate and challenge a merger. However, much of a federal agency's merger investigation file can be shared with an interested state under the voluntary Pre-Merger Disclosure Compact[157] and the states have set up systems that allow them to coordinate investigations

State AGs can challenge a merger under federal or state law.

Some state AGs have become increasingly active in merger enforcement.

and share resources on matters that affect more than one state, as might a merger where the buyer is a hospital chain that is acquiring hospital sites in several states.

While not all states have the interest and ability to review and challenge a merger, in light of the time-sensitive and resource-intensive nature of antitrust review, *some state AGs have become increasingly active in the merger enforcement area in recent years, and on some occasions have challenged mergers that the federal authorities have decided to allow.*[158] The National Association of Attorneys General (NAAG) is encouraging its members to bring more merger challenges, particularly in matters that are too local to be of interest to the federal authorities.[159] Indeed, some local mergers are too small ever to be reported to the federal agencies, so the state authorities are most likely to hear of them first, and hospital mergers often fit this model. In addition, health care is a high priority with most state AGs.

Thus, consumers of threatened reproductive health care services who can present a state AG with a ready-made theory of antitrust harm, plus whatever evidence can be extracted from public documents,[160] may well be able to spark interest. Whether or not the state AG would seek a court order blocking the merger, the mere threat of a state investigation, with its potential to slow or ultimately disrupt the planned merger, may be enough to bring the merging parties to the negotiating table. At this point the state AG may be, in one respect, an even more useful ally than the federal authorities: *while the DOJ and FTC generally deal with problematic mergers by halting them completely or requiring divestiture of overlapping assets, state AGs are sometimes more creative and flexible in crafting remedies.*[161]

C. Private Suits

The Clayton Act also authorizes private parties to sue for an injunction to stop a merger that would violate Section 7 of the Act[162] or for divestiture of the acquired assets after the merger has been completed,[163] and, in limited circumstances, to recover triple the amount of monetary damages caused by the merger.[164] The Act also provides for the award of attorneys' fees and costs to a successful private plaintiff.[165] This means that when a proposed hospital merger or affiliation threatens to eliminate reproductive health services, those likely to be harmed by the merger — such as women likely to need such services or doctors who would be prevented from using the facilities of the merged entity to provide them — could bring suit to stop the merger, either on their own or in a class action representing all such consumers or providers. Such a suit may proceed even if the merger has been reviewed and cleared by government authorities.

In a unanimous 1990 Supreme Court decision confirming that the Clayton Act permits private parties to sue for injunctive relief and divestiture where a merger would violate Section 7 of the Act, the Court emphasized the importance of private suits. The Court noted that the Act "manifest[s] a clear intent to encourage vigorous private litigation against anticompetitive mergers. . . . Private enforcement of the Act was in no sense an afterthought; it was an integral part of the congressional plan for protecting competition."[166] At the same time, however, it is important to recognize that bringing a private merger challenge is difficult, both legally and practically.

On the legal side, the case law requires that private parties seeking to block a merger meet a special "standing" requirement: the plaintiffs must show that if the merger were completed, they would suffer not just any form of injury causally linked to the merger, but an "antitrust injury." The Supreme

Court has defined "antitrust injury" as "injury of the type the antitrust laws were intended to prevent."[167] Antitrust injuries would not include the harm that a competitor might suffer if a merger increases the competition against it, since the antitrust laws are intended to protect against a lessening, not an increase, in competition. In the kind of case at issue here, however, the injury the plaintiffs would suffer is a reduction in the availability of reproductive health services. This should be considered an "antitrust injury" since price increases and output restrictions are precisely the evils the antitrust laws are intended to prevent. Thus, while there is no caselaw directly on point, it appears that the "antitrust injury" requirement could be met in such a case.[168]

On the practical side, however, the potential obstacles are significant. Antitrust litigation is costly and requires not only specialized legal expertise but economic expertise as well. Moreover, in a merger challenge time is of the essence, because if the merger is not stopped before its consummation, courts are generally reluctant to rescind it (*i.e.*, order divestiture) or require a restructuring of the transaction after the fact, in light of the complexities of "unscrambling the eggs." This means that there may be only days or weeks in which to identify plaintiffs and organize a class action, assemble the necessary industry expertise and preliminary factual evidence concerning the structure of the existing market and the merger's likely impact on it, and otherwise prepare to go to court.

Consequently, it may be difficult to act quickly enough without the assistance of one of the government enforcement agencies. For this reason it is preferable, if possible, to seek the assistance of federal or state authorities to challenge a prospective merger, as described in previous sections of this Report.

Conclusion

When faced with reports of a prospective hospital merger that threatens to reduce the availability of women's reproductive health services, those concerned with the loss of such services can use the federal and state antitrust laws to attempt to block the transaction or obtain an agreement to preserve the availability of needed services. The strength of the challenge will depend in each case on the specific characteristics of the market and other facts presented. The authority of the government antitrust agencies to halt a merger before it is consummated, however, provides a tremendous potential source of leverage that can be used to fashion arrangements that will guarantee the continued availability of services.

Accordingly, at the first reports of such a merger, the U.S. Department of Justice and the Federal Trade Commission, along with the relevant state officials, should be contacted immediately and presented with any available information on the harmful effects of the merger. In addition, a private suit seeking to halt the merger can be considered.

Appendix A

Sample Letter to the Antitrust Enforcement Agencies

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Gail Kursh
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[Office of the Attorney General of your state: see Appendix C.]

Dear Mr. Leibenluft, Ms. Kursh, and _____:

We are writing to bring to your attention our concerns about a proposed hospital merger that we believe will have a harmful impact on competition and the delivery of health care in our community. We are [describe your organization or who you are and who else you represent].

We have learned that [Religious Hospital] in [city, state] is planning to merge or affiliate with [modify as appropriate to reflect whatever is known about the nature of the anticipated affiliation] [Secular Hospital] in [city, state]. We are concerned that this merger, by eliminating competition in the local health care market, will result in a loss of services, loss of consumer choice, and increased costs to consumers. Where now there are [#] hospitals in our community, after the merger there will be only [#]. [If there will be only one, express concern over creation of a monopoly — a single entity with no checks on its ability to set prices arbitrarily.]

We are particularly concerned about the impact this proposed merger will have on the availability of reproductive health services in our community. [Religious Hospital] is affiliated with the Catholic church and governed by the Ethical and Religious Directives for Catholic Health Care Services, which prohibit abortion, contraceptive services and counseling, sterilization procedures, infertility treatments, and postcoital emergency contraceptives (the "morning-after pill"). [Modify as appropriate if other religious restrictions are at issue.] We understand that after the merger, if it is allowed to go forward, [Secular Hospital] would also be governed by these prohibitions. [Cite and enclose documentation of this intention.]

[Secular Hospital] currently provides the following services that would be banned under the Directives: [list the affected services]. The elimination of these services will have serious repercussions in our community. [Quantify the loss of services to the extent possible — e.g., how many abortions or tubal ligations did the secular hospital perform in the past year?]

Patients seeking these services will be forced to travel as much as [xx] miles to other hospitals in [cities]. [Describe transportation difficulties, such as lack of public transportation.] Pregnant women seeking tubal ligations after delivery, who are not able or willing to make this trip when they are ready to deliver, will be forced to have their babies at the merged hospital and then undergo a tubal ligation at a later time — at additional cost and risk to their health.

The [#] women who have received abortions each year at [Secular Hospital] will have to go elsewhere. [Describe problems this will pose — e.g., distances to nearest facilities; if nearby clinic exists, what are its limitations, such as violent or harassing anti-choice activities around it.]

[Add any other pertinent information that is readily available — see Appendix B for additional suggestions.]

The harmful consequences of this merger that we have outlined are, in our view, directly relevant to your review of the merger, and we urge you to take full account of them as you carry out your responsibilities under the antitrust laws. Further, we would respectfully request the opportunity to meet with you or the relevant investigatory staff to discuss the matter with you — and to do so before your office reaches a conclusion about the likely impact of the transaction and makes a recommendation on whether to challenge it.

We will call you shortly to follow up, if we do not hear from you. Thank you for your consideration.

Sincerely,

Appendix B

Information to Gather for Presentation to Antitrust Enforcement Agencies

1. ***The number of hospitals in the community (under separate ownership) before the merger and the number after the merger (and the number of beds in each).***

2. ***Evidence that after the merger, religious restrictions will be applied to a previously secular facility.*** This would include, for example, pronouncements to this effect issued by the merging hospitals, or merger planning documents.

3. ***Identification of the specific health care services that are currently available at one of the merging hospitals and slated for elimination after the merger, and an explanation of why these services are important to the community***. These may include, for example, abortions, sterilization procedures, infertility treatments, contraceptive services and counseling, HIV risk reduction counseling, and morning-after pills for rape victims. How many of each of these procedures or services were provided at the secular facility in the past (e.g., how many abortions or postpartum tubal ligations in the past year)? How many people will be affected by the elimination of these services (shown, for example, by estimates of the number of women of reproductive age, or the incidence of HIV or AIDS, in the community)? What services in addition to reproductive health services will be affected by the merger?

4. ***Information on how far patients would have to travel to get to other hospitals for these services after the merger and how difficult such travel would be — to demonstrate that patients are not likely to be willing or able to overcome these burdens.*** What is the travel time to such other hospitals, by car ("drive time") or by public transportation (if it is available)? Are road conditions or weather or geographic barriers potential factors? Would an overnight stay be required, due to transportation difficulties or a waiting period required by state law? What would the associated costs amount to (transportation, lodging, etc.)? Is there a low-income population in the area that would be particularly burdened by such costs?

5. ***Information on what other barriers there are to using these other, more distant, hospitals.*** For example, will the patients' physicians have admitting privileges there? Will their health insurance cover services obtained there?

6. ***Information on why non-hospital alternatives are unavailable or inadequate.*** For example, even if there is a nearby women's health clinic, does it or can it provide the same range of services? If it doesn't perform deliveries, how will it perform postpartum tubal ligations? Will it perform abortions if the only hospital available as back-up is governed by religious restrictions? Has the clinic (or have its staff or patients) been subject to violence or harassment, and is it financially stable?

7. ***An explanation of how hard it would be to bring in new providers to fill the gap in services.*** Would zoning or licensing laws, or local anti-choice sentiment, make it difficult to open a new facility? Is there reason to believe it would be hard to entice new physicians into the area to provide these services?

8. ***Information on the health risks and costs associated with fragmenting services among different providers.*** For example, what are the risks of undergoing a tubal ligation in a separate procedure instead of during hospitalization for delivery? Will insurance cover the sterilization in these circumstances?

9. ***Evidence that large purchasers of health care in the area (such as large employers or insurers) are concerned about an increase in prices as a result of the merger.*** Are they worried that if all area hospitals are under single management, purchasers will lose their ability to bargain for better prices?

10. ***Expressions of concern from prominent physicians in the community about the impact of the merger on the delivery of health care.*** What concerns do they have from the medical perspective? Do they fear that their own practices will be impaired in any way? Are any local physicians who provide abortions or other reproductive health services concerned that they may be denied privileges at religiously-affiliated hospitals if they continue to perform these services elsewhere, or if they publicly support the availability of such services?

Appendix C

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Notes

1. Stanley K. Henshaw & Jennifer Van Vort, *Abortion Services in the United States, 1991 and 1992*, Fam. Plan. Persp., May-June 1994, *reprinted in* Henry J. Kaiser Family Foundation, *What's Happening to Abortion Rates?* 10 (1996) [hereafter Henshaw & Van Vort]; *see also* Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, Fam. Plan. Persp., March- April 1995, *reprinted in* Henry J. Kaiser Family Foundation, *What's Happening to Abortion Rates?* 26 (1996) [hereafter Henshaw].

2. Henshaw & Van Vort, *supra*, at 10-11.

3. *Id.* at 10. Moreover, 92% of counties had no provider that performed at least 400 abortions per year. This is significant because small providers often do not want a large abortion case load, and they usually do not advertise; hence, women may have difficulty finding out about and obtaining services from these providers. *Id.*

4. Henshaw, *supra*, at 11.

5. *Id.* at 10-11. A metropolitan area was defined as a county containing a central city with a population of 50,000 or more, along with any contiguous counties with close economic ties to the central city. *Id.*

6. National Abortion and Reproductive Rights Action League, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights* vii (1998) [hereafter *Who Decides?*].

7. Henshaw & Van Vort, *supra*, at 22.

8. *Id.* at 18.

9. *Id.* at 17.

10. *Id.* at 15. The other providers were abortion clinics, other non-hospital clinics, and physicians' offices. *Id.*

11. *Id.* at 22; *see also* Am. College of Obstetricians and Gynecologists, *Guidelines for Women's Health Care* 128-29 (1996) [hereafter ACOG] (advising that for some later abortions and for patients with certain risk factors, a hospital or ambulatory surgical facility is the preferred setting for abortion and in some states is required). The U.S. Supreme Court has struck down as unconstitutional a requirement that all abortions after the first trimester be performed in a hospital. *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983). However, the Oklahoma state supreme court recently upheld such a requirement, and ordered the state to enforce it, opining that *Akron* is no longer valid. *Davis v. Fieker*, 1997 OK. 156 (Dec. 23, 1997).

12. Henshaw & Van Vort, *supra*, at 22. A 1983 study found that 9% of obstetrician-gynecologists said they did not provide abortion services because they did not have access to a hospital that permitted the procedure. M.T. Orr & J.D. Forrest, *The Availability of Reproductive Health Services from U.S. Private Physicians*, Fam. Plan. Persp. 17 (1985), at 63-69, Table 3.

13. Ellen Gamerman, *Scarce South Shore Abortion Services Prompt Lobbying Effort*, Sts. News Serv., June 30, 1993.

14. Henshaw & Van Vort, *supra*, at 22; *see also*, ACOG, *supra*, at 129 ("Clinics and freestanding ambulatory care facilities should have an established mechanism for transferring [abortion] patients who require emergency treatment to a nearby hospital"); National Abortion Fed'n., *Clinical Policy Guidelines* 31-32, 41 (1997) (recommending transfer to a local hospital in circumstances involving hemorrhage and other emergencies). The American Medical Association estimated that in 1990 in Florida, one out of every 1,000 women undergoing an abortion suffered a complication that required admission to a hospital. Candy Hatcher, *Abortion Services Safer, Harder to Find*, Palm Beach Post, Aug. 9, 1994, at 1A.

15. The concentration of abortion services in freestanding, specialized clinics has produced other troubling consequences. These facilities — and the physicians and staff who work there, as well as patients seeking care — are easy targets for anti-abortion harassment, threats, and outright violence. As a result, some women may be deterred from using their services, and in addition, as abortion services have become more isolated from the mainstream of medical care, it has become more difficult to attract new providers to the field. See, e.g., Jack Hitt, *Who Will Do Abortions Here?*, N.Y. Times Mag., Jan. 18, 1998, at 20. *See also* Henshaw & Van Vort, *supra*, at 23. In addition, as fewer hospitals offer abortion services, even doctors willing to perform abortions have difficulty getting the necessary training.

16. Nineteen states currently have mandatory waiting periods that prohibit a woman from obtaining an abortion until a specified period of time after receiving a mandated lecture or materials. *Who Decides?, supra*, at xi.

17. The "Hyde Amendment" prohibits federal Medicaid funding for abortions except when the woman's life is endangered or the pregnancy is the result of rape or incest. Twenty-seven states have followed the federal precedent and similarly restrict the use of state funds. *Who Decides?, supra*, at xii.

18. Am. Med. Ass'n. Council on Scientific Affairs, *Induced Termination of Pregnancy Before and After Roe v. Wade: Trends in the Mortality and Morbidity of Women* 14 (1992) [hereafter AMA Council on Scientific Affairs].

19. One study showed that about half the women who had an abortion after 15 weeks of pregnancy were delayed by difficulties they encountered in making arrangements to pay for the procedure. AMA Council on Scientific Affairs, *supra*, at 15.

20. Henshaw, *supra*, at 42 (noting that 14% of non-hospital providers reported an average delay of more than one week even before waiting periods were in effect).

21. *Id.* at 41.

22. AMA Council on Scientific Affairs, *supra*, at 14.

23. *Id.* at 15-16.

24. Bruce Japsen, *Another Record Year for Dealmaking*, Modern Healthcare, Dec. 23-30, 1996 [hereafter *Another Record Year*], at 37. Modern Healthcare's list included full-asset mergers, acquisitions, lease agreements, joint ventures and partnerships of various forms in which control or a significant equity stake in a hospital changed hands. It also included acquisitions through what many hospitals, including Catholic facilities, refer to as "sponsorships." *Id. See also* Kevin Lumsdon, *Deals That Went Down the Drain; Mergers and the Health Care Industry*, Hosps. & Health Networks, Nov. 20, 1996, at 20 (reporting that hospitals are leading a "merger marathon").

25. *Another Record Year, supra*, at 37. Modern Healthcare's analysis for 1997 showed a drop-off from 1996 but the numbers remain significant (217 transactions involving 627 hospitals in 1997). Bruce Japsen, *An Off Year for Consolidation*, Modern Healthcare, Jan. 12, 1998, at 39.

26. Jack Reardon & Laurie Reardon, *The Restructuring of the Hospital Services Industry*, 29 Journal of Econ. Issues 1063 (1995).

27. *Id.*; *see also Consolidation in the Health Care Market: Good or Bad for Consumers*, States of Health (The Center for Community Health Action, Boston, Mass.), Feb. 1996, at 1; Tamar Lewin, *As Health Mergers Rise, Some Say Catholic Standards May Affect Care*, N.Y. Times, Mar. 8, 1995 [hereafter Lewin], at A1.

28. *See, e.g.*, Lewin, *supra*, at A1.

29. Bruce Japsen, *Catholic Providers Seek Recapitalization Strategies*, Modern Healthcare, July 8, 1996, at 50; Thomas P. Weil, *The Survival of Catholic Health Care: Geographically Linked Networks*, Health Care Strategic Management, July 1, 1995, at 3.

30. Rhonda L. Rundle, *Hardly Meek: Catholic Hospitals, In Big Merger Drive, Battle Industry Giants*, Wall St. J., Mar. 12, 1997 [hereafter Rundle], at 1. *See also* Lisa W. Foderaro, *In Health Care's New Era, Catholic Institutions Link Up to Compete*, N.Y. Times, June 27, 1996, at B1; Arthur Jones, *Huge Nonprofit System Feels Pressure To Cut Costs, Merge, and Get Bigger*, National Cath. Rep., June 16, 1995, at 11.

31. Catholics for a Free Choice, *Risky Business: The Community Impact of Catholic Health Care Expansion 2* (1995) [hereafter *Risky Business*].

32. *Risky Business, supra*, at 2; *see also*, Lewin, *supra*, at A1.

33. Catholics for a Free Choice, *Reproductive Health at Risk: A Report on Mergers and Affiliations in the Catholic Health Care System* (1995) [hereafter *Reproductive Health at Risk*]. According to the Catholic Health Association, in 1994 there were more than 100 mergers, affiliations, and joint ventures between Catholic and non-Catholic hospitals, health maintenance organizations and managed care networks. Lewin, *supra*, at A1.

34. Catholics for a Free Choice, *When Catholic and Non-Catholic Hospitals Merge: Reproductive Health Compromised* (1998) [hereafter *Reproductive Health Compromised*], at 3, 8.

35. Carole S. Weisman, et al., Kaiser Family Found., *Affiliations Between Catholic and Non-Catholic Health Care Providers and the Availability of Reproductive Health Services: Is there a Common Ground?* (1997) [hereafter Kaiser Report].

36. Kenneth R. White & Yasar A. Ozcan, *Church Ownership and Hospital Efficiency*, Hosp. & Health Serv. Admin. Found. of the Am. College of Healthcare Executives, Sept. 1996; *see also*, Rundle, *supra*, at 1; Catholics for a Free Choice, *Health Care Limited: Catholic Institutions and Health Care in the United States* (1995) [hereafter *Health Care Limited*], for additional information on the scope and nature of the Catholic health care system.

37. *Mission Gives Us An Advantage*, Cath. Health Progress, July-Aug. 1996, at 30-31. The article notes that even the huge Columbia/HCA hospital chain is significantly smaller (with 300 hospitals, 60,000 beds, $14.5 billion in revenues, $16 billion in assets, and only three states with a 20% market share).

38. Catholics for a Free Choice reports that 76 Catholic hospitals, in 26 states, have been designated "sole community providers" by the Health Care Financing Administration of the U.S. Department of Health and Human Services (HCFA). *Reproductive Health*

Compromised, *supra*, at App. G. HCFA defines a sole provider as one that is located at least 35 road miles or 45 minutes by road from the nearest like facility (short-term acute care hospital), or meets certain other criteria. Most of the sole provider Catholic hospitals serve communities that are not predominantly Catholic. *Id.; see also Health Care Limited, supra*, at App. B.

39. *Ethical and Religious Directives for Catholic Health Care Services* [hereafter *Directives*], Preamble.

40. *Directives, supra*, at Part 1, Directive 5.

41. *Id.* at Part 4, Directive 45 ("Abortion, that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus, is never permitted").

42. *Id.* at Part 4, Directive 52 ("Catholic health institutions may not promote or condone contraceptive practices" other than counseling in methods of natural family planning).

43. *Id.* at Part 4, Directive 53 ("Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution when its sole immediate effect is to prevent conception").

44. *Id.* at Part 4, Directives 38-41 (covering assisted conception that "substitutes for the marital act," including in vitro fertilization and artificial insemination).

45. *Id.* at Part 4, Directive 45 (abortion includes termination of pregnancy in the interval between conception and implantation of the embryo); *see also Directives, supra*, at Part 3, Directive 36 and note 19 (recommending that "a sexually assaulted woman be advised of the ethical restrictions which prevent Catholic hospitals from using abortifacient procedures").

46. Clara Bell Duvall Education Fund, Fact Sheet *The Declining Number of Hospitals in Pennsylvania Willing to Perform Abortions* (1997).

47. *Health Care Limited, supra*, at 15.

48. John Lavey, *Nonprofit Medical Partnership Benefits MTMC*, Nashville Bus. J., Oct. 21, 1996, at 6.

49. *Columbia To Do No Abortions in Georgia*, Courier-J., May 18, 1995, at 1C.

50. *Reproductive Health at Risk, supra*, at 5.

51. *Reproductive Health Compromised, supra*, at 24.

52. *Reproductive Health at Risk, supra*, at 24. *See also* Laura Parker, *In Quad Cities, 'a chess match' over abortion*, USA Today, Jan. 19, 1998, at 6A (describing Planned Parenthood's three-year legal battle to obtain approval to open a clinic in the area that would offer abortion services).

53. Kaiser Report, *supra*, at 80-81. In the Kaiser Report, "Case C" is readily identifiable as the Quad Cities merger. In the four cases selected for examination in this study, few changes were found in the availability of reproductive health services overall, with one important exception: abortion services, which were discontinued altogether after two of the mergers. With respect to abortion, the report concludes: "Hospital-based surgical abortions (other than to save the life of the women) are often curtailed after affiliations, although in some cases they may continue to be provided by the non-Catholic partner." *Id.* at 41.

54. *Columbia To Do No Abortions in Georgia, supra*, at 1C. *See also* Janet Gallagher, *Religious Freedom, Reproductive Health Care and Hospital Mergers*, J. Am. Med. Women's Ass'n., Spring 1997, at 65.

55. Family Planning Advocates of New York State's MergerWatch Project, *Religious Hospital Mergers and HMOs: the Hidden Crisis for Reproductive Health Care* 23 (1997-98 edition).

56. Karen Pallarito, *Blessing Withheld: Vatican Rejects Deal Involving N.J. Catholic Hospital*, Modern Healthcare, June 23, 1997, at 20; *see also, Hospital May Eliminate Abortion Services,* Brunswick Home News, Sept. 17, 1996.

57. *Planned Kenosha Hospital Merger Falls Apart Over 'Cultural Differences,'* Health Care Pol. Rep. (BNA), June 30, 1997, at 1031.

58. Arthur Jones, *Huge Nonprofit System Feels Pressure to Cut Costs, Merge and Get Bigger*, Nat'l. Cath. Rep., June 16, 1995, at 11.

59. *See, e.g.*, Liz Kowalczyk, *Local Hospitals Provide Array of Services*, Patriot Ledger, Sept. 24, 1996, at 8A (reporting that Cardinal Law blocked a nearly-completed merger between the Catholic-owned Carney Hospital in Boston and the city-owned Quincy Hospital because doctors at Quincy perform abortions).

60. *Reproductive Health at Risk, supra*, at 21-22, 27-28.

61. Stuart Vincent, *Port Jeff Hospitals in Alliance*, Newsday, May 9, 1996, at A25.

62. Ted Griggs, *Hospitals OK Pact to Expand,* Advocate, Capital City Press, Apr. 9, 1997, at 1A.

63. John Lavey, *Nonprofit Medical Partnership Benefits MTMC*, Nashville Bus. J., Oct. 21, 1996, at 6.

64. Michele Conklin, *Technicality Allows Lutheran Hospital to Continue Abortions*, Rocky Mountain News, Nov. 23, 1996, at 113.

65. Another approach that may be of some value is a referral requirement. In one case where the merged entity stopped providing reproductive health services, it was ultimately required to provide patients with a detailed, up-to-date list of area providers, review the list with patients, and follow up to determine whether the patient obtained the services needed. This requirement resulted from the settlement of a lawsuit brought by Family Planning Advocates of New York State against the state of New York after it approved a merger (under state health laws requiring approval of a change in hospital ownership) between a Catholic and a non-Catholic facility in Troy, New York in 1996. Such a referral requirement, however, may be difficult to enforce and is not a real guarantee of access to services, since it does not restore services that are lost or ensure that they are available elsewhere in the immediate area.

66. 15 U.S.C. §§ 1, 2 (1988).

67. 15 U.S.C. § 12, *et seq.* (1988).

68. A third federal antitrust statute, the Federal Trade Commission Act, prohibits "unfair or deceptive acts or practices." 15 U.S.C. § 45 (1988). It is generally co-extensive with the Sherman and Clayton Acts, but can be enforced only by the Federal Trade Commission.

69. Clayton Act §§ 4, 16, 15 U.S.C. §§ 15, 26 (1988).

70. Section 7 of the Clayton Act prohibits a merger or acquisition "where in any line of commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18. For purposes of antitrust analysis, "mergers" and "acquisitions" can be used loosely and interchangeably to cover a wide variety of transfers or consolidations of rights of ownership or control, whether or not technically a merger or acquisition. The analysis of competitive effects presented here also would apply to any "joint venture" or "interlocking directorate" situation where control over the secular hospital's service options was placed in the hands of the religiously-affiliated hospital. However, there may be situations where the structure of a transaction affects the analysis: for example, a joint venture may be open to challenge only under the Sherman Act.

71. A 1980 amendment to the Clayton Act made this clear. Pub. L. No. 96-349, § 6(a), 94 Stat. 1157 (codified as amended at 15 U.S.C. § 18 (1994)). It is not difficult to show that any hospital engages in activities affecting interstate commerce — such as ordering supplies from out of state or receiving revenues from out-of-state insurers. The federal agencies, however, have issued a policy statement that they will not challenge a hospital merger involving small hospitals (generally meaning where the acquired hospital has an average of fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients), as noted below in the text.

72. Section 7's coverage of acquisitions of assets of not-for-profit entities remains in dispute, although the stronger line of authority holds that it does apply. *Compare FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1214-17 (11th Cir. 1991) (§ 7 covers asset acquisitions of nonprofit hospitals), *and United States v. Rockford Mem'l. Corp.*, 898 F.2d 1278, 1280-81 (7th Cir. 1990) (same), with *United States v. Carilion Health Sys.*, 707 F. Supp. 840, 841 n.1 (W.D. Va. 1989), *aff'd without opinion*, 892 F.2d 1042 (4th Cir. 1989) (such acquisitions beyond scope of § 7), *and FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996) *aff'd,* 121 F.3d 708 (6th Cir. 1997) (non-profit status of hospital not a dispositive consideration, but nevertheless relevant to issue of anticompetitive effects).

73. Under a 1996 agreement intended to avoid duplicative investigations, the DOJ and FTC allocate each merger between them as it arises. Some whole industries historically "belong" to one agency or the other, but they both have a claim to health care and hospital mergers.

74. *See, e.g.*, Joel Brinkley & Laura M. Holson, *Aiding Consumers Is Now the Thrust of Antitrust Push*, N.Y. Times, Mar. 22, 1998, at A1; Steven Pearlstein, *Applying the Brakes to Mergermania: Antitrust Law Enjoys A Revival*, Washington Post, Mar. 10, 1998, at C1.

75. 15 U.S.C. § 18a (1976).

76. The HSR Act and its regulations are very complex, but in general the Act applies to transactions valued at over $15 million if the following prerequisites are met: (a) one of the merging parties has net sales or total assets of at least $100 million, and the other has net sales or total assets of at least $10 million; and (b) after the acquisition, the acquiror holds either (i) 15% or more of the voting securities or assets of the acquired, or (ii) voting securities or assets of the acquired valued in excess of $15 million.

If these size-of-person and size-of-transaction thresholds are met, both the acquired and acquiring parties must submit certain information describing the proposed transaction, the parties' facilities and capabilities, the market(s) in which they compete, and any studies or reports the parties possess that assess the competitive impact of the proposed transaction. The reviewing agency has 30 days to consider this information and decide whether the transaction may proceed or requires further investigation. If further investigation is called for (as it likely will be when market shares are high and customers object), the government will issue a "second request" for further information. HSR prohibits consummation of a merger until a second request is fully responded to. Since sec-

ond requests call for an extensive range of documents and testimony from the parties, issuance of a second request typically delays a merger for another three to seven months.

77. *See, e.g.,* Business Advisory Letter from the Dep't. of Justice to Children's Health Care, P.A. (Mar. 1, 1996) (discussing the difficulty of establishing specialist physician practices).

78. *Department of Justice and Federal Trade Commission Horizontal Merger Guidelines*, reprinted in Antitrust and Trade Reg. Rep. (BNA) (Apr. 2, 1992 Special Supplement) [hereafter *Guidelines*]. The states, through the National Association of Attorneys General, have issued their own Horizontal Merger Guidelines, which differ somewhat from the DOJ-FTC Guidelines, but not in ways that contradict the general overview provided here. *Horizontal Merger Guidelines of the National Association of Attorneys General, reprinted in* Antitrust & Trade Reg. Rep. (BNA) (Apr. 1, 1993 Special Supplement).

79. *Guidelines, supra*, at para 0.1.

80. *Id.* at para 0.1, n. 6.

81. *Id.* at para. 2.1.

82. *Id.* at para. 1.1.

83. *See, e.g., FTC v. Hosp. Bd. of Dir. of Lee Co.*, 38 F.3d 1184 (11th Cir. 1994); *FTC v. Freeman Hosp.*, 69 F.3d 260 (8th Cir. 1995); *Hospital Corp. of Am. v. FTC*, 4 Trade Reg. Rep. (CCH) ¶ 22,301 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987); *In re American Med. Int'l., Inc.*, 104 F.T.C. 1, 4 Trade Reg. Rep. (CCH) ¶ 22,170 at 23,040 (1984); *American Medicorp v. Humana, Inc.*, 445 F. Supp. 589, 605 (E.D. Pa. 1977) (appropriate product market is "the delivery of short term acute care community hospital services").

84. *See, e.g., Butterworth Health Corp.*, 946 F. Supp. 1285 (product market of primary care inpatient hospital services upheld by the court, though merger permitted due to efficiency defense); *United States v. Carilion Health Sys.*, 707 F. Supp. 840 (W.D. Va. 1989) (primary, secondary, and tertiary care product markets upheld by court, though merger permitted due to jurisdictional defense). *But see United States v. Long Island Jewish Med. Ctr. and North Shore Health System, Inc.*, 1997-2 Trade Cas. ¶ 71,960 (E.D.N.Y. Oct. 23, 1997) (rejecting product market of "acute inpatient services provided by anchor hospitals"). *See also* HealthSouth Rehabilitation Corp., 60 Fed. Reg. 5401 (1995) (rehabilitation services adopted as product market in consent order with government); Columbia/HCA Health Care Corp., 59 Fed. Reg. 48883 (1994) (psychiatric services adopted as product market in consent order with government); Charter Medical Corp., 59 Fed. Reg. 60804 (1994) (outpatient surgery services adopted as product market in consent order with government).

85. *See, e.g., Long Island Jewish Med. Ctr.* 1997-2 Trade Cas. ¶ 71,960 (finding separate geographic markets for (1) primary and secondary care, and (2) tertiary care).

86. *See, e.g., FTC v. Freeman Hosp.*, 911 F. Supp. 1213 (W.D. Mo. 1995), *aff'd*, 69 F. 3d 260 (8th Cir. 1995) (13-county/54 mile radius market); *United States v. Mercy Health Servs.*, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated*, Nos. 95-4253, 96-1051, 1997 WL 78396 (8th Cir. Feb. 27, 1997) (70 to 100 mile radius market).

87. Market shares in hospital mergers are usually based upon a facility's licensed bed capacity for the service in question, and sometimes upon occupied beds. These statistics are publicly available from an annual publication of the American Hospital Association (located in Chicago, Illinois): The AHA Guide to the Health Care Field. In addition, most states have some administrative agency that publishes detailed patient discharge data, organized by DRG (Diagnostic Related Group). Ultimately, the calculation of highly reliable market shares requires an economist with access to the operating documents of all the hospitals and clinics in the relevant market. However, for purposes of arousing federal or state interest in a merger, a simple "head count" of hospitals and clinics in a market, and an anecdotal description of their relative size and service offerings, should suffice.

88. *Guidelines, supra*, at para. 1.50-1.52. The HHI is calculated by squaring the percentage market share of each firm in the market and then adding those squares. This results in a number somewhere between zero (an atomistic market) and 10,000 (a monopoly — 100% squared). The HHI is generally the most accurate measure of market concentration because it takes into account both the number and size distribution of all sellers in a market. In order to determine the change in concentration caused by a merger, the HHI is calculated based on the premerger market shares and then again based on the post-merger market shares. The Guidelines state that the DOJ and FTC are likely to challenge a merger in the absence of countervailing factors when the post-merger HHI exceeds 1,800 and the change in the HHI as a result of the merger is greater than 50. An HHI of 1,800 would be achieved in a market with six equally-sized hospitals. In practice, however the federal agencies rarely challenge hospital mergers unless they involve markets with four or fewer significant competitors (that is, a post-merger HHI of over 3,000).

89. Department of Justice and Federal Trade Commission *Statements of Antitrust Enforcement Policy in Health Care*, Statement 1, *reprinted* in 5 Health L. Rep. (BNA) 35 (Aug. 29, 1996) at d34.

90. *Guidelines, supra,* at para. 3.0.

91. However, if women's reproductive health services are fractured into distinct product markets, entry may be deemed easy for any service that can be provided from a doctor's office or freestanding clinic. For example, because contraceptive advice, prescriptions and fittings are not necessarily hospital-based services, their elimination from the merged hospital's offerings might be countered by expanded service from non-hospital sites.

92. Numerous cases have so held. *See, e.g., United States v. Rockford Mem'l. Corp.*, 898 F.2d 1278 (7th Cir. 1990), *cert. denied*, 498 U.S. 920 (1990); *University Health*, 938 F. 2d 1206.

93. *Guidelines, supra*, at para. 4.

94. *Id.*

95. While the Supreme Court has held that cost savings in one product market cannot offset anticompetitive effects in another market, *United States v. Philadelphia Nat'l. Bank*, 374 U.S. 321, 370-71 (1963), the enforcement agencies, in their prosecutorial discretion, do take such arguments into account when deciding whether to challenge a merger — especially in the face of recent court decisions signaling a new receptiveness to "overall community benefit" arguments. *Butterworth*, 946 F. Supp. 1285.

96. A hospital may argue, for example, that if a substantial portion of its revenue comes from government payers (such as Medicare), these payers will be unaffected by hospital efforts to exercise market power, because they set the price at which they will pay for services. If only a small amount of revenues is subject to price competition, then the dollar magnitude of any effects on price due to a merger may also be relatively minor.

97. *See, e.g., University Health*, 938 F.2d at 1223; G. Cary, Deputy Director for Mergers, Federal Trade Comm'n, Staying Ahead of the Merger Wave, Remarks before 15th Annual Corporate Counsel Institute (Dec. 12, 1996).

98. *University Health*, 938 F.2d at 1223; *Rockford Mem'l.*, 717 F. Supp. at 1289; *Mercy Health Servs.*, 902 F. Supp. at 987-88; *see also Long Island Jewish Med. Ctr.*, 1997-2 Trade Cas. ¶ 71,960 (finding that efficiencies produced by the merger would benefit consumers, but based in part on agreement between the merging hospitals and the state Attorney General committing the hospitals to pass on the cost savings to the community).

99. *International Shoe Co. v. FTC*, 280 U.S. 291 (1930); *Citizen Publ'g. Co. v. United States*, 394 U.S. 131 (1969).

100. *Guidelines, supra*, at para. 5.1.

101. *Id.*

102. This excludes those that fall within the small hospital safety zone set out in the Statements of Antitrust Enforcement Policy in Health Care, noted above.

103. There is, on the other hand, some case law holding that the Sherman Act requires a stronger showing of anticompetitive effects than Section 7 of the Clayton Act. *See United States v. Penn-Olin Chem. Co.*, 378 U.S. 158, 170-71 (1964) (comparing standards of illegality under Clayton Act § 7 and Sherman Act § 1). However, later decisions have largely eroded this distinction. *See, e.g., United States v. First Nat'l. Bank & Trust Co.*, 376 U.S. 665, 671-72 (appearing to apply § 7 standards in a challenge under § 1); *Rockford Mem'l.*, 898 F.2d at 1282-83 (judicial interpretation of the two laws has converged); *McCaw Personal Communications, Inc. v. Pacific Telesis Group*, 645 F. Supp. 1166, 1173 (N.D. Cal. 1986) ("the standard . . . under the Sherman Act is similar, if not identical, to that under the Clayton Act"); *United States v. Central State Bank*, 621 F. Supp. 1276, 1294-95 (W.D. Mich. 1985) ("the emphasis on market concentration in § 7 cases is relevant to cases brought under § 1").

104. *McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232, 244 (1980).

105. *Standard Oil Co. v. United States*, 221 U.S. 1, 58 (1911).

106. *National Soc'y. of Prof'l. Engineers v. United States*, 435 U.S. 679, 688, 696 (1978); *Board of Trade v. United States*, 246 U.S. 231, 238 (1918).

107. *Nelson v. Monroe Reg'l. Med. Ctr*, 925 F.2d 1555, 1564 (7th Cir. 1991) (citations omitted). The case was apparently settled on remand, and we are not aware of any cases in which it has been followed.

108. A merger that would result in very high market shares might also be subject to challenge as a violation of Section 2 of the Sherman Act, which prohibits monopolization and attempts to monopolize.

109. *An H.M.O., Catholic Run, Bars Coverage for Abortions*, N.Y. Times, Nov. 17, 1997, at A25. Fidelis reportedly will refer members to other health care providers for these services when they ask, but the lack of access within their own HMO clearly will make it more difficult for these low-income women to obtain needed services.

110. *See, e.g., Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1411 (7th Cir. 1995); *U.S. Health Care v. Healthsource, Inc.*, 986 F.2d 589, 599 (1st Cir. 1993); *Ball Mem'l. Hosp., Inc. v. Mutual Hosp. Ins. Co.*, 784 F.2d 1325, 1329 (7th Cir. 1986).

111. The federal government appears ready to argue for an HMO market in an appropriate case. The FTC and DOJ submitted a joint amicus brief to the 7th Circuit, asking the court to amend its opinion in the Marshfield Clinic case to allow for the possibility that the HMOs could constitute a discrete product market. The court originally had stated that HMO market power must be analyzed in the overall health care financing market, but in response to the FTC/DOJ petition, it modified its position to state that while HMOs did not constitute a market in that particular case, HMOs might be distinguishable from other forms of health care financing on a different record. *Marshfield Clinic*, 65 F.3d at 1411. *See also* Mary Chris Jacklevick, *Court Amends Its Opinion in Marshfield Clinic Ruling*, Modern Healthcare, Oct. 1995, at 2.

112. Catholics for a Free Choice cites an example of a religiously-affiliated health center in Springfield, Missouri that bought out the practices of dozens of local physicians, leaving independent practitioners with almost no patients. An insurance company that runs another HMO in Missouri warned that such massive physician-hospital organizations in Missouri had formed "an almost impenetrable wall" deterring competition by other health plans. *Health Care Limited, supra*, at 24.

113. Department of Justice and Federal Trade Commission *Statements of Antitrust Enforcement Policy in Health Care, supra*, at Statements 8 and 9.

114. Examples of physician-owned health plans are individual practice associations (IPAs) and preferred provider organizations (PPOs). These affiliations typically provide medical services to subscribers of health plans, but do not act as an insurer, as does an HMO. However, the concern over foreclosure also arises in the context of "multiprovider networks," such as physician-hospital organizations, and could extend to insurer-owned plans, such as HMOs, provided the market is not held to be national health care financing (see discussion above).

115. As noted earlier, the geographic boundaries of a market will vary according to the typical patient's willingness and ability to travel for a specific service. The product market in this context would include physician-provided reproductive health services regardless of whether offered in a hospital, physician's office, or elsewhere.

116. According to one report, "Subtly or overtly, church authorities sometimes try to prevent physicians affiliated with Catholic facilities from performing abortions or sterilizations at non-Catholic facilities." *Health Care Limited, supra,* at 22.

117. *Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 761 (1984).

118. *Compare, e.g., Nurse Midwifery Assoc. v. Hibbert*, 918 F.2d 605 (6th Cir. 1990), and *Bolt v. Halifax Hosp. Med. Ctr.*, 891 F.2d 810 (11th Cir.), *cert. denied*, 110 S. Ct. 1960 (1990) (finding conspiracy) *with Potters Med. Ctr. v. City Hosp. Ass'n.*, 800 F.2d 568 (6th Cir. 1986) (finding no conspiracy).

119. *See, e.g., Weiss v. York Hosp.*, 745 F.2d 786 (3rd Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985); *Oksanen v. Pase Mem'l. Hosp.*, 912 F.2d 73 (4th Cir. 1990).

120. *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440 (9th Cir. 1988).

121. *Medical Staff of Mem'l. Med. Ctr.*, 110 F.T.C. 541 (1988).

122. *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 30 (1984).

123. *FTC v. Indiana Fed'n. of Dentists*, 476 U.S. 447, 460-61 (1986).

124. One approach is to call the head of each agency's Health Care Division, located in Washington, D.C., who may refer the call to the appropriate staff attorney. Currently, the FTC's Health Care Division, within the Bureau of Competition, is headed by Robert Leibenluft (202-326-3688). DOJ has a Health Care Task Force within the Antitrust Division, currently headed by Gail Kursh (202-307-5799).

125. Lawrence R. Fullerton, *The Role of Third Parties in Agency Merger Reviews (How Can I Stop That Merger?),* Antitrust, Spring 1995, at 37-38.

126. *Id.* at 38.

127. *Id.* at 39-40.

128. *See* Section 16 of the Clayton Act, 15 U.S.C. § 26 (1994); *see also Georgia v. Pennsylvania R.R. Co.*, 324 U.S. 447 (1945) (establishing common law authority of state to sue under federal antitrust law for injunctive relief as parens patriae for threatened harm to its general economy and welfare).

129. *See* Section 4C of the Clayton Act, 15 U.S.C. § 15c (1988).

130. The Antitrust Section of the American Bar Association has published a three-volume treatise entitled "State Antitrust Practice and Statutes," which is an excellent source of information on state laws.

131. The states would thereby follow federal precedent under which mergers can be challenged as unreasonable restraints of trade. *But see California ex rel. Van de Kamp v. Texaco, Inc.,* 762 P.2d 385 (Cal. 1988), holding that a merger may not be challenged under California's analogue to Section 1 of the Sherman Act (the Cartwright Act).

132. Alaska Stat. § 45.50.568 (Michie 1994); Ark. Code Ann. § 4-75-302 (Michie 1991); Colo. Rev. Stat. § 6-4-107 (Michie 1994); Haw. Rev. Stat. § 480-7 (1985); La. Rev. Stat. Ann. § 51:125 (West 1987); Me. Rev. Stat. Ann. tit. 10, § 1102-A (West 1994); Miss. Code Ann. § 75-21-13 (1973); Neb. Rev. Stat. § 59-1606 (1993); N.J. Stat. Ann. § 56:9-4 (West 1989); Ohio Rev. Code Ann. § 1331.021 (Anderson 1993); S.C. Code Ann. § 39-3-110 (Law Co-op. 1985); Tex. Bus. & Com. Code Ann. § 15.05(d) (West 1987); Wash. Rev. Code Ann. § 19.86.060 (West 1989).

133. These statutes are intended to provide certain mergers and other transactions with an exemption from federal antitrust scrutiny under the "state action immunity" doctrine, by subjecting the transactions to state regulatory control. Numerous court decisions recognize that when a state takes official action to replace competition with regulation, that "state action" and the conduct it endorses are immune from liability under federal antitrust laws. *Parker v. Brown*, 317 U.S. 341 (1943). However, it remains an open question whether, and under what circumstances, this state action immunity doctrine will apply to health care mergers that have passed state review under these statutes. The Supreme Court has not yet addressed the issue of state action immunity in the specific context of private hospital mergers.

134. Hospital Efficiency and Cooperation Act, 1993 Colo. Sess. Laws 120 (codified as amended at Colo. Rev. Stat. §§ 25.5-1-501 to -516 (1995)).

135. Health Reform Act of 1993, 1993 Fla. Laws ch. 129 (codified at Fla. Stat. Ann. § 395.304 (1993), renumbered as 381.04065 and amended by 1995 Fla. Laws ch. 95-298, amended by 1997 Fla. Laws ch. 97-237).

136. Hospital Authorities Law, 1993 Ga. Laws 1020 (codified at Ga. Code Ann. § 31-7-72.1 (1993)).

137. Idaho Health Planning Act, 1994 Idaho Sess. Laws 283 (codified at Idaho Code §§ 39-4901 to 4904 (1994)).

138. Health Care Provider Cooperation Act, 1994 Kan. Sess. Laws 153 (codified at Kan. Stat. Ann. §§ 65-425, 65-4909 (1996)).

139. Hospital Cooperation Act of 1992, 1992 Me. Laws 814 (codified as amended at Me. Rev. Stat. Ann. tit. 22, §§ 1881-88 (West 1995)).

140. Act Providing for Universal Health Care Access, 1993 Mont. Laws 606 (codified at Mont. Code Ann. § 50-4-601 *et. seq.* (1993); amended by 1995 Mont. Laws ch. 378, 526)).

141. Health Care Facility-Provider Cooperation Act, 1994 Neb. Laws 1223 (codified at Neb. Rev. Stat. Ann. § 71-7701 to 7711 (Michie 1994)).

142. Cooperative Programs and Networks in Rural Areas Act, 1993 N.Y. Laws 731 (codified as amended at N.Y. Pub. Health Law §§ 2950-2958 (McKinney 1997)).

143. Hospital Cooperation Act of 1993, 1993 N.C. Sess. Laws 529 (codified at N.C. Gen. Stat. § 131E-192.1 to -192.13 (1996)).

144. Health Care Provider Cooperative Agreements, 1993 N.D. Laws 263 (codified as amended at N.D. Cent. Code §§ 23-17.5-01 to -12 (1995)).

145. Voluntary Cooperative Actions to Improve Health Care, 1992 Ohio Laws 209 (codified at Ohio Rev. Code Ann. §§ 3727.21 to .24 (Anderson 1996)).

146. Cooperative Programs for Transplant Services, 1993 Or. Laws 769 (codified as amended at Or. Rev. Stat. §§ 442.700 to .760 (1996)).

147. Health Care Cooperation Act, 1994 S.C. Acts 437 (codified at S.C. Code Ann. §§ 44-7-500 to -590 (Law Co-op. 1996)).

148. Hospital Cooperation Act of 1993, 1993 Tenn. Pub. Acts 331 (codified at Tenn. Code Ann. §§ 68-11-1301 to -1309 (1993)).

149. Act Relating to Cooperative Agreements Among Hospitals, 1993 Tex. Sess. Law Serv. (codified as Tex. Health & Safety Code Ann. §§ 314.001-.008 (West. Supp. 1997)).

150. Health Services Act of 1993, Wash. Laws 492; §§ 44638 (codified as amended at Wash. Rev. Code §§ 43.72.300-.310 (1997)).

151. 1991 Wisconsin Act 250 Regarding Health Care Cooperative Agreements, 1991 Wis. Laws 250 (codified as amended at Wis. Stat. ann. §§ 150.84-.92 (West 1998)).

152. An overview on the nature and extent of these state laws, as of 1994, is provided in a report of the U.S. General Accounting Office entitled *Health Care: Federal and State Antitrust Actions Concerning the Health Care Industry*, GAO/HEHS-94-220 (August 1994).

153. Mont. Code Ann. § 50-4-603(2) (1995).

154. In reviewing the likely effects of the merger, state officials interviewed local providers and others, solicited and reviewed public comments, and held a public hearing. The record showed that about 12 abortions a year were being performed at the non-Catholic hospital.

155. *Montana Department of Justice Certificate of Public Advantage in the Matter of Columbus Hospital and Montana Deaconess Medical Center,* Great Falls, Montana, Mar. 6, 1996 (copy of State of Montana Department of Justice Findings of Fact, Conclusions of Law and Certificate of Public Advantage on file with the National Women's Law Center).

156. Review under the regulatory statutes cited in the previous footnotes may be lodged in a different unit of state government, but, if so, the state AG's office will redirect inquiries, so it is still the best place to approach first.

157. *Premerger Disclosure Compact*, reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,410 (1994).

158. *See* Richard Blumenthal et al., *Antitrust Review of Mergers by State Attorneys General: The New Cops on the Beat*, 67 Conn. B.J. 1 (Feb. 1993).

159. As noted, NAAG has issued Horizontal Merger Guidelines for its members' use. In addition, Massachusetts and Pennsylvania have issued statements outlining their own antitrust analyses of hospital mergers.

160. These might include, for example, the merging parties' statements of intent to eliminate reproductive health services, the religious directives that mandate such elimination, an explanation of the geographic boundaries of the local markets and a "quick count" of the competitive hospitals in the local market, along with some statistics on the number of women affected and the increased costs they will face in obtaining reproductive health services after the merger.

161. *See, e.g., Wisconsin v. Kenosha Hosp. and Med. Ctr.*, No. 96-CV-1459, 1996 WL 784584 (E.D. Wis. Dec. 31, 1996) (requiring merged hospital to save $43.7 million in operating costs over five years, or pay the deficiency to an indigent care fund; hospital must allow all qualified physicians to join its staff); *Pennsylvania v. Providence Health Sys. Inc.*, No. 4:CV-94-772, 1994 WL 374424 (M.D. Pa. May 26, 1994) (similar provisions).

162. *See* Section 16 of the Clayton Act, 15 U.S.C. § 26 (1994).

163. *California v. American Stores Co.*, 495 U.S. 271 (1990).

164. *See* Section 4 of the Clayton Act, 15 U.S.C. § 15 (1994).

165. 15 U.S.C. § 15(a) (1994).

166. *California v. American Stores,* 495 U.S. at 284.

167. *Brunswick Corp. v. Bowl-O-Mat, Inc.*, 429 U.S. 477 (1977). Although the antitrust injury doctrine was originally applied as a limitation on the standing of plaintiffs to seek damages in a merger case, it was subsequently extended to injunction actions as well. *Cargill, Inc. v. Monfort of Colo., Inc.*, 479 U.S. 104 (1986).

168. In a private merger suit seeking damages rather than injunctive relief, the standing requirements are more onerous, as a result of the courts' concern to avoid multiple and duplicative recoveries for the same antitrust violation. In a damage suit, the plaintiff must suffer injury to the plaintiff's "business or property" (*Cargill,* 479 U.S. 104); and the injury must be to "direct" purchasers (*Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1977)). In the circumstances presented here, such injury could include costs incurred by women forced to travel long distances to obtain reproductive health services, or harm to the medical practice of a physician left without a hospital in which to provide such services. But even if it were possible to satisfy these requirements in the kind of hospital merger challenge at issue here, there is an additional problem: in a private damage suit, the plaintiff must show actual injury, as opposed to "threatened" loss or damage from the merger (compare Sections 4 and 16 of the Clayton Act). Such actual merger-caused injury is notoriously difficult to prove because the defendants will attempt to attribute any harm to intervening causes unrelated to the merger. Therefore, few private damage actions are brought in merger cases, it is likely to be difficult to prevail in such an action here, and if relatively small monetary damages are likely to be proved, even tripled they may not justify the expense and difficulties of litigation.

Hospital Mergers and the Threat to Women's Reproductive Health Services: *Using Antitrust Laws to Fight Back*

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The increasing frequency of mergers involving religiously-affiliated hospitals represents a growing threat to the availability of women's reproductive health services. When hospitals governed by religious restrictions on abortion and other reproductive health services merge with other institutions that provide these services, needed health care services are often discontinued and members of the community lose access to them. One way in which those concerned about this erosion of services can take action to stop it is by using the antitrust laws, which are aimed at preserving vigorous competition between rival providers of goods and services, to ensure consumer choice.

Hospital Mergers and the Threat to Women's Reproductive Health Services: Using Antitrust Laws to Fight Back is a first-of-its kind resource guide, designed to provide health care advocates and others seeking to preserve access to reproductive health services with an understanding of how to use the nation's antitrust laws to challenge proposed hospital mergers that threaten to reduce or eliminate these services. Part One of the report provides information on the underlying problem—the diminishing availability of abortion and other women's reproductive health services—and the way in which mergers between secular and religiously-affiliated hospitals are making it worse. Part Two explains how antitrust laws apply to a prospective hospital merger that threatens to eliminate women's reproductive health services; outlines the factors antitrust enforcement authorities consider in analyzing these mergers; and describes ways to mount a challenge under the antitrust laws. The report also contains practical tools, such as a sample letter to the antitrust agencies, to assist advocates in making their case.

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