New Guidelines May Facilitate Hospital Mergers

BY DAVID A. ETTINGER, JD

On April 2, 1992, the U.S. Justice Department (DOJ) and Federal Trade Commission (FTC) issued their revised *1992 Merger Guidelines*, setting forth the federal agencies' antitrust analysis of mergers, acquisitions, and consolidations involving competitors.[1] The 1992 guidelines contain substantial information, both positive and negative, for hospitals contemplating transactions with competitors.

Most significantly, the 1992 guidelines appear to deemphasize the role of market share in analyzing hospital and other mergers. Market share was previously the most important factor in merger analysis, but now other factors, including the likelihood of anticompetitive effects, may be equally important. As James F. Rill, head of the DOJ Antitrust Division when the 1992 guidelines were issued, stated:

> There currently is growing recognition, in the new Guidelines and elsewhere, that it is *conduct*, not structure, that causes anticompetitive effects, although structure can influence the likely effect of conduct. Accordingly, the new Guidelines treat concentration [market share] not as an end in itself, but as an indicator that needs to be interpreted and considered along with other market factors.[2]

This change in the government's approach to mergers may offer a significant opportunity to hospitals with high market shares that have considered, and rejected, pursuing transactions with competitors. Under the new guidelines, some of these transactions may well be defensible.

However, not all antitrust enforcement officials appear to agree with Rill's view that other factors are of equal importance to market share in a merger analysis. The FTC may interpret this and other provisions of the guidelines differently. Thus, although the changes in the guidelines may prove important to hospitals, the success of a particular transaction could also depend on which antitrust agency reviews it.

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Market Share Analysis

One of the most important changes in the 1992 guidelines concerns their treatment of the parties' market shares, as reflected in the Herfindahl-Hirschmann Index (HHI). The HHI measures the degree of "concentration" (the size of the market shares and number of competitors) in a market. This is calculated by squaring the market shares of the parties in a market after a merger. The 1984 guidelines indicated that the government would "likely" challenge a transaction where the posttransaction HHI ranged from 1,000 to 1,800 with an increase of 100 or more resulting from the transaction.

Many hospital transactions would create increases that fall into this range. For example, a merger of two hospitals in a market with eight hospitals of equal size would result in an HHI of about 1,560, with an increase of 312. As a matter of practice, however, challenges in this HHI range have been rare. The 1992 guidelines now simply say that mergers in this range "potentially raise significant competitive concerns," depending on the other factors mentioned in the guidelines.

The 1984 guidelines stated that transactions with postacquisition HHIs greater than 1,800 and an increase of 100 or more would be challenged except in "extraordinary circumstances." (These HHI levels could be reached in markets with as many as six or seven competitors.) The 1992 guidelines indicate that for such transactions, a challenge will be "presumed," but that this presumption can be rebutted by the other factors.

The agencies have assessed the relative importance of concentration quite differently. Charles James, now acting head of the DOJ's Antitrust Division, has emphasized that "concentration is merely the starting point" in merger analysis, since the assessment of likely competitive effects

plays an "equal" role.[3] However, Kevin J. Arquit, head of the FTC's Bureau of Competition, states that "the 1992 Guidelines represent basic continuity with the earlier Guidelines' approach"[4] and "retain the prior Guidelines' concept that market concentration is fundamental to establishing the level of competitive concerns about a merger."[5]

Further Analysis of Markets

The 1992 guidelines also provide a basis for further analysis of the markets in which hospital transactions take place. Market definition, especially geographic market definition, is critical to analyses of many hospital mergers, since, in most cases, the larger the market, the lower the market shares and HHI levels. The 1992 guidelines do not, in most respects, significantly change the 1984 guidelines' treatment of market definition; however, the new guidelines do stipulate that the relevant market include, among others, so-called uncommitted entrants—firms that would likely begin to participate in the market within one year if prices were to rise a small but significant amount.

Hospital markets often include such uncommitted entrants, since a hospital can "enter" a new geographic area by such relatively inexpensive activities as expanding specialist outreach programs, establishing satellite clinics and educational programs, and increasing contacts with local hospitals and physicians in the new area. Some attorneys and economists have considered these factors as appropriate in defining relevant hospital markets. The 1992 guidelines confirm this analysis. Of course, such an "expansion" of the market will support arguments that a merger involves low shares and is not likely to lead to antitrust concerns.

Competitive Effects

The 1992 guidelines develop in much greater detail the factors other than concentration that can affect analysis of a transaction. One of these factors—the likelihood that the market will be conducive to collusion after the transaction—was contained in the 1984 guidelines. But it is emphasized and discussed in much greater detail in the 1992 guidelines, which refer to collusion as "coordinated interaction."

Among other things, the 1992 guidelines (like the 1984 guidelines) suggest that the existence of past collusion in a market will be very significant in determining whether the transaction will be challenged. Thus analysts of a hospital merger should carefully consider the history of contacts between competitors in the market to determine the possibility of collusion.

Geographic market definition is critical to analyses of many hospital mergers, since, in most cases, the larger the market, the lower the market shares and Herfindahl-Hirschmann Index levels.

The 1992 guidelines appear to limit the significance of large buyers in merger analysis, suggesting that their presence is important only in certain circumstances affecting the likelihood of collusion. This contrasts with a number of recent decisions in which courts approved mergers involving high market shares primarily because of the procompetitive influence of large buyers in the market.[6] This difference is crucial to hospitals, since large buyers of hospital services such as major payers and employers can substantially affect hospital markets, even those with high market shares. However, the guidelines may be less important than the case law in this area.

A new subject in the 1992 guidelines concerns a merger's effect on the merged firm's ability to raise its prices unilaterally. The 1992 guidelines indicate a challenge may be more likely under some circumstances where firms in the market sell distinctive products or services, and the merging firms' products or services are most similar. They suggest that a merger may have anticompetitive effects if:

1. A firm merges with or acquires the competitor that produces the goods or services which are the closest substitutes for those of the firm.
2. The merging firms have a combined market share of at least 35 percent.
3. The other firms in the market cannot easily reposition themselves to provide good substitutes for the products or services of the merging firms.

The theory behind this provision is that purchasers who prefer the services of the two merging firms may not have a good second choice after the merger. As a result, the merging firms may be able to raise prices, even when other competitors are in the market. The government has used this argument occasionally in the past, but it may become more prevalent now that it is formally contained in the guidelines.

It is possible that the government could attempt to apply this analysis to hospital mergers, since hospitals frequently offer distinctive services. For example, a transaction involving two hospitals that are close to each other, but far away from other hospitals in the market, might receive close attention from the government. The theory might be that, after the merger, persons living close to the two merging hospitals would not be inclined to use other hospitals because of their greater distance. Under this theory the transaction might therefore permit the merging hospitals to raise prices and still retain their business.

Similarly, if the two merging hospitals for the most part shared the same medical staff and the other hospitals in the market had mostly different physicians on their medical staffs, the government

might be concerned about the transaction. Under the guidelines' analysis, if patients did not wish to switch to hospitals at which their doctors did not practice, the merging hospitals might be able to raise prices and still retain their patients. In these circumstances, hospital mergers could pose concerns, even where the relevant HHI levels were under 1,800. However, to date this theory has not been accepted by the courts.

Efficiencies

Under the 1992 guidelines one factor in hospital merger analysis—the creation of efficiencies as a result of the merger—could grow in significance. The 1984 guidelines stated that efficiencies would be considered only when "clear and convincing" evidence of their importance existed. This phrase is absent from the 1992 guidelines, which indicate only that the merging parties carry the burden of proof with regard to efficiencies. Rill of the DOJ has indicated that this change reflects a conclusion that the "skepticism" concerning efficiencies in the 1984 guidelines was inappropriate.

The FTC, however, is apparently still skeptical about claims that mergers will increase efficiency. Arquit states that, in a defense of a "competitively troubling merger, . . . it is appropriate to limit significantly the ability of parties to justify the transaction on efficiency grounds."[7]

Additionally, the agencies may differ as to whether the benefits of increased efficiency will be credited if they are not passed on to consumers. Some government officials had previously required that gains from improved efficiencies be passed on to consumers in the form of lower prices before they would be considered relevant to merger analysis. Rill suggests this requirement will no longer be applied. Again, however, statements by FTC officials indicate that the FTC will be more inclined to credit the purported efficiencies when they are likely passed on to consumers.

Despite the differences between the two agencies, efficiencies are still a major factor in merger analysis—perhaps the most critical one in defending a merger between competing hospitals in a market with few competitors.

Financial Weakness

The 1992 guidelines appear to make it more difficult for firms to argue that their financial weakness is relevant to analysis of a merger. Unlike the 1984 guidelines, the new guidelines explicitly consider financial weakness only in connection with the "failing firm" defense, which is likely to apply in limited circumstances. The 1992 guidelines eliminate the 1984 provision that financial weakness can be considered in deciding whether a firm's market share overstates its competitive strength. This change could signal governmental skepticism about financial weakness arguments in mergers.

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It appears, however, that the DOJ considers the new guidelines to be neutral on the relevance of a firm's financial condition. Statements by James indicate that the elimination of the "financial weakness" reference was editorial, rather than substantive.[8] Again, the FTC has a different view. Arquit has stated that the elimination of the 1984 section "Financial Condition of Firms in the Relevant Market" from the new guidelines means that "poor financial condition, standing alone and short of imminent failure, [cannot] justify an anticompetitive merger."[9]

Despite the differences between the two agencies, financial weakness may still be a critical factor in many hospitals' decisions to merge. The FTC's comments indicate that its officials will be more interested in financial weakness as a symptom of an underlying structural problem, than as an independent reason to discount a hospital's market share.

More Than Market Shares

On balance, the 1992 guidelines suggest that an evaluation of a hospital merger cannot proceed simply on the basis of a mechanical application of market shares. Parties interested in pursuing a merger should—at the beginning of the planning process—carefully examine the merging hospitals, their history, and the market in which they operate. This kind of examination can maximize the possibility of success, even for a merger involving hospitals with high market shares. □

NOTES

1. 4 Trade Reg. Rep. (CCH), para. 13, 104.
2. James F. Rill, address to the American Bar Association's 40th Annual Antitrust Spring Meeting, Washington, DC, April 3, 1992.
3. Charles James, remarks before the Manufacturers' Alliance for Productivity and Innovation, Washington, DC, April 10, 1992.
4. Kevin J. Arquit, "Perspectives on the 1992 U.S. Government Horizontal Merger Guidelines," prepared remarks before the American Bar Association, Section of Antitrust Law, Washington, DC, April 2, 1992.
5. Kevin J. Arquit, "Further Thoughts on the 1992 U.S. Government Horizontal Merger Guidelines," prepared remarks before the State Bar of Texas, Dallas, April 24, 1992.
6. See, for example, *United States v. Baker Hughes, Inc.*, 908 F.2d 981 (D.C. Cir. 1990).
7. Arquit, "Further Thoughts."
8. James.
9. Arquit, "Perspectives."