

ARTICLES

HOSPITAL MERGERS AND THE THREAT TO WOMEN'S REPRODUCTIVE HEALTH SERVICES: APPLYING THE ANTITRUST LAWS

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I.

INTRODUCTION

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 of challenging these mergers is to use the antitrust laws, which are aimed at preserving vigorous competition between rival producers of goods and services to ensure consumer choice.

This article suggests that the antitrust laws provide an important set of tools for those concerned about the impact of a hospital merger on reproductive health services. The nation's antitrust laws are designed to preserve vigorous competition among rival providers of goods and services, in order to ensure that consumers can obtain the highest quality products and services at the lowest possible prices.¹ Mergers between hospitals are governed by these laws, principally section 7 of the Clayton Act, which bars mergers and acquisitions that may substantially lessen competition.² Proposed mergers that are large enough must be reported in advance to the

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1. This concept is embodied at the federal level in the Antitrust Amendments (Sherman) Act of 1990, 15 U.S.C. §§ 1, 2 (1994 & Supp. IV 1998), which prohibits agreements in restraint of trade and monopolization, and the Clayton Act, 15 U.S.C. §§ 13, 14-19, 20, 21, 22-27 (1994 & Supp. IV 1998), and 29 U.S.C. §§ 52, 53 (1994). See discussion *infra* Part III. A third federal antitrust statute, the Federal Trade Commission Act, prohibits "unfair or deceptive acts or practices." 15 U.S.C. § 45 (1994). It is generally coextensive with the Sherman and Clayton Acts, but can be enforced only by the Federal Trade Commission.

2. 15 U.S.C. § 18.

federal antitrust enforcement authorities, the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC).³ A merger subject to this "pre-merger clearance" requirement is delayed a minimum of thirty days to allow the DOJ or FTC to review it and, if necessary, to seek an injunction halting the transaction.⁴ The proposed merger may be enjoined if the court finds that it is likely to lead to substantially reduced competition in the relevant market.⁵

Both the DOJ and the FTC recently have become increasingly active in invoking this authority to challenge anticompetitive mergers, prompting considerable commentary on the revival of federal merger enforcement.⁶ State attorneys general also have authority to challenge mergers under the Clayton Act, as well as under state antitrust laws in many jurisdictions.⁷ Some, like their federal counterparts, have become increasingly active in merger enforcement in recent years.⁸ In light of these developments, those concerned about the harmful effects of hospital mergers on the availability of women's reproductive health services would be remiss if they did not consider the application of the antitrust laws to such transactions. It is also important to note that antitrust analysis applies to other types of transactions as well, such as mergers between HMOs,⁹ HMO activity that "locks

3. See *id.* § 18a(a).

4. *Id.* § 18a(b).

5. *Id.* § 18a(g)(2).

6. See, e.g., *FTC Touts Record Year for Enforcement Workload*, 75 *Antitrust & Trade Reg. Rep. (BNA)* 437 (1998) (stating that director William J. Baer attributed increased workload to merger filings); *For the Record*, MOD. HEALTHCARE, Oct. 26, 1998, at 32 (reporting that FTC received record 4643 pre-merger notifications and brought 50 antitrust enforcement actions—including 12 in health care sector—in fiscal year 1998, 43% increase over previous year); 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 Brakes to Mergermania: Antitrust Law Enjoys a Revival*, WASH. POST, Mar. 10, 1998, at C1; William J. Baer, Dir., Bureau of Competition, Federal Trade Comm'n, Remarks before the American Bar Association, Antitrust Section (Apr. 15, 1999), <http://www.ftc.gov/speeches/other/baerspaba99.htm> (noting that "merger wave" resulted in increased FTC activity).

7. 15 U.S.C. § 26.

8. See *Enforcement: ABA Committee Surveys Landscape of State Antitrust Law and Trade Regulation*, BNA ANTITRUST & TRADE REG. DAILY, Apr. 26, 1999 (one moderator noting "explosion" of cases brought by states); *Health Care: FTC Antitrust Official Identifies Trends in Enforcement for Health Care Industry*, BNA ANTITRUST & TRADE REG. DAILY, Mar. 10, 2000 (FTC official observing increased enforcement activity and cooperation with state authorities); *Mergers and Acquisitions: State-Federal Coordination Is Explored at ABA Spring Meeting*, BNA ANTITRUST & TRADE REG. DAILY, Apr. 18, 2000 (panelist noting increased state enforcement over last decade, including states pursuing their own cases).

9. For example, in 1997 a Catholic-affiliated HMO covering Medicaid patients in New York City, Fidelis Care New York, took over a secular HMO and eliminated coverage of abortion and contraceptive and sterilization services. *An H.M.O., Catholic Run, Bars Coverage for Abortions*, N.Y. TIMES, Nov. 17, 1997, at B5. 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.

up" most of the health care providers in a community,¹⁰ and hospitals' denial of physician staff privileges,¹¹ which may also give rise to antitrust concerns.

The remainder of this article is divided into four sections followed by a brief conclusion. Part II describes the availability of hospital-based reproductive health services and the potential impact of hospital mergers on these services. Part III analyzes how basic antitrust principles apply to a hospital merger that threatens to eliminate reproductive health services. Part IV discusses ways in which those concerned with the possible impact of a pending merger on reproductive health services in their area can work with antitrust enforcement agencies at the federal and state levels. Finally, Part V is a case study of one community in upstate New York in which local activists confronting a proposed merger successfully translated their concerns into antitrust terms, developed a cooperative relationship with the FTC, and thereby had an impact on the ultimate decision by the parties to the prospective merger to call off the transaction.

II. BACKGROUND

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."¹² The reasons for this trend include an industry belief that hospitals must be larger in order to reduce costs and enhance their

10. 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. See CATHOLICS FOR A FREE CHOICE, *HEALTH CARE LIMITED: CATHOLIC INSTITUTIONS AND HEALTH CARE IN THE UNITED STATES* 24 (1995) (citation omitted) [hereinafter *HEALTH CARE LIMITED*]. In general, the DOJ and FTC consider such lock-ups to be of serious concern. See U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, *STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE*, reprinted in 5 *Health L. Rep. (BNA)* 1295 (Aug. 29, 1996) (Statements 8, 9), WL 5 BHLR 35 d34.

11. According to one report, Church authorities sometimes try, subtly or overtly, to prevent physicians affiliated with Catholic facilities from performing abortions or sterilizations at other, non-Catholic facilities. *HEALTH CARE LIMITED*, *supra* note 10, at 22.

12. See Lawrence E. Singer, *Realigning Catholic Health Care: Bridging Legal and Church Control in a Consolidating Market*, 72 *TUL. L. REV.* 159, 177 (1997); Michelle Bitoun Blecher, *Size Does Matter*, *HOSPS. & HEALTH NETWORKS*, June 20, 1998, at 28; Karen Palmarito, *Healthcare Philanthropy's Big Challenge: Merger Mania Among Hospitals*, *Health Systems Can Be Troubling, Costly for Charitable Foundations*, *MOD. HEALTHCARE*, Oct. 2, 1995, at 76; Alex Pham, *Jobs Shift from Hospitals to "Health Care Systems"*, *BOSTON GLOBE*, Oct. 18, 1998, at 4 (Special Section); Rhonda L. Rundle, *Hardly Meek: Catholic Hospitals, In Big Merger Drive, Battle Industry Giants*, *WALL ST. J.*, Mar. 12, 1997, at A1.

market power.¹³ In addition, 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.¹⁴

Religiously-affiliated hospitals are by no means immune from these pressures, and they too are being swept along in the merger wave.¹⁵ 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.¹⁶ 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."¹⁷ While merger activity has recently slowed throughout the hospital industry,¹⁸ mergers involving Catholic hospitals tripled from 1997 to 1998.¹⁹ A recent study also notes that although overall activity is down, health care consolidations in 2000 have shown their first quarter-to-quarter increase since 1998.²⁰

Until recently, Catholic health institutions tended to consolidate by aligning themselves with one another, rarely "marrying outside the church."²¹ 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.²²

13. Jack Reardon & Laurie Reardon, *The Restructuring of Hospital Services Industry*, 29 J. ECON. ISSUES 1063 (1995).

14. *Id.*; see also *Consolidation in the Health Care Market: Good or Bad for Consumers*, STATES OF HEALTH (Ctr. for Community Health Action, Boston, Mass.), Feb. 1996, at 1; Tamar Lewin, *With Rise in Health Unit Mergers, Catholic Standards Face Challenge*, N.Y. TIMES, Mar. 8, 1995, at A1.

15. See, e.g., Lewin, *supra* note 14, at A1. MergerWatch, a project of Family Planning Advocates of New York, is a nonprofit organization that closely monitors religious and secular mergers nationwide and maintains a website (<http://www.mergerwatch.org>) with current information on pending and consummated mergers.

16. Bruce Japsen, *Catholic Providers Seek Recapitalization Strategies*, MOD. HEALTHCARE, July 8, 1996, at 50; Thomas P. Weil, *The Survival of Catholic Health Care: Geographically Linked Networks*, HEALTH CARE STRATEGIC MGMT., July 1995, at 8.

17. Rundle, *supra* note 12; 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*, NAT'L CATH. REP., June 16, 1995, at 11.

18. Deanna Bellandi, *Levin: Mergers Fell Sharply in '98*, MOD. HEALTHCARE, Jan. 25, 1999, at 8 (reporting that health firm reported that publicly announced deals dropped from 199 in 1997 to 146 in 1998).

19. CATHOLICS FOR A FREE CHOICE, CAUTION: CATHOLIC HEALTH RESTRICTIONS MAY BE HAZARDOUS TO YOUR HEALTH 5 (1999) [hereinafter HAZARDOUS TO YOUR HEALTH]; see also Deanna Bellandi, *Catholic Deals with Non-Catholics Grow*, MOD. HEALTHCARE, Mar. 15, 1999, at 24 (citing CATHOLICS FOR A FREE CHOICE, *supra*).

20. *For the Record*, MOD. HEALTHCARE, Aug. 7, 2000, at 14.

21. CATHOLICS FOR A FREE CHOICE, RISKY BUSINESS: THE COMMUNITY IMPACT OF CATHOLIC HEALTH CARE EXPANSION 2 (1995).

22. *Id.*; see also Lewin, *supra* note 14, at A1.

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.²³ In updates to the study, CFFC has documented another 38 completed consolidations between Catholic and non-Catholic hospitals in 1996 and 1997,²⁴ and an additional 43 in 1998.²⁵ 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.²⁶

The Catholic health care system is no small player in the nation's health care industry. Catholic hospitals are the largest single group of non-profit, nonfederal hospitals and account for over 11% of all community hospitals, 16.2% of community hospital beds, and 16.7% of all community hospital admissions.²⁷ 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 \$44 billion in assets; in 19 states they had at least a 20% market share.²⁸ New Catholic health care systems have recently developed, providing the environment for further acquisitions by these systems trying to establish themselves in new markets.²⁹ Of the ten largest nonprofit health care systems, four are Catholic owned, with three falling behind only the U.S. Department of Veterans Affairs in net patient revenues.³⁰ Moreover, in many rural areas a Catholic hospital

23. CATHOLICS FOR A FREE CHOICE, *REPRODUCTIVE HEALTH AT RISK: REPORT ON MERGERS AND AFFILIATIONS IN THE CATHOLIC HEALTH CARE SYSTEM 5* (1995) [hereinafter *REPRODUCTIVE HEALTH AT RISK*]. According to one well-respected hospital industry consultant, seventeen percent of all hospital mergers from 1994 to 1999 were between Catholic and nonreligious facilities. John Wilkerson, *Hospitals Awaiting Bishops' Directives*, WASH. POST, Jan. 6, 2001, at B9.

24. CATHOLICS FOR A FREE CHOICE, *WHEN CATHOLIC AND NON-CATHOLIC HOSPITALS MERGE: REPRODUCTIVE HEALTH COMPROMISED 3, 8* (1998) [hereinafter *REPRODUCTIVE HEALTH COMPROMISED*].

25. *HAZARDOUS TO YOUR HEALTH*, *supra* note 19, at 5.

26. CAROL S. WEISMAN, AMAL J. KHOURY, VIRGINIA A. SHARPE, CHRISTOPHER CASIRER & LAURA L. MORLOCK, KAISER FAMILY FOUND., *AFFILIATIONS BETWEEN CATHOLIC AND NON-CATHOLIC HEALTH CARE PROVIDERS AND THE AVAILABILITY OF REPRODUCTIVE HEALTH SERVICES: IS THERE A COMMON GROUND?* 1 (1997).

27. Catholic Health Association, *Facts About the Catholic Health Association of the United States*, <http://www.chausa.org/aboutcha/chafacts.asp> (last visited Aug. 31, 2000). See generally *HEALTH CARE LIMITED*, *supra* note 10, for additional information on the scope and nature of the Catholic health care system.

28. Kevin Sexton, *Mission Gives Us an Advantage*, CATH. HEALTH PROGRESS, July–Aug. 1996, at 30. This article notes that even the huge Columbia/HCA hospital chain is significantly smaller (with 300 hospitals, 60,000 beds, \$14.5 billion in assets, and only three states with 20% market share). *Id.* at 31.

29. Deanna Bellandi, *Catholic Mergers Take Hold*, MOD. HEALTHCARE, Jan. 3, 2000, at 26.

30. *10 Largest Not-For-Profit Healthcare Systems*, MOD. HEALTHCARE, July 31, 2000, at 41

is the only hospital for many miles around.³¹ In light of the significant role that Catholic hospitals play, Catholic hospital “merger mania” thus stands to have a major nationwide impact.

A. Catholic Health Care and Restrictions on Reproductive Health Services

Catholic hospitals and other health care facilities affiliated with the Catholic Church must operate within the dictates of the Catholic Church. The National Conference of Catholic Bishops (NCCB) has issued *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 derive from Church doctrine.³² In response to the increasing number of Catholic/non-Catholic health care transactions, the NCCB has recently announced its intention to revise the *Directives* to further restrict Catholic/non-Catholic partnerships that may conflict with the religious principles of the Church.³³ Officials involved in at least one merger are placing their deal on hold pending the revised *Directives*.³⁴ These revisions could, of course, have a drastic impact on the structure and scope of transactions involving Catholic hospitals and health care systems.

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.”³⁵ Part 4 of the *Directives*, governing “Issues in Care for the Beginning of Life,” is particularly relevant here. Part 4 of the *Directives* prohibits the following reproductive health care

31. Catholic hospitals comprised 46 of the 708 hospitals designated as “sole providers” by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services in 1994 using 1990 census data. *HEALTH CARE LIMITED*, *supra* note 10, at 7. HCFA defines a sole provider as one that is located at least 35 road miles or 45 minutes by automobile from the nearest like facility (e.g., short-term acute care hospital), or meets certain other criteria. Most of the sole provider Catholic hospitals serve communities that are not predominantly Catholic. See *HAZARDOUS TO YOUR HEALTH*, *supra* note 19, at 6.

32. NAT’L CONFERENCE OF CATHOLIC BISHOPS, *Preamble to ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 1* (Jan. 1995) [hereinafter *DIRECTIVES*].

33. See *News at Deadline*, MOD. HEALTHCARE, Oct. 9, 2000 (church official stating that rules to be voted on in June 2001 would establish structure for deals to ensure that Catholic partner complies with Church law).

34. Joe Manning, *Merger of Women’s Health Services on Hold*, MILWAUKEE J. SENTINEL, Sept. 28, 2000 (reporting delay in merger of obstetrics and gynecology units of secular and Catholic hospital pending revision of *Directives*).

35. *DIRECTIVES*, *supra* note 32, at 4 (Directive 5).

services: abortion,³⁶ contraceptive services or counseling (including counseling about the use of condoms by HIV-positive patients to prevent the transmission of HIV/AIDS),³⁷ sterilization procedures (such as tubal ligation),³⁸ and infertility treatments.³⁹ 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.⁴⁰

The *Directives*, or at least some portions of them, tend to be applied quite strictly. Of eighteen Catholic hospitals responding to a survey in Pennsylvania in 1995, only three reported that they would perform an abortion even in an emergency.⁴¹ In a 1999 nationwide telephone survey of 589 Catholic hospital emergency rooms, 82% said that they would not provide emergency contraception, with no exceptions made in cases of rape.⁴² A recent study of emergency contraception policies in emergency rooms revealed that although the standard of care for rape victims in non-Catholic hospitals includes emergency contraception, many Catholic hospitals had policies that did not allow for the discussion, referral, or dispensation of emergency contraception.⁴³ This same study noted that some Catholic hospitals did attempt to conform to the standard of care.⁴⁴ In 1992, fourteen Catholic hospitals in and around Chicago denied the morning-after pill to more than 1000 women who had been raped, while twenty-two of twenty-six non-Catholic hospitals did offer it.⁴⁵

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

36. Directive 45 states: “Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted.” *Id.* at 9.

37. Directive 52 states: “Catholic health institutions may not promote or condone contraceptive practices” other than counseling in methods of “natural” family planning. *Id.* at 10.

38. Directive 53 states: “Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution” when its sole immediate affect is to prevent conception. *Id.*

39. Directives 38 to 41 cover assisted conception as a substitute for the “marital act,” including in vitro fertilization and artificial insemination. *Id.* at 9.

40. Directive 45 makes clear that “abortion” includes the destruction of an embryo “in the interval between conception and implantation.” *Id.* at 9. A footnote to Directive 36 recommends that “sexually assaulted women be advised of the ethical restrictions which prevent Catholic hospitals from using abortifacient procedures.” *Id.* at 8 n.19.

41. CLARA BELL DUVAL EDUC. FUND, *THE DECLINING NUMBER OF HOSPITALS IN PENNSYLVANIA WILLING TO PERFORM ABORTIONS* (1997).

42. *HAZARDOUS TO YOUR HEALTH*, *supra* note 19, at 10.

43. Steven S. Smugar, Bernadette J. Spina & Jon Merz, *Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims*, 90 AM. J. PUB. HEALTH 1372, 1374 (2000).

44. *Id.*

45. *HEALTH CARE LIMITED*, *supra* note 10, at 15.

policy of performing abortions only in cases where the life of the woman is in danger and in other very limited circumstances.⁴⁶ The Georgia Baptist Convention, which owns a health care system in Georgia that includes the Georgia Baptist Medical Center, also has a policy against performing abortions.⁴⁷

B. Access to Hospital-Based Reproductive Health Services

Access to women's reproductive health services in the United States is seriously threatened. In particular, as abortion services become an increasingly scarce commodity in many parts of the country, the legally-guaranteed right to abortion is being compromised as a practical matter. For a woman forced to travel to a distant provider, the relative unavailability of abortion services can mean significantly increased costs and risks to her health.

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.⁴⁸ This presents a very real problem for many women in this country. In 1996, the most recent year for which national data is available, 86% of the counties in the United States had no abortion provider.⁴⁹ Nearly one-third of women of reproductive age lived in one of the counties where there was no abortion provider.⁵⁰ Moreover, the number of providers has been dropping precipitously in recent years; between 1992 and 1996 the number fell 14%.⁵¹ The shortage of providers is most acute outside urban areas; in 1996, 95% of nonmetropolitan areas had no abortion services, and 87% of nonmetropolitan women lived in the unserved counties.⁵² In South Dakota and North Dakota, there is only one provider in each state.⁵³

The number of hospitals providing abortion services has undergone a particularly steep decline.⁵⁴ In 1996, only 14% of all short-term, general

46. John Lavey, *Nonprofit Medical Partnership Benefits MTMC*, NASHVILLE BUS. J., Oct. 21, 1996, at 6.

47. *Columbia to Do No Abortions in Georgia*, COURIER-J. (Louisville, Ky.), May 18, 1995, at 1C.

48. See Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, SEXUALITY AND AMERICAN SOCIAL POLICY 29 (Henry J. Kaiser Family Found., ed. 1996) [hereinafter Henshaw 1996].

49. Stanley K. Henshaw, *Abortion Incidence and Services in the United States, 1995-1996*, 30 FAM. PLAN. PERSP. 263, 267 (1998) [hereinafter Henshaw 1998].

50. *Id.* Moreover, 92% of counties had no provider that performed at least 400 abortions per year. *Id.* at 266. This is significant because small providers often do not have a large abortion case load, and they usually do not advertise; hence, women may have difficulty learning of and obtaining services from these providers. *Id.*

51. *Id.* at 267.

52. *Id.* at 266.

53. NAT'L ABORTION AND REPROD. RIGHTS ACTION LEAGUE FOUND., WHO DECIDES? A STATE-BY-STATE REVIEW OF ABORTION AND REPRODUCTIVE RIGHTS 158, 193 (2000) [hereinafter WHO DECIDES].

54. Henshaw 1998, *supra* note 49, at 268.

hospitals provided abortion services.⁵⁵ In 1996, there were only 42% as many public hospitals and 53% as many private hospitals providing abortions as there were in 1982.⁵⁶ And while only 7% of all abortions were performed in hospitals as of 1996, the question of the availability of hospital abortion services is vital for several reasons.⁵⁷ First, many abortion patients, such as diabetics and those with heart conditions, require overnight postoperative observation or emergency equipment that only a hospital can provide.⁵⁸ Second, other women may be unable to obtain services if their personal physicians insist on performing abortions only in a hospital.⁵⁹ Third, for low-income women, hospital emergency rooms often are the only option.⁶⁰ Fourth, even when abortion services are available in a freestanding clinic, the clinic must be able to transfer patients to a local hospital in emergencies.⁶¹ Thus, for many women, the absence of nearby hospital-based abortion services can be significant even if a clinic or other provider is otherwise available.⁶² While FDA approval of the medical abortion pill

55. *Id.*

56. *Id.*

57. *Id.* The other providers were abortion clinics, other nonhospital clinics, and physicians' offices. *Id.*

58. AM. COLL. OF OBSTETRICIANS AND GYNCOLOGISTS, GUIDELINES FOR WOMEN'S HEALTH CARE 128–29 (1996) [hereinafter ACOG] (advising that for some later abortions and for patients with certain risk factors, hospital or ambulatory surgical facility is 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 Ctr. for Reprod. Health*, 462 U.S. 416 (1983). However, the Oklahoma Supreme Court recently *upheld* such a requirement and ordered the state to enforce it, opining that *Akron* is no longer valid. *Davis v. Fieker*, 952 P.2d 505 (Okla. 1997).

59. See Stanley K. Henshaw & Jennifer Van Vort, *Abortion Services in the United States: 1991–1992*, SEXUALITY AND AMERICAN SOCIAL POLICY (Henry J. Kaiser Family Found., ed. 1996). 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. Margaret Terry Orr & Jacqueline Darroch Forrest, *The Availability of Reproductive Health Services from U.S. Private Physicians*, 17 FAM. PLAN. PERSP. 63 tbl.3 (1985).

60. Ellen Gamerman, *Scarce South Shore Abortion Services Prompt Lobbying Effort*, Sts. News Serv., June 30, 1993, available in LEXIS, States News Service File.

61. ACOG, *supra* note 58, 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.”); NAT’L ABORTION FED’N, CLINICAL POLICY GUIDELINES 31–32, 41 (1997) (recommending transfer to local hospital providing reproductive health services in circumstances involving hemorrhage and other emergencies). Some states, such as Pennsylvania, require that abortion clinics have preexisting “transfer agreements” with local hospitals, thus barring clinics that are unable to find a willing hospital. Julia Duin, *Hospitals Block Pa. Abortion Clinic*, WASH. TIMES, Sept. 8, 2000, at A2 (noting that county’s five hospitals, while not Catholic-affiliated, considered deeply religious community’s opposition to clinic). The American Medical Association estimated in 1990 that one in every 1000 women undergoing an abortion suffered a major complication requiring admission to a hospital. Candy Hatcher, *Abortion Services Safer, Harder to Find*, PALM BEACH POST, Aug. 9, 1994, at 1A.

62. See, e.g., Amy Goldstein, *A Life at Risk, an Abortion Denied: Ailing Louisiana Woman at Center of a Debate Over Access*, WASH. POST, Oct. 20, 1998, at A1 (chronicling

(RU-486) should increase access to abortion services, proposed legislation requiring that physicians administering the drug have admitting privileges at a nearby hospital could limit the distribution of the drug in areas where the only hospital is Catholic.⁶³ As with other abortion services, rural women suffer the brunt of the impact. For example, recent reports on hospital-based access to abortion revealed that rural parts of both California and Massachusetts are without abortion-accessible hospitals.⁶⁴

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.

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 periods⁶⁵ and restrictions on public funding.⁶⁶ 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

attempt of woman who needed hospital-based abortion due to heart condition; all Louisiana public hospitals refused to perform procedure because her life was not adequately endangered). 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 antiabortion harassment, threats, and outright violence. As a result, some women may be deterred from using their services. 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. In addition, as fewer hospitals offer abortion services, even doctors willing to perform abortions have difficulty getting the necessary training. *See* MED. STUDENTS FOR CHOICE, ABORTION TRAINING IN U.S. OBSTETRICS & GYNECOLOGY RESIDENCY PROGRAMS ii (1999).

63. *See* Sheryl Gay Stolberg, *The 2000 Campaign: The Abortion Issue*; 2 G.O.P. Lawmakers Offer Bill Limiting Access to Abortion Pill, N.Y. TIMES, Oct. 5, 2000, at A23. Hospitals have restricted physicians' outside practices based on their adherence to Catholic doctrine, thus precluding physicians with admitting privileges at Catholic hospitals from administering RU-486.

64. THE ABORTION ACCESS PROJECT, ABORTION MAY BE LEGAL, BUT WHO CAN GET ONE? 8, 13 (1999); CAL. HOSP. ABORTION ACCESS PROJECT, HOLES IN THE SAFETY NET: THE LACK OF ABORTION ACCESS IN CALIFORNIA HOSPITALS 7 (1999).

65. 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. Fourteen of these laws are enforced. WHO DECIDES, *supra* note 53, at 239.

66. Twenty-nine states exclude abortion from their state medical assistance programs except in cases of life endangerment, rape, or incest. Two states, in violation of federal law, exclude abortion from their state medical assistance programs except when the woman's life is endangered. *Id.* at 242–43.

child care.⁶⁷ The delay entailed in such travel—especially where there are waiting periods and other restrictions, or when time is needed to raise the necessary funds⁶⁸—can be significant. Some clinics schedule abortions only one or two days a week; compliance with a mandatory twenty-four-hour waiting period for an abortion at such a clinic can translate into a significant delay.⁶⁹

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.⁷⁰ 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.⁷¹

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.⁷²

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. Sometimes after a merger is consummated, the new entity completely eliminates all reproductive health services.⁷³ In other cases, proposed mergers have been abandoned as a result of differences over abortion and other

67. COUNCIL ON SCIENTIFIC AFFAIRS, AM. MED. ASS'N, INDUCED TERMINATION OF PREGNANCY BEFORE AND AFTER *ROE V. WADE*: TRENDS IN THE MORTALITY AND MORBIDITY OF WOMEN 14 (1992) [hereinafter AMA COUNCIL ON SCIENTIFIC AFFAIRS].

68. One study showed that about half the women who had an abortion after fifteen weeks of pregnancy were delayed because they encountered difficulties in securing funds to pay for the procedure. *Id.* at 15.

69. Henshaw 1996, *supra* note 48, at 42 (noting that 14% of nonhospital providers reported average delay of more than one week even before waiting periods were in effect).

70. *Id.* at 41.

71. AMA COUNCIL ON SCIENTIFIC AFFAIRS, *supra* note 67, at 14.

72. *Id.* at 15–16.

73. Most recently, CFFC found that reproductive health services were discontinued in 48% of the 1998 completed mergers on which it was able to obtain information. HAZARDOUS TO YOUR HEALTH, *supra* note 19, at 5.

reproductive health services.⁷⁴ Other mergers have been stopped by church officials concerned about the risk that Catholic policies would be violated.⁷⁵

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. In fact, the *Directives* specifically contemplate business arrangements that allow the Catholic institution to limit its direct involvement with partners that conduct activities deemed morally wrong by the Church, although the *Directives* may soon be revised to limit such arrangements.⁷⁶ This set of outcomes is particularly significant because it suggests that in a legal challenge to a merger, including one brought under the antitrust laws, the goal can be an agreement guaranteeing that needed services will continue to be made available after the merger, rather than outright cancellation of the merger plans.

CFFC has 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.⁷⁷

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

74. See *Planned Kenosha Hospital Merger Falls Apart Over 'Cultural Differences,'* 5 Health Care Pol. Rep. (BNA) 1031 (June 30, 1997), WL 5 HCP 26 d 39; Ralph Jimenez, *N.H. Hospital Merger Fails Over Ethics Impasse*, BOSTON GLOBE, Feb. 16, 1999, at B1 (reporting that five-year-old merger in Manchester, New Hampshire, was undone due to inability to agree on abortion policy); Jones, *supra* note 17, at 11 (reporting that Catholic hospital abandoned merger because merger partners decided to continue to offer tubal ligations); Michael McNutt, *Enid Hospitals Scrap Plan to Build Women's Center*, DAILY OKLAHOMAN, Mar. 6, 1999, at 8 (reporting that plan for joint venture by secular and Catholic hospital to create women's health facility where *Directives* would apply was abandoned due to physician and community resistance); Karen Pallarito, *Blessing Withheld: Vatican Rejects Deal Involving N.J. Catholic Hospital*, MOD. HEALTHCARE, June 23, 1997, at 4.

75. See, e.g., Liz Kowalczyk, *Local Hospitals Provide Array of Services*, PATRIOT LEDGER (Quincy, Mass.), Sept. 24, 1996, at 8A (reporting that Cardinal Bernard Law blocked nearly-completed merger between Catholic-owned Carney Hospital in Boston with city-owned Quincy Hospital because doctors at Quincy occasionally perform abortions).

76. DIRECTIVES, *supra* note 32, at 13 (Directive 69) ("When a Catholic health care institution is participating in a partnership that may be involved in activities judged morally wrong by the Church, the Catholic institution should limit its involvement in accord with the moral principles governing cooperation.").

77. REPRODUCTIVE HEALTH AT RISK, *supra* note 23, at 21-22, 27-28.

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.⁷⁸ While abortion rights advocates support these arrangements because they preserve services, and antitrust officials have approved of such arrangements, institutions must take care to limit their cooperation to those acts that have been approved by antitrust agencies. One such arrangement has been recently found to violate antitrust laws because the institutions were acting outside of their agreement.⁷⁹

Some of the creative arrangements that have been utilized to minimize the harmful consequences of a merger are less effective than others. An agreement 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 *Directives* and refuses to perform sterilization procedures. Moreover, freestanding women's health clinics and their staff and patients are frequently the targets of antiabortion violence and harassment, and there is no 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.⁸⁰

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.

78. Michele Conklin, *Technicality Allows Lutheran Hospital to Continue Abortions*, ROCKY MTN. NEWS, Nov. 23, 1996, at B1.

79. Labeled a "virtual merger," in 1992 two hospitals in upstate New York, one secular and one Catholic, entered a joint operating agreement (JOA) to provide certain clinical services, thus allowing the facilities to save operating costs while preserving the identity of each institution. In July 2000 a court dissolved the collaboration, finding that the hospitals had exceeded the scope of the JOA, fixing prices and allocating other services in violation of antitrust laws. *New York v. Saint Francis Hosp.*, 94 F. Supp. 2d 399 (S.D.N.Y. 2000). See also Mark Taylor, *Judge Orders End to 'Virtual Merger,'* MOD. HEALTHCARE, July 3, 2000, at 2.

80. 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 in 1996 (under state health laws requiring approval of a change in hospital ownership) between a Catholic and a non-Catholic facility in Troy, New York. See David Bauder, *Troy Hospital to Provide Counseling*, DAILY GAZETTE, May 15, 1995, at 1. Such a referral requirement, however, may be difficult to enforce and is not an effective 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.

With this background, the remainder of this article focuses on the applicability of the antitrust laws.

III.

THE APPLICABLE ANTITRUST PRINCIPLES

A. *Clayton Act Analysis (Federal Merger Guidelines)*

When analyzing a proposed merger under federal law, the starting point is section 7 of the Clayton Act, which prohibits stock or asset acquisitions that may substantially lessen competition or tend to create a monopoly.⁸¹ Section 7 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.⁸² And it has been interpreted to apply to nonprofit as well as for-profit entities.⁸³

Two federal agencies are charged with enforcing the Clayton Act: the U.S. Department of Justice and the Federal Trade Commission [hereinafter collectively "agencies" or individually "agency"]. Only one of these agencies will review a specific merger, and in the area of health care it is not

81. Section 7 of the Clayton Act prohibits a merger or acquisition "where in any line of commerce or in any activity affecting 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 (1994 & Supp. IV 1998). For purposes of antitrust analysis, the terms "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 technically a merger or an 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. A joint venture, for example, may be open to challenge only under the Sherman Act.

82. A 1980 amendment to the Clayton Act made this clear. Pub. L. No. 96-349, § 6(a), 94 Stat. 1154, 1157-58 (1980) (codified as amended at 15 U.S.C. § 18). It is not difficult to show that any hospital engages in activities affecting interstate commerce—such as ordering supplies from another 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 forty patients). See U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ENFORCEMENT POLICY AND ANALYTICAL PRINCIPLES RELATING TO HEALTH CARE AND ANTITRUST 12 (1994) [hereinafter STATEMENTS].

83. Section 7's coverage of acquisitions of assets of nonprofit entities remains in dispute, although the stronger line of authority holds that it does apply. See Laura L. Stephens, *Nonprofit Hospital Mergers and Section 7 of the Clayton Act: Closing an Antitrust Loophole*, 75 B.U. L. REV. 477, 499-500 (1995). Compare *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1214-17 (11th Cir. 1991) (holding that section 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) (finding such acquisitions beyond scope of section 7), *aff'd without opinion*, 892 F.2d 1042 (4th Cir. 1989), and *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1296 (W.D. Mich. 1996) (finding nonprofit status of hospital not dispositive consideration, but nevertheless relevant to issue of anticompetitive effects), *aff'd*, 121 F.3d 708 (6th Cir. 1997).

possible to say in advance which one it will be.⁸⁴ 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.

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 in which the effect “*may* be substantially to lessen competition, or to *tend* to create a monopoly.”⁸⁵ This approach is bolstered by a pre-merger reporting requirement for large mergers under the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (HSR).⁸⁶ A recent amendment to HSR increased the pre-merger reporting threshold from \$15 million to \$50 million.⁸⁷ Mergers valued at over \$50 million must first be reported to the agencies, and then delayed a minimum of thirty days before being consummated.⁸⁸ 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

84. The agencies allocate each merger between them as it arises. Some entire industries historically “belong” to one agency or the other, but they both have a claim to health care and hospital mergers. See STATEMENTS, *supra* note 82, at *Introduction*.

85. 18 U.S.C. § 18 (emphasis added).

86. Pub. L. No. 94-435, tit. III, § 301, 90 Stat. 1383, 1394–96 (1976) (codified at 15 U.S.C. § 18a (1976)).

87. H.R. 5548, 106th Cong. § 630(a) (2000), Pub. L. No. 106-553, § 1(a)(2), 114 Stat. 2762, 2762 (2000). This amendment is expected to cut the number of mergers subject to pre-merger review by half. Jenna Greene, *Deal Appeal: A Record Number of Mergers, but FTC, DOJ Make Their Marks*, LEGAL TIMES, Dec. 18, 2000, at 34.

88. In general, HSR applies to a proposed merger if (a) one of the parties has annual net sales or total assets of \$10 million or more, and (b) the other party has annual net sales or total assets of \$100 million or more, and (c) the acquiring party would hold an aggregate amount of the voting securities and assets of the acquired party totaling over \$50 million. Transactions valued at over \$200 million, regardless of the size of the parties, are also subject to HSR filing. 18 U.S.C. § 18a(a) (1994). 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. *Id.* § 18a(d). The reviewing agency has thirty days to consider this information and decide whether the transaction may proceed or requires further investigation. *Id.* § 18a(b)(1)(B). If further investigation is called for (as will be likely when market shares are high and consumers object), the government will issue a second request for further information. *Id.* § 18a(e)(2). HSR prohibits consummation of a merger until a second request is fully responded to. *Id.* § 18a(b). Since second requests call for an extensive range of documents and testimony from the parties, issuance of a second request may delay a merger for many months. See, e.g., Richard G. Parker, Dir., Bureau of Competition, Federal Trade Commission, Prepared Remarks at the Spring 2000 Meeting of the American Bar Association Federal Trade Commission Committee (Apr. 7, 2000), available at <http://www.ftc.gov/speeches/other/rparkerspingaba00.htm> (noting that most second request investigations are completed within 120 days).

merger several more months while it reviews the data. If, based on the initial pre-merger filing and any additional information submitted, the agency concludes that the proposed merger may substantially lessen competition, the agency may seek an injunction in federal court to block the transaction.⁸⁹

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 pre-merger review—usually face the much greater challenge of remedying anticompetitive effects after the merger. 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 other "assets," such as trained health care professionals who will leave a market in which they can no longer practice, and who may not be easily or quickly enticed back, even if a center providing such services were subsequently established.⁹⁰

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.⁹¹ 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 both a detailed analysis of the market structure before the merger and predictions regarding what that structure will be after the merger.⁹²

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 U.S. Department of Justice and Federal Trade Commission's *Horizontal Merger Guidelines*.⁹³ While

89. 18 U.S.C. § 18a(f).

90. See, e.g., Letter from Anne K. Bingaman, Assistant Attorney General, to Steven J. Kern on behalf of Children's Healthcare, P.A. (Mar. 1, 1996), available at <http://www.usdoj.gov/atr/public/busreview/0555.htm> (discussing difficulty of establishing specialist physician practices).

91. See *United States v. Penn-Olin Chem. Co.*, 378 U.S. 158, 170–71 (1964).

92. See *id.* at 171.

93. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES (issued Apr. 2, 1992, revised Apr. 8, 1997), available at http://www.usdoj.gov/atr/public/guidelines/horiz_book/hmg1.html (relating to efficiencies) [hereinafter DOJ MERGER GUIDELINES]. The states, through the National Association of Attorneys General (NAAG), have issued their own guidelines, which differ somewhat from the DOJ-FTC *Guidelines*, but not in ways that contradict the general overview provided here. NAT'L ASS'N OF ATT'YS GEN., HORIZONTAL MERGER GUIDELINES, reprinted in 64 Antitrust & Trade Reg. Rep. (BNA) No. 1608, at S-3 (Apr. 1, 1993).

the *Guidelines* do not have the force of precedent in a federal court, they distill the holdings of numerous antitrust cases and outline the enforcement policies of the two agencies. A merger that appears to be anticompetitive under the *Guidelines* is likely to be vulnerable to state challenge as well.

The five-part analysis under the *Guidelines*, as it applies here, is as follows.

1. *Market Power*

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 profitably to 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."⁹⁴ The *Guidelines* note that "market power also may lessen competition on dimensions other than price, such as product quality, service, or innovation."⁹⁵

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 prices). The collusion can be tacit or express.⁹⁶ The second is through unilateral action—that is, the exertion of what can loosely be described as monopoly power, preventing consumers from finding substitutes for the product or service now controlled by the merged entity, and forcing them to pay a higher price or do without.

Merger analysis under the Clayton Act thus poses a 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.

2. *Market Definition and Competitive Effects*

The basic question of market power cannot be answered without defining the relevant product and geographic markets, and then assessing the structure of those markets and the change in structure that the merger will bring about.

94. DOJ MERGER GUIDELINES, *supra* note 93, § 0.1.

95. *Id.* § 0.1 n.6.

96. *Id.* § 2.1.

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.⁹⁷ 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.⁹⁸

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 anti-trust 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.⁹⁹ 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.¹⁰⁰ When two hospitals merge, and certain reproductive health care services are consequently 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 either provided in hospitals or dependent upon hospital facilities for back-up. To establish this product market, it would be necessary

97. Services are treated the same as "products" in this analysis. See, e.g., *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 336 (1991).

98. DOJ MERGER GUIDELINES, *supra* note 93, § 1.0.

99. See, e.g., *FTC v. Hosp. Bd. of Dirs. of Lee County*, 38 F.3d 1184, 1186 (11th Cir. 1994); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1226 (W.D. Mo.), *aff'd*, 69 F.3d 260 (8th Cir. 1995); see also *Am. Medicorp, Inc. v. Humana, Inc.*, 445 F. Supp. 589, 605 (E.D. Pa. 1977) (stating appropriate product market is "the delivery of short term, acute care community hospital services").

100. See, e.g., *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1291, 1301 (W.D. Mich. 1996) (upholding product market of primary care inpatient hospital services, but permitting merger due to efficiency defense); *United States v. Carilion Health Sys.*, 707 F. Supp. 840, 847–48 (W.D. Va. 1989) (upholding primary, secondary, and tertiary care product markets, but permitting merger due to jurisdictional defense); see also *Healthsouth Rehabilitation Corp.*, 60 Fed. Reg. 5401, 5401 (1995) (adopting rehabilitation services as product market with respect to proposed consent agreement); *Columbia/HCA Healthcare Corp.* 59 Fed. Reg. 48,883, 48,883 (1994) (adopting outpatient surgery services as product market with respect to proposed consent agreement); *Charter Med. Corp.*, 59 Fed. Reg. 60,804, 60,805 (1994) (adopting psychiatric services as product market with respect to proposed consent agreement). But see *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 138 (E.D.N.Y. 1997) (rejecting product market of "acute inpatient services" provided by anchor hospitals).

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 payers can attest to the fact that women’s need for these services cannot be satisfied by other types of health care.¹⁰¹

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 if the product market is defined too narrowly, to include only those services that are not available elsewhere, those services might represent only a small part of the hospital’s general acute care services, enabling the hospital to argue that the efficiencies to be gained by the merger will outweigh any harm to consumers.¹⁰² 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, through the testimony of area physicians, that physicians who could theoretically provide the services in their offices or in 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 the *Directives*.

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 often has been defined as the county or metropolitan area in which the hospital is situated. Some courts have emphasized that the relevant inquiry is where patients “practicably” could

101. See, e.g., Joseph Berger, *Slaying Spotlights Fear as Abortion Access for Poor Is Cut*, N.Y. TIMES, Nov. 3, 1998, at B8 (noting that women who are young and/or poor tend not to have regular physicians and are increasingly turning to hospitals or specialized clinics for care); Maria Alicia Gaura, *Reproductive Rights Ban at Gilroy Hospital: Catholic Health Group Takes Over Public Facility*, S.F. CHRON., Oct. 1, 1999, at A1 (reporting that Catholic hospital’s decision to cease providing tubal ligation will most impact poor women wishing to have procedure performed after delivery, forcing women in labor to undergo dangerous journey of twenty-five to thirty-five miles to access nearest such provider).

102. See discussion *infra* Part III.A.4.

go to obtain services from an alternative provider, not where they actually have gone in the past.¹⁰³

There are two cautionary notes to the general rule of hospital competition as a local phenomenon. First, the geographic nature of competition can vary with the service offered.¹⁰⁴ 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.¹⁰⁵ 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.¹⁰⁶

To define the geographic market, the agencies and courts 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).¹⁰⁷ Because such data only give a snapshot of past behavior, the agencies and courts are

103. See, e.g., *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995).

104. See *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 141-42 (finding that primary and secondary care market and tertiary care market constitute two separate geographic markets).

105. See, e.g., *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1219-21 (W.D. Mo.), *aff'd*, 69 F.3d 260 (8th Cir. 1995) (13-county/54-mile radius market); *United States v. Mercy Health Serv.*, 902 F. Supp. 968, 972 (N.D. Iowa 1995) (70- to 100-mile radius market), *vacated*, 107 F.3d 632 (8th Cir. 1997).

106. See, e.g., *FTC v. Tenet Healthcare Corp.*, 186 F.3d 1045 (8th Cir. 1999) (reversing district court's injunction prohibiting Poplar Bluff, Missouri, hospital merger). Citing the "significant and profound changes" within the health care industry, the court called the notion of physician loyalty "outdated," and included hospitals sixty-five miles outside of the town in the relevant geographic market. *Id.* at 1053-55. The antitrust community was surprised by the decision, and commentary has been highly critical, in large part because the appeals court disregarded the district court's reliance on consumer testimony on the impact of the merger and long-accepted standard of the relevant geographic market. See Mark Taylor, *So What Is a Monopoly?: Appeals Court Decision in Missouri Case Deals Yet Another Blow to Antitrust Regulators*, MOD. HEALTHCARE, July 26, 1999, at 2, 12 (reporting that former antitrust official called ruling "unbelievable"); Robert W. Doyle, Jr. & Brett A. Snyder, *The Customer Is Not Always Right*, LEGAL TIMES, Aug. 1, 1999, at 19 (reporting that ruling is "contrary to 8th Circuit precedent" and FTC's horizontal merger guidelines). The FTC has decided not to appeal this case, but it has announced a plan to revisit other hospital mergers that were approved, citing the importance of regulation in this area to protect consumers in the new managed care environment. Mark Taylor, *FTC Will Not Appeal in Mo. Antitrust Case*, MOD. HEALTHCARE, Dec. 13, 1999, at 16; *FTC Reconsiders Merged Hospitals, Weighs Actions in Pharmaceutical Industry*, 8 Health Care Pol'y Rep. (BNA) 321 (Feb. 28, 2000).

107. The DRG system assigns a code to most inpatient diagnoses and procedures, and is used by hospitals and insurers to classify diagnosis and procedures for payment. *Tenet*, 186 F.3d at 1051 n.9.

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 also attempt to define both “drive time” and physician loyalty in order to measure consumers’ willingness 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 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.¹⁰⁸

The broader the area defined as the geographic market, the harder it will be to challenge a local merger, because it means a larger number of competing providers will be available in the market. Therefore, a successful challenge will require evidence that most women needing reproductive health services cannot or would not travel long distances to obtain these services, due to the cost or time-sensitive nature of the services (as is the case, for example, with abortion, the morning-after pill, or postpartum tubal ligation), physician loyalty, or other factors such as unfamiliarity with a more distant region. Obviously, the costs of such travel are likely to weigh most heavily with 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—one for the initial consultation and another for the abortion.¹⁰⁹ Data on these factors will aid in definition of the geographic market.

c. *Competitive Effects*

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, supply is controlled by fewer and larger firms and there is increased risk

108. In *FTC v. Tenet*, 17 F. Supp. 2d 937 (E.D. Mo. 1998), *rev’d* 186 F.3d 1045 (8th Cir. 1999), the district court considered several of these factors in deciding to enjoin a hospital merger, noting for example that the evidence showed that “drive time” to alternative hospitals would be over an hour, and in some cases over two hours, on secondary roads in a rural area, and that patients are loyal to their primary physicians and unwilling to use a hospital if they would be required to change doctors. *Id.* at 942–43. Although the court of appeals discounted these factors in its reversal of the district court, they are usually deemed important in antitrust analysis. See generally sources cited *supra* note 106.

109. Nineteen states currently have mandatory waiting periods that could force a woman to make two visits to an abortion provider before the abortion can be performed. WHO DECIDES, *supra* note 53, at xv.

that one of them could exercise market power.¹¹⁰ To measure concentration, the market shares of each of the merging firms and all their competitors in the relevant market are calculated,¹¹¹ and a comparison is made of the market's concentration before and after the merger. Concentration ratios—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. Courts are increasingly turning, however, to the mathematically more precise measure used by the 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.¹¹² 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.¹¹³

Thus, to assess the competitive effects of a hospital merger that would eliminate reproductive health services, a court may consider not only the change in market concentration that the merger would produce, but also evidence of the merger's likely impact on prices (such as those paid by managed care or large employers in community) and on the range and quality of services offered—including reproductive health services.

3. *Ease of Entry*

The third step in the analysis is to inquire whether the ease by which other competitors can enter the market might deter or counteract the merger's presumptive anticompetitive effects.¹¹⁴ 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

110. Even where concentration is high, however, other factors—such as the ease of entry of new competitors—may make the exercise of market power unlikely.

111. 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. STATEMENTS, *supra* note 82, at 12 (Statement 1).

112. DOJ MERGER GUIDELINES, *supra* note 93, §§ 1.5 to 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 pre-merger market shares and then again based on the post-merger market shares. These *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 1800 and the change in the HHI as a result of the merger is greater than 50. An HHI of 1800 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 3000). *Id.*

113. *But see* discussion, *supra* note 82 (regarding small hospital exception). State authorities are not bound by this DOJ-FTC policy, however, and may be susceptible to an argument that a small hospital is such a significant force in the market for women's reproductive health services that its elimination would harm competition.

114. DOJ MERGER GUIDELINES, *supra* note 93, § 3.0.

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 pre-merger prices), and (3) sufficient (able to service enough of the market to provide consumers with a meaningful alternative to the merged firm)?¹¹⁵

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.¹¹⁶ 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.¹¹⁷ Indeed, managed care and other industry factors, including the growth of outpatient services, are expected to contribute to a decrease in the number of hospitals in the years to come.¹¹⁸ 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 points to the 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."¹¹⁹ "Cognizable efficiencies" are considered to be merger-specific efficiencies

115. *Id.* §§ 3.2 to 3.4.

116. 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 nonhospital sites.

117. Numerous cases have so held. See, e.g., *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1211 (11th Cir. 1991); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990).

118. See Deanna Bellandi, *Marginally Better Off: Hospitals' Aggregate 5.7% Profit May Indicate Downturn*, MOD. HEALTHCARE, Dec. 6, 1999, at 2; *Health Care Spending and GPO Influence to Take Off in Next Decade, Study Predicts*, HOSP. MATERIALS MGMT., Nov. 1, 1998, at 7.

119. DOJ MERGER GUIDELINES, *supra* note 93, § 4.

that enhance the merged firm's "ability and incentive to compete" and "do not result from anticompetitive reductions in output or service."¹²⁰

Most mergers will result in at least some operating efficiencies for the merging parties, and if 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.¹²¹ 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.¹²² 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.¹²³ In general, courts have been skeptical of efficiencies defenses, treating them as inflated or too speculative.¹²⁴

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,¹²⁵ is recognized by the *Guidelines* as a narrow defense to an otherwise objectionable merger.¹²⁶ 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

120. *Id.*

121. While the Supreme Court has held that cost savings in one product market cannot offset anticompetitive effects in another market, *United States v. Phila. 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. *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1298 (W.D. Mich. 1996).

122. A hospital may argue, for example, that if a substantial portion of its revenues 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 percentage 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.

123. See, e.g., *Univ. Health*, 938 F.2d at 1223; G. Cary, Deputy Dir. for Mergers, Fed. Trade Comm'n, *Staying Ahead of the Merger Wave*, Remarks before the Fifteenth Annual Corporate Counsel Institute (Dec. 12, 1996). Moreover, elimination of excess bed capacity is not an adequate basis for an efficiencies defense. See *Univ. Health*, 938 F.2d at 1219-20.

124. *Univ. Health*, 938 F.2d at 1223; *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1289 (7th Cir. 1990); *United States v. Mercy Health Serv.*, 902 F. Supp. 968, 987-88 (N.D. Iowa 1995); see also *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 135, 148-49 (E.D.N.Y. 1997) (finding that efficiencies produced by merger would benefit consumers, but based in part on agreement between merging hospitals and state Attorney General committing hospitals to pass on cost savings to community).

125. See *Citizen Publ'g Co. v. United States*, 394 U.S. 131 (1964); *Int'l Shoe v. FTC*, 280 U.S. 291 (1930).

126. DOJ MERGER GUIDELINES, *supra* note 93, § 5.1.

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.”¹²⁷

This defense has rarely been successful. To date, the antitrust agencies and courts have resisted broadening the defense to include distressed industries, “failing” firms, or struggling units of financially healthy companies.¹²⁸ Failing firm and distressed industry issues can surface in the competitive effects, market power, and efficiencies stages of the analysis, however, and can tip the balance toward an endorsement of the proposed merger.

In summary, to determine whether a given hospital merger raises anti-trust concerns under the Clayton Act, the merger must be subjected to the *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,¹²⁹ especially if there is obvious proof of intent to eliminate services, such as that exhibited by the *Directives*. 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.¹³⁰ An advantage of a Sherman Act challenge is that there is 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.”¹³¹

127. *Id.*

128. *See Univ. Health*, 938 F.2d at 1221.

129. This excludes those that fall within the small hospital safety zone. *See* discussion *supra* note 82.

130. Antitrust Amendments (Sherman) Act of 1990, 15 U.S.C. §§ 1–7 (1994 & Supp. IV 1998). Both the DOJ and the FTC have brought challenges to anticompetitive conduct under the Sherman Act.

131. 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 section 7 of Clayton Act with section 1 of Sherman Act). Later decisions, however, have largely eroded this distinction. *See, e.g., United States v. First Nat’l Bank & Trust Co.*, 376 U.S. 665, 671–72 (1964) (appearing to apply section 7 standards in a challenge under section 1); *United States v. Rockford Mem’l Corp.*, 898 F.2d 1278, 1282–83 (7th Cir. 1990) (demonstrating that judicial interpretation of the two laws has converged); *McCaw Pers. Communications, Inc. v. Pac. Telesis Group*, 645 F. Supp. 1166, 1173 (N.D. Cal. 1986) (observing “the standard . . . under the Sherman Act is similar, if not identical, to that under

To establish a violation of section 1 of the Sherman Act, there must be proof of: (i) a contract, combination, or conspiracy (ii) among two or more independent entities (iii) that unreasonably restrains trade (iv) in or affecting interstate or foreign commerce.¹³² Three of the 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 commerce¹³³—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 described above. Because the Sherman Act has been interpreted to bar only "unreasonable" restraints of trade,¹³⁴ all the factual circumstances of a case will be weighed before a decision can be reached about the merger's impact on competition.¹³⁵

We are aware of only one merger case involving such a Sherman Act challenge, but its facts bear a striking resemblance to those in a merger challenge based on the unavailability of reproductive health services. 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. When that clinic was acquired by the other, the acquiring clinic adopted the acquired clinic's refusal to do business with the plaintiffs.¹³⁶ Reversing the lower court's dismissal of the case, the Seventh Circuit Court of Appeals stated:

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

the Clayton Act"); *United States v. Cent. State Bank*, 621 F. Supp. 1276, 1294-95 (W.D. Mich. 1985) (noting "the emphasis on market concentration in § 7 cases is relevant to cases brought under § 1").

132. 15 U.S.C. § 1.

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

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

135. See *Nat'l Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 688, 696 (1978); *Bd. of Trade of Chicago v. United States*, 246 U.S. 231, 238 (1918).

136. *Nelson v. Monroe Reg'l Med. Ctr.*, 925 F.2d 1555 (7th Cir. 1991).

made non-competitive by a merger, it is the kind of price increase that is a central concern of the Sherman Act.¹³⁷

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

IV.

MOUNTING A CHALLENGE

A. *Approaching the Federal Agencies:*

Federal Trade Commission and U.S. 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—potential litigants concerned about the possible effects of a merger should go to them first, or at least at the same time as state officials are approached. The FTC (through its Bureau of Competition) and the DOJ (through its Antitrust Division) can be contacted simultaneously to improve the odds of prompting government action. Since the agencies 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 agencies 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.¹³⁸ 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 proposed consent order with the merger parties.¹³⁹ There is no prescribed 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.¹⁴⁰

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 above, the merger would substantially lessen competition. The case will be even more persuasive if the merger threatens the availability of

137. *Id.* at 1564 (quotations omitted).

138. Lawrence R. Fullerton, *How Can I Stop That Merger? The Role of Third Parties in Agency Merger Reviews*, 9 ANTITRUST 37, 38 (1995).

139. *Id.* at 38.

140. *Id.* at 39–40.

other lines of health care services in addition to women's reproductive health services, since such allegations would broaden and intensify the merger's alleged anticompetitive effects. The more data that is provided to the agencies (regarding geographic market, hospital concentration, plans to discontinue services, etc.), the more likely they are to take note. If the agencies are interested at that point, they will then use their 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 federal antitrust laws,¹⁴¹ and for treble damages, as well as for attorneys' fees and costs of suit.¹⁴² Moreover, every state except Pennsylvania and Vermont has a state antitrust statute of general application, i.e., a counterpart to section 1 and/or section 2 of the Sherman Act, prohibiting agreements in restraint of trade and monopolization. These laws can also be invoked to challenge mergers.¹⁴³ Furthermore, thirteen states have state statutory provisions relating specifically to mergers, although not all of them are as comprehensive as section 7 of the Clayton Act.¹⁴⁴

In addition, many state laws provide 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 mechanism for challenging a merger with potentially anticompetitive consequences in the states.¹⁴⁵ The following

141. See Clayton Act § 16, 15 U.S.C. § 26 (1994 & Supp. IV 1998); see also *Georgia v. Pa. R.R.*, 324 U.S. 439, 447 (1944) (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).

142. See 15 U.S.C. § 15(c).

143. 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, 399 (Cal. 1988) (holding that merger may not be challenged under the Cartwright Act, California's analogue to section 1 of Sherman Act).

144. ALASKA STAT. § 45.50.568 (Michie 1995); ARK. CODE ANN. § 4-75-302 (Michie 1996); COLO. REV. STAT. § 6-4-107 (1999); HAW. REV. STAT. § 480-7 (1993); LA. REV. STAT. ANN. § 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 (1998); N.J. STAT. ANN. § 56:9-4 (West 1989); S.C. CODE ANN. § 39-3-110 (Law Co-op. 1985); TEX. BUS. & COM. CODE ANN. § 1505(d) (West 1987); WASH. REV. CODE ANN. § 19.86.060 (West 1989).

145. These statutes are intended to exempt certain mergers and other transactions from federal antitrust scrutiny under the "state action immunity" doctrine, by subjecting the transactions to state regulatory control. Numerous decisions recognize that when a state

states have enacted this kind of "regulatory statute" to facilitate cooperative endeavors or mergers between hospitals or other health care providers: Colorado,¹⁴⁶ Florida,¹⁴⁷ Georgia,¹⁴⁸ Idaho,¹⁴⁹ Kansas,¹⁵⁰ Maine,¹⁵¹ Montana,¹⁵² Nebraska,¹⁵³ New York,¹⁵⁴ North Carolina,¹⁵⁵ North Dakota,¹⁵⁶ Ohio,¹⁵⁷ Oregon,¹⁵⁸ South Carolina,¹⁵⁹ Tennessee,¹⁶⁰ Texas,¹⁶¹ Washington,¹⁶² and Wisconsin.¹⁶³ These state laws vary considerably in the types of providers and activities covered, the state authorities responsible for reviewing the transaction, the issues that must be addressed before approval is granted, and the nature and extent of postapproval monitoring or supervision by the state.¹⁶⁴

takes official action to replace competition with regulation, that "state action" and the conduct it endorses are immune from liability under federal antitrust laws. See *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.

146. Hospital Efficiency and Cooperation Act, 1993 Colo. Sess. Laws 120 (codified as amended at COLO. REV. STAT. §§ 25.5-1-501 to 25.5-1-516 (1999)).

147. Health Reform Act of 1993, 1993 Fla. Laws ch. 129 (codified as amended at FLA. STAT. ANN. § 381.04065 (West 1998)).

148. Hospital Authorities Law, 1993 Ga. Laws 1020 (codified at GA. CODE ANN. § 31-7-72.1 (Harrison 1993)).

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

150. Health Care Provider Cooperative Act, 1994 Kan. Sess. Laws 153 (codified at KAN. STAT. ANN. §§ 65-425, 65-4909 (1996)).

151. Hospital Cooperation Act of 1992, 1992 Me. Laws 814 (codified as amended at ME. REV. STAT. ANN. tit. 22, §§ 1881-1888 (West 1998)).

152. Act Providing for Universal Health Care Access, 1993 Mont. Laws 606 (codified as amended at MONT. CODE ANN. §§ 50-4-601 to 50-4-623 (1999)).

153. Health Care Facility-Provider Cooperation Act, 1994 Neb. Laws 1223 (codified at NEB. REV. STAT. §§ 71-7701 to 71-7711 (1996)).

154. 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)).

155. Hospital Cooperation Act of 1993, 1993 N.C. Sess. Laws 529 (codified at N.C. GEN. STAT. §§ 131E-192.1 to 131E-192.13 (1997)).

156. Health Care Provider Cooperative Agreements, 1993 N.D. Laws 263 (codified as amended at N.D. CENT. CODE §§ 23-17.5-01 to 23-17.5-12 (1999)).

157. Voluntary Cooperative Actions to Improve Health Care of 1992, OHIO REV. CODE ANN. §§ 3727.2 to 3727.24 (Anderson 1996).

158. Cooperative Program on Heart and Kidney Transplants of 1993, OR. REV. STAT. §§ 442.700 to 442.860 (1996).

159. Health Care Cooperation Act of 1994, S.C. CODE ANN. §§ 44-7-500 to 44-7-590 (Law Co-op. 1996).

160. Hospital Cooperation Act of 1993, TENN. CODE ANN. §§ 68-11-1301 to 68-11-1309 (1993).

161. Act Relating to Cooperative Agreements Among Hospitals of 1993, TEX. HEALTH AND SAFETY CODE ANN. §§ 314.001 to 314.008 (West Supp. 1997).

162. Health Services Act of 1993, WASH. REV. CODE §§ 43.72.300 to 43.72.310 (1997).

163. Health Care Cooperative Agreements Act of 1991, WIS. STAT. ANN. §§ 150.84 to 150.92 (West 1998).

164. An overview on the nature and extent of these 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 (1994).

These "antitrust immunity" 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 likely result in lower health care costs or improve health care access or quality without any undue increase in health care costs.¹⁶⁵ Under this authority, the state in 1995 imposed conditions on the merger of Great Falls' only two hospitals—one Catholic and one secular—to address concerns that services previously available at the non-Catholic hospital would not be offered after the merger. 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, several services offered prior to the merger: elective sterilizations, information and counseling on the morning-after pill for rape victims, and HIV risk-reduction counseling.¹⁶⁶

Most state-level merger reviews under the antitrust laws are conducted by attorneys in the office of the state's attorney general (AG). 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 have 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,¹⁶⁷ and states have set up systems that allow them to coordinate investigations and share resources on matters that affect more than one state, such as mergers in which 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

165. MONT. CODE ANN. § 50-4-603(2) (1995).

166. Certificate of Public Advantage in the Matter of Columbus Hospital and Montana Deaconess Medical Center, (Mont. Dep't of Justice Mar. 6, 1996) (copy on file with the National Women's Law Center).

167. NAT'L ASS'N OF ATT'YS GEN., VOLUNTARY PRE-MERGER DISCLOSURE COMPACT, reprinted in 66 Antitrust & Trade Reg. Rep. (BNA) 337 (1994).

merger enforcement area in recent years, and on some occasions have challenged mergers that the federal authorities have decided to allow.¹⁶⁸ 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.¹⁶⁹ Indeed, since some local mergers are too small ever to be reported to the federal agencies, the state authorities are most likely to hear of them first. Hospital mergers often fit this model.

Consequently, 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,¹⁷⁰ 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.¹⁷¹

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 Act¹⁷² or for

168. See, e.g., *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057 (N.D. Cal. 2000) (sustaining state attorney general's challenge to merger asserting anticompetitive effect, after failing-firm defense and showing of substantial number of hospitals in relevant market).

169. NAAG has issued *Horizontal Merger Guidelines* for its members' use. See *supra* note 93. In addition, Massachusetts and Pennsylvania have issued statements outlining their own antitrust analyses of hospital mergers. See *State Convinces Two Hospitals to Drop Merger Plans, But Approves Other Merger*, 68 Antitrust & Trade Reg. Rep. (BNA) 60 (Jan. 19, 1995), WL 68 ATRR 60; *State Offers Guidelines for Hospital Mergers; Market Definitions Included*, 2 Health L. Rep. (BNA) 1134 (Aug. 26, 1993), WL 2 BHLR 34 d11.

170. 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.

171. See *Wisconsin v. Kenosha Hosp. & Med. Ctr.*, No. CIV.A.96-C-1459, 1996 WL 784584, at *2 (E.D. Wis. Dec. 31, 1996) (requiring merged hospital to avoid \$24 million in capital and duplicative-services costs and to generate \$19.7 million in operational savings, or else pay cash difference to Indigent Care Fund supervised by the attorney general); *Pennsylvania v. Providence Health Sys.*, No. 4:CV-94-772, 1994 WL 374424, at *2 (M.D. Pa. May 26, 1994) (noting that if merged hospitals did not achieve \$40 million in net cost savings within five years, deficit would be paid in cash to health care fund established by attorney general).

172. See Clayton Act § 16, 15 U.S.C. § 26 (1994 & Supp. IV 1998).

divestiture of the acquired assets after the merger has been completed,¹⁷³ and also, in limited circumstances, to recover treble damages for harm caused by the merger.¹⁷⁴ The Act also provides for an award of attorneys' fees and costs to a successful private plaintiff.¹⁷⁵ This private right of action permits those likely to be harmed by a proposed hospital merger or affiliation that threatens to eliminate reproductive health services—such as women likely to need such services or doctors who would be prevented from using the facilities to provide them—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 affirming 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."¹⁷⁶ 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."¹⁷⁷ Antitrust injuries would not include the harm that a competitor might suffer if a merger increased 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 case law directly on point, it appears that the "antitrust injury" requirement could be met in such a case.¹⁷⁸

173. See *California v. Am. Stores Co.*, 495 U.S. 271 (1989).

174. See 15 U.S.C. § 15(c).

175. *Id.* § 15(a).

176. *Am. Stores*, 495 U.S. at 284.

177. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (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).

178. 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

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, time is of the essence in a merger challenge, because courts are generally reluctant to rescind a merger once consummated (i.e., to 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.

V.

A CASE STUDY: THREE-WAY MERGER IN KINGSTON, NEW YORK

The response of a community in upstate New York to a proposed merger that threatened reproductive health services there provides a useful case study of how the antitrust laws can be utilized in such a situation. In 1997, plans for a two-step merger of three-hospitals in the mid-Hudson River Valley region were revealed. First, two secular hospitals—Kingston Hospital in Kingston, and Northern Dutchess Hospital across the river in Rhinebeck—would join, forming Cross River HealthCare.¹⁷⁹ More troubling to members of the community was the plan for Cross River to merge with a third facility—Benedictine Hospital, a Catholic institution in Kingston—and for the unified three-hospital entity to abide by the *Directives*, which ban abortions, sterilizations, contraceptive counseling and services,

duplicative recoveries for the same antitrust violation. In a damages suit, the plaintiff must suffer injury to the plaintiff's "business or property," *Cargill*, 479 U.S. at 111, and the injury must be to direct purchasers, *Ill. Brick Co. v. Illinois*, 431 U.S. 720, 745-46 (1977). In the circumstances presented here, both women and physicians could have suffered such injuries. A woman is injured financially when she is forced to travel long distances to obtain reproductive health services, while a physician is injured when she is restricted in the number of services she can provide to her patients. However, even if injury were proven here, the plaintiff in a private merger suit faces the additional requirement of showing an actual injury from the merger, as opposed to the more lenient standard of a "threatened damage or loss." Cf. 15 U.S.C. §§ 15, 26. An injury that was actually caused by the merger would be extremely difficult to prove, because the defendant could easily argue that an intervening cause resulted in the injury to the plaintiff. Therefore, few private actions for damages are brought to mergers. In addition, the small monetary damages likely to be awarded and the burdens of litigation itself could further discourage the potential plaintiff from initiating such an action.

179. *Two Hudson Valley Hospitals Merge*, TIMES UNION (Albany, N.Y.), Feb. 21, 1997, at B2.

in vitro fertilization, and other services.¹⁸⁰ These services, with the exception of in vitro fertilization, previously had been available at the two secular hospitals.¹⁸¹

As soon as the terms of the merger were announced, local groups organized to oppose it, based on their concern that the community stood to lose important health care services. Working through a coalition of three groups, community members held rallies, obtained 10,000 signatures on petitions, put up hundreds of lawn signs, testified before state regulatory bodies, visited editorial boards, generated letters to public officials, and otherwise voiced their concerns and urged the hospitals to reconsider.¹⁸² The hospitals' only response was to announce in January 1998 that a new freestanding clinic providing first-trimester abortions would be opened in Kingston after completion of the three-way merger, and to note that patients seeking postpartum tubal ligations could travel to hospitals in Poughkeepsie and other towns as much as sixty-five miles from Kingston and Rhinebeck.¹⁸³ This did not allay objections to the merger for several reasons, including the concern that a stand-alone abortion clinic would be a lightning rod for harassment and violence, and the fact that there would be no local hospital available for postpartum tubal ligations.¹⁸⁴ Nonetheless, the deal seemed headed for closure.¹⁸⁵

The FTC then entered the picture. In February 1998, *Modern Healthcare* magazine reported that the FTC was investigating the proposed Cross River-Benedictine merger. According to this account, which the FTC would not confirm or deny (as is its standard practice), the FTC had requested information on the merger from the hospitals, even though no Hart-Scott-Rodino pre-merger filing had been made, and FTC investigators were looking into the transaction's likely effects on competition.¹⁸⁶ This disclosure prompted community activists to shift their attention to the FTC.

Acting on behalf of the local advocates, MergerWatch Project of Family Planning Advocates of New York State, based in Albany, and attorneys with the National Women's Law Center in Washington, D.C., contacted the

180. Esther B. Fein, *Hospital Deals Raise Concern on Abortion*, N.Y. TIMES, Oct. 14, 1997, at B5.

181. *Id.*

182. Andrea Barrist Stern, "Process of Healing": Kingston Hospital Confirms Demise of a Plan to Merge with Benedictine, WOODSTOCK TIMES (N.Y.), Sept. 3, 1998, at 1.

183. Press Release, Cross River HealthCare, Cross River HealthCare Details Plan to Relocate Reproductive Services (Jan. 29, 1998) (on file with the National Women's Law Center); see also Christine Ngeo, *Partners Try Two-Step: FTC Investigates Second Phase of N.Y. Hospital Deal*, MOD. HEALTHCARE, Feb. 16, 1998, at 24 (reporting opening of Women's Care Center of Westchester County Medical Center).

184. Ngeo, *supra* note 183, at 24.

185. *Id.* (reporting that "the deal is expected to close shortly"); 1997 *Hospital Mergers, Acquisitions, Joint Ventures and Long-Term Leases*, MOD. HEALTHCARE, Jan. 12, 1998, at 44 (reporting that deal is "expected to close late this year").

186. Ngeo, *supra* note 183, at 24.

FTC. With this assistance, the local advocates were able to open up a dialogue with the FTC staff in the agency's New York Regional Office. From this process, community activists gained an understanding of the kinds of information the FTC considers relevant in a merger investigation, and they set about assembling it. Residents of the affected area traveled to the hospitals in Poughkeepsie and elsewhere that the merging parties had claimed were easily accessible, and they presented the FTC with detailed information on travel time and travel obstacles such as poor road conditions and inadequate public transportation. They collected medical information on the health risks associated with outpatient tubal ligation as an alternative to sterilization immediately following delivery, and on other deleterious consequences of fragmenting women's health care into different settings. They identified large employers in the area with concerns about the impact of the merger on health care costs. To the FTC, such information was relevant to the geographic market definition and the likely competitive effects of the merger.¹⁸⁷

While the FTC actively conducted its investigation, Cross River and Benedictine representatives continued to express optimism that the FTC would soon clear the merger, but they held off on closing the deal while the investigation was pending.¹⁸⁸ Then, in July 1998, the relationship between Kingston and Northern Dutchess, which had formed Cross River, fell apart, and the Cross River board of trustees voted to dissolve the agreement.¹⁸⁹ But this did not end the matter, because Kingston and Benedictine Hospitals indicated that they intended to pursue a two-way merger.¹⁹⁰

Community activists made it clear in a public forum that a Kingston-Benedictine merger would be just as unacceptable as the original three-way deal, because it would deprive residents on the Kingston side of the Hudson River of the services banned under the *Directives*.¹⁹¹ They also argued that it should be of no less concern to the FTC, because a Kingston-Benedictine merger would create a monopoly on one side of the river.¹⁹² FTC staff were quoted in the media the next day expressing the same view.¹⁹³ The very same week, the FTC won a hospital merger challenge in a district

187. Letter from Alan. B. Loughnan, FTC Attorney, to Lois Uttley, MergerWatch, a Project of Family Planning Advocates of New York State (Mar. 23, 1998) (on file with the National Women's Law Center).

188. *Competing Values: Federal Inquiry into Hospital Merger Raises Questions of How Much the Plan Would Cost Consumers*, WOODSTOCK TIMES (N.Y.), May 7, 1998, at 14.

189. Cynthia Werthamer, *Cross River Collapses*, KINGSTON DAILY FREEMAN (N.Y.), July 23, 1998, at 1.

190. *Id.*

191. Cynthia Werthamer, *Hospital Merger Protest Stays Alive*, KINGSTON DAILY FREEMAN (N.Y.), July 28, 1998, at 1.

192. *Id.*; Darren O'Sullivan, *Groups Vigilant on Hospital Services*, POUGHKEEPSIE J. (N.Y.), July 28, 1998, at 1B.

193. A local newspaper quoted an FTC attorney as stating, "A combination of the only two hospitals in Kingston . . . would remain, I think, problematic." Cynthia Werthamer, *FTC Concern Clouds Merger*, KINGSTON DAILY FREEMAN (N.Y.), July 29, 1998, at 1.

court in Poplar Bluff, Missouri, prompting comments from antitrust experts to the effect that the government's victory there should make hospitals all over the country more wary of joining forces with their neighbors.¹⁹⁴ Shortly thereafter, Kingston and Benedictine Hospitals broke off their talks indefinitely.¹⁹⁵

Some close observers have attributed the demise of the Kingston merger at least in part to the FTC's involvement, and have identified the community's work¹⁹⁶ with the FTC as a factor in fueling the FTC's investigation. This saga thus provides some important lessons for those concerned about proposed hospital mergers that threaten to eliminate services in a community. First, the antitrust agencies are interested in hearing the concerns of the affected community. Second, the community's concerns about reproductive health services can be translated into terms that are legally relevant to an antitrust analysis, such as geographic market definition and competitive effects. Third, the community can be a valuable source of information for the antitrust enforcement authorities on these issues. Finally, the existence of an active antitrust investigation, even before it has reached the point of formal agency action to challenge a proposed merger, can be a factor in altering the merging parties' plans.

VI.

CONCLUSION

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 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 the case—including, for example, the number of hospitals and other facilities providing relevant services in the area, and the ability of patients to obtain these 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 prompt the merging parties to fashion arrangements that will guarantee the continued availability of needed services, and may even stop the transaction in its tracks.

194. Kristen Hallam, *FTC Wins a Round in Mo. Antitrust Case*, MOD. HEALTHCARE, Aug. 3, 1998, at 3. *But see supra* note 106, regarding the status of the case.

195. Michelle Vellucci, *Health Facility Union Fizzles*, POUGHKEEPSIE J. (N.Y.), Sept. 2, 1998, at 1. Kingston Hospital officials said they would consider affiliating with another secular institution instead of Benedictine. Cynthia Werthamer, *Hospital Rethinks Its Future*, KINGSTON DAILY FREEMAN (N.Y.), Sept. 2, 1998, at 1.

196. Stern, *supra* note 182, at 1.