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Roanoke or *Rockford*: Two Divergent Approaches to Antitrust Enforcement for Not-for-Profit Hospital Mergers

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Roanoke or *Rockford*: Two Divergent Approaches to Antitrust Enforcement for Not-for-Profit Hospital Mergers

I. Introduction

In 1988, the Department of Justice took a new step in its 98 year history of federal antitrust enforcement. The Department challenged consolidations of non-profit charitable hospitals by bringing injunctive actions designed to stop proposed transactions in Roanoke, Virginia, and Rockford, Illinois.[1] The two cases, decided only ten days apart, exhibit very different approaches by the Courts in respect to antitrust enforcement against nonprofit charitable hospital mergers; namely: which sections of the antitrust laws should apply, Section 7 of the Clayton Act[2] or Section 1 of the Sherman Act?[3] The questions these divergent approaches leave to nonprofit hospitals considering mergers are many; not the least of which is what will be the direction of the higher courts when analyzing future merges of nonprofit hospitals?

II. The Clayton Act

The first and perhaps the most important question to be answered is whether Section 7 of the Clayton Act[4] is applicable to nonprofit hospital mergers. The *Roanoke* court dismissed the gov-

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1. United States v. Carilion Health System, 707 F. Supp.840 (W.D.Va. 1989), hereinafter *Roanoke*, United States v. Rockford Memorial Corporation, 717 F. Supp. 1251 (N.D.Ill. 1989) hereinafter *Rockford*.

2. Section 7 of the Clayton Act states as follows:
"No person shall acquire, directly or indirectly, the whole or any part of the stock or other share capital and no person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of one or more persons engaged in commerce or in any activity affecting commerce, where in any line or commerce or in any activity affecting commerce, in any section of the country, the effect of such acquisition of such stocks or assets, or of the use of such stock by the voting or granting of proxies or otherwise, may be substantially to lessen competition or to tend to create a monopoly." 15 U.S.C.A. § 18. (1982).

3. Section 1 of the Sherman Act states in part:
Sec 1. "Every contract, combination. . . or conspiracy, in restraint of trade or commerce among the several states or with foreign nations is hereby declared to be illegal. . . ." 15 U.S.C.A. § 1 (1982).

4. 15 U.S.C.A. § 18 (1982).

ernment's Clayton Act claim.[5]

> In dismissing the claim, the court noted that sec. 7 had two clauses one that prohibited certain stock acquisitions and a second that barred certain assets acquisitions by persons subject to the jurisdiction of the Federal Trade Commission. The court found that the clause addressed to stock acquisitions did not apply to defendants because no stock was involved in their transaction. Both defendants are non-stock, non profit corporations. The court also ruled that the assets clause did not apply either because the FTC Act did not confer jurisdiction over nonprofit entities on the FTC.[6]

The government, by a motion filed during the trial, asked the court to reconsider its ruling that section 7's stock clause does not apply to the planned affiliation.

> The government points out that defendant Carilion is a holding company that through the affiliation will acquire control of defendant Community. The government argues that even if Carilion cannot acquire Community's stock, if it is consummated its planned acquisition of Community, it would acquire Community's "share capital" thereby subjecting its transaction to sec. 7 scrutiny. The government points to no case however, in which a court has applied sec. 7 to a merger of non-stock, nonprofit corporations, and the court again concludes that sec. 7's stock clause is worded so as to address only acquisitions of stock or of an interest equivalent to stock. Community which has no private owners, has not issued and by law cannot issue, any share capital equivalent to stock, and sec. 7 therefore does not govern its affiliation with Carilion.[7]

Although the court in *Roanoke* stated that the government had pointed to no case in which section 7 had been applied to a merger of a non-stock, nonprofit corporation, only ten days later, the *Rockford* court held that section 7 of the Clayton Act applied to the proposed consolidation of two non profit hospitals.[8] In that case, the government filed a verified complaint to prevent and restrain the merger of Rockford Memorial Corporation (RMC) and Swedish American Corporation (SAC) and to adjudge the transaction to be in violation of Section 7 of the Clayton Act and Section 1 of the Sherman Act.[9]

The defendant's position in *Rockford* with respect to the applicability of section 7 to their proposed transaction is very similar to the reading of section 7 provided by the *Roanoke* court. The defendants rely on a literal reading of the first part of section 7 as

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5. 707 F.Supp 840, 841 (W.D.Va 1989).
6. *Id.* n.1.
7. *Id. See* Mem. op. on Defendants Motion to Dismiss at 3-6 (Sept. 30, 1988).
8. 717 F. Supp. 1251 (N.D.Ill. 1989).
9. *Id.* at 1252.

being made up of two provision—the first provision referring to an acquisition of "stock" or "share capital" and the second provision referring to an acquisition of "assets".[10] The defendants in essence argued that a nonprofit hospital does not have and by law cannot have stock or for that matter share capital. This is in line with the *Roanoke* courts statement that "the clause addressed to stock acquisitions did not apply to defendants because no stock was involved in their transaction. Both defendants are non-stock, nonprofit corporations."[11] Additionally, the *Rockford* defendants argued that the assets acquisition provision applied only to persons under the jurisdiction of the Federal Trade Commission (FTC) and not-for-profit companies such as defendants are not under the aegis of the FTC.[12] Once again this line of reasoning is in accord with the statement of the *Roanoke* court that "the assets clause did not apply either because the FTC Act did not confer jurisdiction over nonprofit entities to the FTC."[13] The *Rockford* court however rejected defendants interpretation of section 7 of the Clayton Act and instead relied on an analysis of *United States v. Philadelphia National Bank*[14] to show that section 7 is indeed applicable to a merger of two entities outside the FTC's jurisdiction.

The *Philadelphia National Bank* case involved the proposed merger between two banks not under the jurisdiction of the FTC. The *Philadelphia* court began by analyzing the Celler-Kefauver Antimerger Act[15] which amended section 7 of the Clayton Act to include an assets-acquisition provision. Although the court found the legislative history silent on the specific questions of why the amendment made no explicit reference to mergers, and why asset acquisitions by corporations not subject to FTC jurisdiction were not included, the *Philadelphia* court concluded that "Congress primarily sought to bring mergers within section 7 and thereby close what it regarded as a loophole in the section."[16] The court went on to find that the stock acquisition and assets-acquisition sections when *read together*, (emphasis by court) reach mergers which fit neither category perfectly but lie somewhere between the two ends

10. *Id.*
11. 707 F. Supp. at 841.n.1.
12. 717 F. Supp. at 1252.
13. 707 F. Supp. at 841 n.1.
14. 374 U.S. 321, (1963). hereinafter *Philadelphia.*
15. Celler-Kefauver Antimerger Act, Act of December 29, 1950, 15 U.S.C. § 18 (1982).
16. 374 U.S. at 341.

of the spectrum.[17] So construed, the specific exception for acquiring corporations not subject to the FTC's jurisdiction, excluded from the coverage of section 7 asset acquisitions made by acquiring corporations which were not accomplished by merger.[18] The court further stated that "it is unquestioned that the stock acquisition provision of section 7 embraces every corporation engaged in commerce, including banks. And it is plain that Congress in amending section 7 considered a distinction for antitrust purposes between acquisition of corporate control by purchase of stock and acquisition by merger completely unsupportable, and sought to overrule the decisions of this Court which had recognized such a distinction."[19]

The *Rockford* Court essentially takes the analysis of the *Philadelphia* courts interpretation of section 7 as refuting the defendants argument that the first provision of section 7 only reaches consolidations accomplished through an acquisition of "stock" or "share capital."[20] The court finds that the bottom line to the *Philadelphia* decision is that Congress amended section 7 in order to reach mergers without qualification.[21] Accordingly, the court finds that section 7 of the Clayton Act reaches non-stock mergers by persons not subject to the jurisdiction of the FTC and thus the proposed consolidation of the two hospitals is subject to a section 7 Clayton Act analysis.[22]

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17. *Id.* at 342.

18. *Id.*

19. Id. at 343.

> The purpose of the proposed legislation [the 1950 amendments to sec. 7] is to prevent corporations from acquiring another corporation by means of its assets, where under the present law it is prohibited from acquiring the stock of said corporation. Since the acquisition of stock is significant chiefly because it is likely to result in control of the underlying assets, failure to prohibit direct purchase of the same assets has been inconsistent and paradoxical as to the overall effect of existing law.

74 U.S. at 341, n.19.

20. 717 F. Supp. at 1254. Quoting from *Philadelphia* the court rules on the following: "The specific exception for acquiring corporations [not merely banks] not subject to the FTC's jurisdiction excludes from the coverage of sec. 7 only asset acquisitions by such corporations when not accomplished by merger". 374 U.S. at 342. Further the court did not limit to banks the following findings: "It is unquestioned that the stock acquisition provision of sec. 7 embraces every corporation engaged in commerce, including banks". 374 U.S. at 343. "If therefore, mergers in other industries outside the FTC's jurisdiction were deemed beyond the reach of sec. 7 the result would be precisely that difference in treatment which Congress rejected." 374 U.S. at 333-34. Finally, the court explicitly acknowledges that "[w]e have not overlooked the fact that there are corporations in other industries not subject to the FTC's jurisdiction". 374 U.S. at 344 n.22.

21. *Id.* at 1256.

22. *Id.* at 1258.

Did the Rockford court strain the interpretation of the *Philadelphia* decision to apply section 7 of the Clayton Act to nonprofit hospital mergers? Kopit and McCann in their article *Toward a Definitive Antitrust Standard for Nonprofit Hospital Mergers*[23] argue that applying Section 7 to nonprofit charitable hospitals would amount to a wholesale restructuring of the law without any support whatsoever in either the statutory language or legislative history.[24] The authors appear to rely on the following from the *Philadelphia* case. Mergers and consolidations should be analyzed to a covered acquisition of stock rather than a noncovered acquisition of assets.[25] The court emphasized that the legislative history of the 1950 Amendments supported the analogy: "When you talk about mergers, you are talking about a stock transaction . . . Actually what you do is merge the stockholdings of both corporations. . . . and you issue stock in the one corporation in lieu of stock in the other corporation . . . so it really is a stock transaction in the final wind up regardless of what you call it."[26]

The authors argue that unlike the factual situation in *Philadelphia*, no stock will (or could) change hands in the typical merger, consolidation or acquisition of one nonprofit charitable hospital by another.[27] Thus, unlike in *Philadelphia* there is no statutory ambiguity to resolve.[28] The original Section 7 never reached nonstock, nonprofit organizations at all and the assets acquisition language added by the 1950 amendments cannot be said to have expanded the statute in that regard when its terms explicitly exclude nonprofit corporations.[29]

Which interpretation of section 7 of the Clayton Act will other courts follow? A literal reading of the act which results in section 7

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23. Kopit & McCann, *Toward a Definitive Antitrust Standard for Nonprofit Hospital Mergers*, JOURNAL OF HEALTH, POLITICS, POLICY AND LAW. Vol. 13., No. 4 (1988), 635.

24. *Id.* at 653.

25. 374 U.S. at 341.

26. *Id.* at 345.

27. Kopit & McCann, *supra* note 23 at 653.

28. *Id.*

29. *Id.* In footnote 60, the authors state:

> moreover, any attempt to treat an affiliation between nonprofit hospitals as somehow . . . analogous to the creation of a stockholding company would inject an internal inconsistency into the Clayton Act. Asset acquisitions by nonprofit organizations are excluded from coverage by the express language of the statute. The postulated analogy, therefore, would make jurisdiction over stock acquisitions broader than jurisdiction over assets acquisitions rather than harmonize the two grants of authority. Moreover, the legislative history makes clear that jurisdiction over stock and asset acquisitions was intended to be constructive.

Id.

not being applicable to nonprofit hospital mergers stated by the *Roanoke* court; or an analogy to the *Philadelphia* case which permits application of section 7 to nonprofit hospital mergers as read by the *Rockford* court. The final analysis will likely rest on a number of issues some of which have not been discussed in either case. One issue which will need to be explored further is whether the nonprofit status of hospitals should be considered in the *Philadelphia* analogy. The Rockford court did not thoroughly address this issue and it was recently noted that "there is a possible gap in the FTC's jurisdiction over acquisitions involving nonprofit corporations.[30] The Department of Justice, however, argues that the tax and charitable status of hospitals or any business for that matter is not relevant to merger enforcement.[31]

In the long run, the courts and maybe Congress, will decide the applicability of section 7 to hospital mergers. However, it appears that a literal reading of the statute may be a more prudent way to proceed in light of the fact that there is no legislative history or jurisprudential guidance related to the issue.

III. Market Definition

When the proposed merger is analyzed under section 1 of the Sherman Act,[32] the courts will typically use a "rule of reason" analysis for determining whether most business combinations or contracts violate the prohibitions of the Sherman Act.[33] Whether a particular combination is unreasonable depends on such factors as the facts peculiar to the business in which the restraint is applied, the nature of the restraint and its effects and the history of the restraint and the reason for its adoption.[34] The *Roanoke* court relying on *Topco* analyzed the proposed merger under the rule of reason standard.

When the proposed merger is analyzed under section 7 of the Clayton Act, the court must determine whether the challenged acquisition may be substantially to "lessen competition" in that market.[35] Proof of actual anticompetitive practices is not required; rather evidence that these practices are likely to occur in the fu-

30. Hospital Corporation of America v. F.T.C. 807 F.2d 1381, 1390 (7th Cir. 1986).

31. Rule, *Antitrust Enforcement and Hospital Mergers: Safeguarding Emergency Price Competition*, 21 Journal of Health and Hospital Law, 125 (1988).

32. 15 USC § 1 (1982).

33. United States v. Topco Associates, Inc., 405 U.S. 596, 606-07 (1972).

34. *Id.* at 607.

35. 374 U.S. at 362.

ture is all that is necessary. This standard allows anticompetitive tendencies to be arrested in their incipiency.[36]

This protective standard was utilized by the *Rockford* court. The first step in either analysis is to determiné the product and geographic market. The *Roanoke* and *Rockford* courts differed in their definition of product market. The *Roanoke* court concluded that the relevant product market included both inpatient and outpatient services. The court noted that because patients or their doctors can choose to have problems treated in either a hospital or in an outpatient clinic or doctors's office in a significant number of cases, the court found that certain clinics and other providers of outpatient services compete with the defendant's hospitals to treat various medical needs.[37] The *Rockford* court, on the other hand, rejected defendants definition of a product market which included both inpatient and outpatient care provided by all health care providers, instead the court found that acute inpatient hospital care is the economically significant submarket of the healthcare industry that should be analyzed for purposes of determining the competitive effects on the defendants consolidation.[38] The court again relied on *Philadelphia* by referring to inpatient care as a cluster of services and noting that the concept that a combination or cluster of services could serve as a relevant product market was adopted in *Philadelphia*.[39] In rejecting defendants and for that matter the *Roanoke* courts definition of product market, the court had this to say "[T]he court agrees that there is interchangeability between outpatient and inpatient services. The court however does not agree that the relevant line of commerce includes outpatient care."[40] Thus we are left once again with two very different approaches to product market definition. Assistant Attorney Generaly Rule, of the Antitrust Division of the Department of Justice adopts the *Rockford* definition when he states the services that might comprise the relevant product market are limited to acute care inpatient services because it is a hospital's provision of those

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36. *Id.*, *citing* Brown Shoe Co. v. United States, 370 U.S. at 317, 322 (1962).

37. 707 F. Supp. at 845.

38. 717 F.Supp at 1259-1260.

39. *Id.* at 1260.

40. *Id.* at 1259. The court also relied on the definition of product market from *In re HCA* where the FTC found that while hospital services may well have outpatient substitutes, the benefit that accrues to the patient is derived from the complimentary cluster of services and that there is no readily available substitute supplier of the benefit that this complementing or combination of services confers on the acute care patient. *Id.* at 1260, quoting from *In re HCA* 106 F.T.C. at 436, 466.

services that most clearly distinguishes it from other health care providers.[41] Others have argued that in competitive environments where hospitals offer substantial services on an outpatient basis and/or have meaningful nonhospital competition for their services, a separate relevant market for non acute care services may need to be defined.[42] Given the variety of services which are provided by today's hospitals and the many alternative delivery systems with which they are in competition, it appears that the broader market definition adopted by the *Roanoke* court more accurately describes the "cluster of services" provided by hospitals.

The *Roanoke* court found the applicable geographic market to be all of the counties and cities from which Roanoke Memorial draws at least 100 patients a year.[43] This broad definition resulted in a geographic area comprising 16 counties, three independent cities of Virginia and three counties of West Virginia.[44] While the *Roanoke* court used a very straightforward definition of geographic market, the *Rockford* court took information supplied by the defendant to draw its own geographic boundaries. The methodology they used in part is based on the Elzinga-Hogarty test,[45] when

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41. *See*, Rule *supra*, note 31 at 126.

42. Klingensmith, *Applying Antitrust Concepts to the Acute Care Hospital Industry: Defining the Relevant Market for Hospital Services.* 13 JOURNAL OF HEALTH, POLITICS, POLICY AND LAW, 153-62 (1988).

43. 707 F. Supp. at 847-48.

44. *Id.* at 848.

45. Rockford *supra.* at 1271. The Elzinga-Hogarty test uses the following methodology:

> Step l(a): Determine the merging hospitals service area, i.e., the area from which they draw 90% of their business.
>
> Step l(b): Determine the collective service area of all hospitals located within the merging hospitals service area.
>
> . . .
>
> This area satisfies the LOFI test (i.e., little out from the inside).
>
> Step 2: Determine the area containing those hospitals that supply 90% of all the business that comes from patients residing in the collective service area.
>
> . . .
>
> This area satisfies the LIFO test (Little in from the outside).
>
> . . .
>
> The hospitals identified by this procedure are within the geographic market relevant to the proposed merger. *Id* at 1267. It is also important to note that two well known circumstances tend to overstate or understate the Elzinga-Hogarty test. The test can understate its market when customers between two producers are divided between A & B on either side of a point between A and B. These circumstances can produce one market for A and another for B. However, in the event one producer sought to exercise market power, customers may be willing to travel (out of the market) to the other producer. In sum, the static market is smaller than the market after an exercise of market power and thus by definition is understated. The test can overstate the mar-

used by the defendants, it resulted in a large (ten county) geographic market, the court instead found the test to be a useful tool for eliminating certain geographic areas from consideration as relevant markets. The courts rationale for keeping the geographic market relatively small rested on three findings:

> 1. Physician and patient preferences for nearby hospitals is the main reason for keeping the geographic market relatively small. The key of course is physician admitting patterns to the three Rockford hospitals and the three Rockford hospitals almost exclusively.[46]
> 2. The evidence demonstrates that the patients who do travel from outside the Rockford area do so a majority of the time for specialized care unavailable at their local hospitals.[47]
> 3. The defendants themselves generally perceived that they compete with one another and Saint Anthony Medical Center.[48]

These three rationales led the court to believe that if there was a small but significant non-transitory price increase at the defendants hospitals, it is very unlikely that patients inside the Rockford area would travel to the outlying community hospitals or that patients outside the Rockford area would stop inmigrating into Rockford hospitals.[49] The final geographic market was smaller than that identified by the defendants but larger than the one requested by the government.

As with all antitrust cases, the market definition is one of the most important elements. Whether the courts will proceed with the Rockford analysis, the Roanoke analysis or somewhere in between still needs to be resolved. Both approaches result in a reasonable geographic market, but as with the product definition, the final determination may depend on the community or type of hospital involved. Professor Klingensmith of the University of Pittsburgh argued what appears to be in line with both courts analysis that the relevant geographic market should turn on the competitive environmental characteristics and product market definition.[50]

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ket where geographic price discrimination is employed. Because the product or services cannot be resold, a producer could control the competitive effect of its exercise of market power by pricing its services or produce differently to one segment of the market as opposed to another. *Id.* at 1267, n.12.

46. *Id.* at 1277.

47. *Id.*

48. *Id.*

49. *Id.*

50. *See* Klingensmith, *supra*, note 42 at 163. Table 2, for example:
Competitive Environments Characteristics: All hospitals offer comparable services to the same population and have no other meaningful competition.
Product Market Definition: Clusters of activities knows as acute care services . . .

It is to the hospitals benefit to have the court accept a broad geographic market. Therefore, it is important that whatever definition they use is backed up by verifiable statistics and if the Elzinga-Hogarty test is utilized it is correctly applied. Also, when using it, instead of shaping the market to fit preconceived notions, the examiner should simply allow the figures and market to take shape and let the "appropriate" market and percentages rise to the surface.[51] The Department of Justice approach to geographic market should also be noted. Rule stated that in most cases the geographic market will be highly localized, reflecting the strong needs and preferences of both patients and their physicians for convenience for prompt service in time of emergency and for accessibility to relatives and others in the community during a hospital stay.[52] However, Rule does note that there may be cases where hospitals serve product markets of different geographic scope and in that case they may have broader geographic markets. Sometimes even national as in the case of the Mayo Clinic.[53]

IV. Analysis and Defenses

Once the product and geographic market are settled, the court turns to an analysis of whether the proposed transaction will be in violation of the Antitrust policies and particular statutes being applied. In *Roanoke*, the court used a rule of reason standard.[54] They noted that in analyzing a merger under section 1, the court must evaluate the percentage of business the new merged entity would control, the strength of remaining competition whether the action springs from business requirements or purpose to monopolize, the possible development of the industry, consumer demands and other characteristics of the market.[55] Using this analysis, the court

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generally measured in hospital beds or patient admissions.

Geographic Market Determination: That territory in which a patient reasonably would seek alternative services of hospitalization for most medical needs.

Id.

51. 717 F. Supp. at 1272.

52. *See*, Rule *supra*, note 31 at 127. This principle is also well established in case law. *See* In re American Medical International, 104 F.T.C. 177, 195 (F.T.C. opinion 1984) (relevant geographic markets are both the city and county of San Luis Obispo); In re Hospital Corporation of America, 106 F.T.C. 455, 466 (F.T.C. opinion 1985) market for general acute care hospital services is the Chattanooga Urban area not the broader Chattanooga Metropolitan Statistical Area) Rule *supra*, note 31 at 130, n, 14.

53. *See*, Rule *supra*, note 31 at 127.

54. 707 F.Supp at 846.

55. *Id.* at 847 *quoting* United States v. Columbia Steel Co., 334 U.S. 495, 527 (1948). The court reads United States v. First National Bank and Trust Co. of Lexington 376 U.S.

finds that the governments projection of a 70% market share to be too much, however, the court never finally stated what the market share was. Instead, they found the following which leads to a conclusion that the proposed transaction would not constitute an unreasonable restraint of trade under Sherman Act section 1.[56]

> 1. "Financial and legal barriers (reference to certificate of need laws and licensed but not staffed beds) to expansion by existing hospitals cannot be viewed as prohibitive, and so defendants various competitors in the geographic market would be able to expand their capacity if necessary in order to compete more vigorously with defendants.[57]
> 2. "Also relevant is the fact that defendants seek to merge in order to strengthen rather than reduce competition. Based on Roanoke Memorial's services need to expand and Community's need for more patients, they have found various ways in which more efficient operations can save money and thereby enable them to offer their services more competitively than ever to the patients benefit. That business requirements and consumer demand, rather than a monopolistic design motivate defendants to merge argues strongly in favor of the planned mergers reasonableness".[58]
> 3. "Defendants nonprofit status also militates in favor of finding their combination reasonable. Defendants boards of directors both include business leaders who can be expected to demand that the institutions use the savings achieved through the merger to reduce hospital charges which are paid in many cases by employers either directly or though insurance carriers . . . without deciding whether defendants nonprofit status should exempt their merger from section 1 scrutiny, the court concludes that their nonprofit status weighs in favor of their mergers being reasonable".[59]

One other point which the court finds credible in reaching their determination is that charitable, nonprofit hospitals tend to charge lower rates than for-profit hospitals. Relative to other products and services consumers buy, hospital services are not price sensitive in the relevant market.[60]

By contrast, the *Rockford* court in its section 7 analysis finds that "absent clear proof to the contrary, a horizontal merger violates section 7 of the Clayton Act if it produces a firm controlling an undue percentage of the post merger market, and a significant

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665 (1964) as not standing for the proposition that section 1 prohibits any merger between major competitive factors in a relevant market. 376 U.S. at 673. By quoting *Columbia Steel*, the court indicated that, as in any rule of reason analysis, courts must weight various factors, some peculiar to the industry under consideration, in analyzing a merger under § 1. 707 F. Supp. at 847.

56. *Id.* at 849.
57. *Id.* at 848-49.
58. *Id.* at 849.
59. *Id.*
60. *Id.*

increase in the concentration of the post merger market."[61] To determine whether the market concentration increased the court applied the Herfindahl-Hirschman Index (HHI),[62] using three different bases of market share: state inventoried beds, inpatient admissions and inpatient days.[63] The market before the merger has an HHI above 1800.[64] After the merger the increase is greater than 50 points which according to the Merger Guidelines, there is concern that the merger may harm competition.[65] However, that presumption may be overcome by other factors such as ease of entry, difficulty of collusion and efficiencies.[66]

The *Rockford* court once again relying on *Philadelphia* found that the resultant market shares to be inherently anticompetitive.[67] The court noted that in *Philadelphia* the pre-merger market's two largest firms controlled a 44% share of the market, and after the merger the top two firms would control 59% of the market.[68] By comparison, in the instant case, the two largest firms control approximately two thirds of the present market and after the merger, the two largest firms will control 90% of the market.[69] The court continued with its analysis noting that in *Philadelphia* the other important measure of anticompetitive behavior is whether one firm will control an "undue percentage share of the relevant market" as a result of the hospital merger.[70] In this case, the merged entity will account for nearly 70% of the beds, admissions and inpatient days in the relevant market.[71] In this regard, the *Philadelphia* court found the following: "Without attempting to specify the smallest market share which would still be considered to threaten undue concentration, we are clear that 30% presents that threat".[72]

The *Roanoke* Court thus found that the merger would produce a firm controlling an undue percentage share of the relevant market based on the 30% *Philadelphia* standard, and absent proof that

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61. 717 F.Supp at 1279.

62. U. S. Department of Justice Merger Guidelines, as amended June 14, 1989, and *reprinted at* 2 Trade Reg. Rep. (CCH) 4490, (1986) (hereinafter Merger Guidelines).

63. 717 F. Supp. at 1280.

64. *Id.*

65. *See* Merger Guidelines, *supra* note 62 § 3.11(e).

66. *Id.*

67. 717 F. Supp. at 1292.

68. *Id.* at 1280 *quoting Philadelphia*, 374 U.S. at 365.

69. *Id.*

70. Id. at 1281, *quoting Philadelphia*, 374 U.S. at 363.

71. *Id.*

72. *Id. quoting Philadelphia*, 374 U.S. at 364.

the merger is not likely to have anticompetitive effects, the concentration of the post-merger market will inherently lessen competition substantially in the relevant market.[73] Here, once again, we find a difference between the approaches taken by the *Roanoke* court to determine that the proposed merger was reasonable were not accepted by the *Rockford* court as proof that the merger would not have anticompetitive consequences.

First, the *Roanoke* Court noted that "Financial and legal barriers to expansion by existing hospitals [should not] be viewed as prohibitive".[74] The *Rockford* Court, on the other hand, found that the CON laws and the high costs of market entry are prohibitive and that the CON laws would work to limit the expansion of services or new market participants and as such "the barriers to entry in the relevant market reinforce rather than diffuse the likelihood of anticompetitive tendencies marked by a concentrated market.[75]

Second, the *Roanoke* court evaluated the business justifications and proposed savings which would result from the merger and found them to be reasonable.[76] The *Rockford* court reviewed the business justifications and proposed savings set forth by the defendants and found them to be speculative at best and not necessarily the type that can only be obtained from a merger.[77]

Finally, the *Roanoke* court found that defendants non-profit status and board make-up of Community representatives militated in favor of finding their combination reasonable.[78] The *Rockford* court found that the defendants "consumer-aligned" boards and not-for-profit status will not necessarily prevent the defendants from engaging in anti-competitive activity.[79]

One other defense which was not specifically discussed in *Roanoke*, but which the Department of Justice apparently allows in hospital merger cases, is the "ailing hospital" defense.[80] Rule states that the Department is willing to consider the realistic prospects of

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73. *Id.*

74. 707 F. Supp at 848-49.

75. 717 F. Supp. at 1282.

76. 707 F. Supp. at 849.

77. 717 F. Supp. at 1288-91.

78. 707 F. Supp. at 849.

79. 717 F. Supp. at 1285. The fact that the boards of the hospitals involved in this case had worked together in the past to prevent Chicago Blue Cross from contracting with them to provide healthcare at a rate below the level in defendants' previous contract. The court noted that defendants' past conduct is one of the activities cited by this court as an anti-competitive particularly suitable for the best merger market. *Id.* at 1286.

80. *See*, Rule *supra*, note 31 at 129.

an ailing hospital's service as a circumstance indicating that the hospitals' market share overstates its strength as a competitive force in the market.[81] The *Rockford* court found the "failing market" or "writing on the wall" defense too broad and ungainly to ward off a section 7 violation," particularly when both defendants were solvent but future projections bode some financial trouble.[82]

V. Conclusion

The above comparison of the two courts' approaches shows that there is a wide range of opinion between what is considered an unreasonable restraint of trade for non-profit hospital mergers and what is not. It should also be noted here that the Department of Justice did not challenge proposed mergers in Danville, Illinois, and Portsmouth, Ohio, where the result of the merger was that the new entity was the only hospital left in town.[83] Thus, it appears that the non-profit hospital considering a merger has no clear path to follow at this time. It may even be argued that there is no clear cut definition of what unreasonable restraint of trade means in the hospital context, particularly if as stated in Roanoke, the majority of consumers are not price sensitive to hospital care and also "what kind of monopoly has little or no control over 80 percent of its business."[84]

However, given the larger number of hospital closures this country is experiencing each year,[85] it will become imperative that a clear guideline be established for hospital mergers so that our community hospitals may realistically evaluate the options available to them and take action before it is too late, not only for the hospital, but for the patient. As Rule stated in his description of why the Justice Department will consider the ailing hospital defense "consumers of health care, unlike those of most products, will not necessarily benefit from the market directed struggle to determine which hospital will emerge victorious. Such a struggle could produce levels of care at the failing hospital that are inadequate from

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81. *Id.*

82. 717 F. Supp. at 1289.

83. *See*, Rule *supra*, note 31 at 129-30.

84. Bryant, *Should Not-For-Profit Organizations be Exempt from Antitrust Laws*? 42(6) Healthcare Financial Management, 70, 79 (1988). The author is argued that a greater concern today is monopsony control by buyers over the demand for hospital services.

85. The American Hospital Association (AHA) reported that closures have increased steadily from 1982 when only 23 hospital ceased operation to 1986 when a record number of 79 hospitals closed (*Modern Healthcare* 1988) Klingensmith at 36.

a health care perspective, but which might not be apparent to patients choosing a hospital."[86]

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86. *See*, Rule *supra*, note 31 at 129.