STATE ATTORNEYS GENERAL AND HOSPITAL MERGERS PART II

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In two recent hospital merger cases, Commonwealth of Pennsylvania v. Providence Health System, Inc.,[2] and State of Wisconsin v. Kenosha Hospital and Medical Center,[3] the Pennsylvania and Wisconsin Attorneys General negotiated fairly novel and creative consent decrees, which permitted the mergers to be consummated in exchange for the merging parties agreeing to a number of conditions. These conditions included numerous provisions to protect competition, not only in the traditional inpatient, acute care hospital services market, but also in various ancillary markets such as home health care, durable medical equipment, physician services, and health care insurance markets.[4]

In addition, these decrees required the merging parties to achieve specific levels of net cost savings within the first five years.[5] Further, the decrees mandated that most of these savings be passed onto consumers in the form of low-cost or free health care programs for the community, or by reducing prices or limiting actual price increases for existing services.[6] Finally, the decrees included penalty provisions against the hospitals if the total net cost savings were not met within the five-year period.[7]

In the lead article in the summer 1997 issue of the Chronicle entitled, "State Attorneys General and Hospital Mergers," the question was pointedly raised whether the Pennsylvania/Wisconsin hospital merger model is too "regulatory" in nature. By eschewing the traditional antitrust approach of accepting only structural relief, such as divestiture to remedy a market power problem, the author stated his fear that the states have created a "dangerous precedent" for merger law. The article concludes by suggesting that these decrees are "at odds with the efficiency provisions of the NAAG Horizontal Merger Guidelines,[8] and with the traditional antitrust position taken by twenty-five states, including Pennsylvania and Wisconsin, in an amicus brief filed in Federal Trade Commission v. Butterworth Health Corp.[9]

The article focuses almost exclusively on the efficiencies component of the decrees and appears to ignore the other parts of the decrees. Moreover, in describing these consent decrees as "regulatory" simply because they contain a number of mandatory relief/conduct restriction provisions, begs the real question that we should be asking, which is: Are these decrees advancing the public interest? By focusing on this question instead, hopefully, we can move beyond merely assigning semantical and somewhat pejorative labels such as "regulatory" simply because the decrees contain mandatory relief provisions.

In addressing this "public interest" question, we must first consider the alternative to a negotiated settlement, which was in both cases a challenge to the transaction itself. Litigation presents its own set of risks and costs that must be weighed in each case by both the antitrust enforcement agency and the parties to the transaction, who agreed to the consent judgments at issue rather than risk a challenge. Moreover, given the recent track record of the federal enforcement agencies in challenging hospital mergers, the competition-enhancing provisions contained in a negotiated consent decree, even one that allows the merger to proceed, begins to look quite attractive in retrospect.[10]

Second, implicit in the criticism that the decrees are too regulatory is that the states were somehow embarking on a course of action not generally followed by their federal counterparts. This is simply not true. Indeed, there is a rich tradition in federal antitrust enforcement of negotiating consent decrees with mandatory relief provisions which could be labeled "regulatory" at some level.

The garden variety merger consent decree ordering divestiture of assets can often include numerous forward-looking provisions which amount to fairly tight control of the merged entities' business by the courts and antitrust enforcement agencies.[11] But, even in the non-merger area, one encounters decrees that include mandatory injunctive provisions. For example, the AT&T divestiture decree, arguably the mother of all consent judgments, negotiated by the United States Department of Justice in the early 1980s, essentially provided a road map for Judge Greene to regulate the telecommunications industry for over a decade until passage of the Telecommunications Act of 1996.[12]

The so-called "regulatory" aspects of state health care antitrust decrees simply pale in comparison to some of these non-health care decrees and underscores that we should focus instead on whether the provisions in the decrees are in the public interest. There can be little doubt that when we do that, the competitive-enhancing and cost-savings guarantee provisions in the state consent decrees have been and are in the public interest.

Another criticism raised against the Pennsylvania/Wisconsin hospital merger model appears to be that the states have acted inconsistently with the efficiency provisions of the NAAG Merger Guidelines; and, by doing so, have created a "dangerous precedent" for the future. To the contrary, Pennsylvania and Wisconsin did follow the Merger Guidelines in conducting their respective investigations and in analyzing the merging parties' claimed efficiencies. Indeed, the Merger Guidelines provide that efficiencies "count" only when passed on to consumers. Merger Guidelines § 5.3.

Both Pennsylvania and Wisconsin, again using the Merger Guidelines, concluded in their respective investigations, that the merger would create an entity that would likely have undue market power at least for a period of a few years, in violation of section 7 of the Clayton Act if left alone. However, instead of suing to enjoin the transaction, the two states exercised their prosecutorial discretion of accepting consent decrees instead of litigating and facing the possible risk of receiving no tangible benefits for consumers or competitors if they lost. Although no two cases are identical,

this risk must be given some weight given the recent litigation experience of the federal enforcement agencies in losing three different lower court decisions involving hospital mergers.[13]

It can reasonably be asked which approach has better served the public interest. The states' approach where the mergers were allowed to proceed in return for significant competitive safeguards and strict guarantees that consumers will enjoy the benefits of the efficiency savings created by the merger, or the federal approach of "all-or-nothing" litigation which has resulted in court decisions that find the relevant geographic market for inpatient, acute care services to be a 100-mile radius around the merging hospitals. Does anyone really believe that Dubuque, Iowa and Madison, Wisconsin or Williamsport, Pennsylvania and Harrisburg, Pennsylvania, for example, are in the same geographic market for most hospital services? On the other hand, does anyone believe that just because the hospital discharge data for the two Kenosha hospitals indicates that residents of Kenosha County receive virtually all of their acute inpatient hospital care at the two hospitals mean that the relevant geographic market is Kenosha County? In short, the unpredictability of the law regarding geographic market definition as applied to hospital services drives both the government and the merging parties to a negotiated settlement.

While the Merger Guidelines were used by both states in their respective analyses, it is important to realize that the Merger Guidelines simply represent a starting point for analyzing the competitive effects of a merger. Any responsible enforcement agency must carefully consider and examine all the facts that make up its case before deciding what course to pursue. A thorough review requires one to do more than must calculate HHIs; one must focus as well on the realities of the marketplace uncovered during the course of the investigation. Where opinions in the community vary greatly, and the economic evidence is murky, the enforcement agencies and the parties face unpredictable litigation prospects.

A final alleged inconsistency raised in the earlier article relating to the states' amicus brief in the Butterworth case[14] must be addressed. The article asserts that Pennsylvania's and Wisconsin's decision to join twenty-three other state Attorneys General in filing that brief demonstrated an inconsistency in their positions, because the Butterworth hospitals willingly accepted a consent decree modeled loosely on the Pennsylvania/Wisconsin model.

This argument is patently specious. In the two state cases, the state Attorneys General negotiated the consent decrees to include the type of relief they felt was absolutely necessary to protect consumers and other market participants from future market abuses. In the Butterworth case, on the other hand, the Federal Trade Commission never participated in, or otherwise approved, the "Community Commitment" developed by the merging parties themselves. Indeed, the Federal Trade Commission convinced the judge that its view of the relevant geographic market was correct and, hence, it had good reason to believe that its case against the merger was very strong.

The Federal Trade Commission exercised its prosecutorial discretion in not accepting the hospitals' proposal and instead sought an injunction to stop the merger. A "Community Commitment" developed solely by the merging parties with no input or involvement from the

investigating enforcement agency does not equal a consent decree negotiated at arms length by such an agency. The states' position, therefore, simply supported the Federal Trade Commission's prerogative to challenge a merger that clearly violated section 7 of the Clayton Act.

To conclude, we do not see the need to amend the NAAG Merger Guidelines or for the states to disavow these types of settlements in the future. To the contrary, while these types of settlements may not be feasible in every case, especially if the contemplated relief does not fit the business needs of the merging hospitals, or if the relevant state Attorney General finds the terms of such relief unacceptable in an individual case, these types of settlements do provide a basis for finding alternative ways for the hospitals to achieve their purported efficiencies while preserving effective competition, without the state and the hospitals resorting to litigation and its obvious disadvantages and risks.

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2. Commonwealth of Pennsylvania v. Providence Health System, Inc., 1994-1 Trade Cas. (CCH) ¶ 70,603 (M.D. Pa.); see also Commonwealth of Pennsylvania v. Capital Health System Services, 1995-2 Trade Cas. (CCH) ¶ 71,205 (M.D. Pa.).

3. State of Wisconsin v. Kenosha Hospital and Medical Center, 1997-1 Trade Cas. (CCH) ¶ 71,669 (E.D. Wis.).

4. These conditions include requirements to hold the hospitals' case-mix adjusted net inpatient revenues constant except for an agreed-upon inflation adjustment; to cap the number of physicians the hospitals may employ; to maintain an open staff policy; to not enter into exclusive contracts except in limited circumstances; to negotiate in good faith will all health plans in the market; to obtain the state's approval prior to acquiring any health plan or hospital in its market; to not require any patient or provider to purchase durable medical equipment, nonemergency transport or home health services from any entity affiliated with the hospitals; and to inform patients and providers needing such equipment, transportation or services of the availability of same from competing companies.

5. In Providence, the targeted amount is $40 million and in Kenosha, the targeted amount is $43.7 million.

6. In Providence, the net savings to be passed on to consumers is at least $31.5 million, and in Kenosha, the amount to be passed on is $41.7 million. The Providence settlement has now completed two full years and the results to date have been impressive. Pennsylvania's own efficiencies' expert has confirmed that the newly-created system has thus far realized $26,123,000 in merger-related savings and has passed $24,020,000 back to the community in the form of increased support and lower prices for patients. At the time Mr. Hisiro left the Pennsylvania Office of Attorney General, there was also anecdotal evidence that some employers in the market were receiving health care premium reductions from their insurers.

7. The decrees implicitly recognize that once the merger is consummated, there is no practical, realistic way to ever undo the transaction. Instead, the decrees rely on the payment of a penalty if the anticipated savings are not realized. However, the expectation -- indeed the entire premise of the decrees -- is that the cost savings will be achieved.

8. Reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,406, § 5.3 (March 30, 1993) (hereinafter "Merger Guidelines").

9. F.T.C. v. Butterworth Health Corp., 946 F. Supp. 1285, 1996-2 Trade Cas. (CCH) ¶ 71,571 (W.D. Mich. 1996), aff'd 121 F.3d 708, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th Cir. 1997).

10. For anyone keeping tally since 1995, the score is four losses and no wins for the federal enforcement agencies in hospital merger cases. Butterworth, supra n.9; F.T.C. v. Freeman Hospital, 911 F. Supp. 1213, 1995-1 Trade Cas. ¶ 71,037 (W.D. Mo. 1995) aff'd 69 F.3d 260, 1995-2 Trade Cas. ¶ 71,167 (8th Cir. 1995); United States v. Mercy Health Systems, 902 F. Supp. 968, 1995-2 Trade Cas. ¶ 71,162 (N.D. Iowa 1995) vacated 107 F.3d 632, 1997-1 Trade Cas. ¶ 71,728 (8th Cir. 1997); United States v. Long Island Jewish Medical Center, ___ F. Supp. ___, 1997 WL 662731 (E.D.N.Y. 1997).

11. In the Matter of Time Warner Inc., et al., F.T.C. No. C-3709, 1997 (Complaint and Final Order). The final order is discussed in detail in Antitrust Law Developments (Fourth), Vol. II at 1174-75 (1997).

12. Pub. L. No. 104-104, 110 Stat. 56 (1996). This act was a comprehensive rewrite of the Communications Act of 1934. 47 U.S.C. §§ 151, et seq.

13. See note 10, supra.

14. Federal Trade Commission v. Butterworth Health Corp., "Brief of Twenty-five States as Amici Curiae on Behalf of the Federal Trade Commission," No. 96-2440 (6th Cir. December 18,

1996).