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VERTICAL INTEGRATION AND ANTITRUST IN HEALTH CARE MARKETS

A dramatic increase in the amount and scope of vertical integration in the health care industry has given rise to increased scrutiny of related conduct under the antitrust laws. For the most part, however, the judicial opinions in this area have not satisfactorily addressed either the legal or economic underpinnings of these issues. Basically, the courts have failed to confront whether there are any characteristics of health care markets that require that they be analyzed differently than other industries.

Under certain narrow and well-defined conditions, vertical practices can raise competitive concerns. In health care cases these practices have principally involved either some type of exclusionary conduct (such as exclusive dealing or reciprocity) or tying agreements. The actual ways in which these practices can reduce competition are limited. In principle, exclusionary practices can raise the cost of entry or increase the costs of existing rivals. Similarly, tying agreements can facilitate coordination among a group of competitors or allow a firm with market power either to avoid regulation or to price discriminate more effectively.

These strategies differ considerably in how they might harm competition and in the conditions necessary for that harm to occur. The basic logic behind the raising rivals' cost strategy is that a single firm or a group of firms, with or without preexisting market power, will be able to charge higher prices as its rivals' costs increase. By contrast, the various tying strategies require preexisting market power. In the case of both regulatory avoidance and price discrimination, the market power typically resides in an individual firm and can be effected through unilateral behavior. When tying is used to facilitate coordination, however, it necessarily involves some form of group behavior.

The competitive harm identified by these theories has seldom formed the basis for legal review. Some decisions, such as the Eleventh Circuit's panel decision in *Key Enterprises* (ultimately vacated *en banc*), fail to distinguish between the impact on an individual competitor and the impact on the process of competition. This opinion did not even address whether Venice Hospital's integration into the provision of durable medical equipment (DME) services created, facilitated or enhanced market power. Instead, the court dealt solely with the effect of the vertical practices on the plaintiff and, in so doing, likely reached the wrong conclusion. The panel focused on an agreement in which home health agencies were given access to Venice Hospital's patients, allegedly in exchange for promoting a hospital-owned DME supplier. The court analyzed this arrangement as reciprocal dealing, yet never conducted a detailed analysis of the existence or effects of market power.

The decision provides no basis for the conclusion that market power was exercised by raising rivals' costs. It considered neither the cost curves facing a DME firm nor its efficient scale or sunk costs. Moreover, the defendants' ability to force DME competitors to inefficient levels of output is called into question by both the plaintiff's 30 percent share of overall DME sales and the large portion (more than 40 percent) of DME sales that were not related to Venice Hospital referrals.

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The decision also failed to provide a factual basis to support any of the tying strategies. The court found that Venice Hospital had market power, but failed to consider any of the other elements necessary for tying to be used to avoid regulation or price discriminate. The decision also failed to identify any regulation that might be circumvented through DME referrals. Regulation might be avoided by tying hospital services to a related DME provider with lower costs and lower quality, but the panel failed to explore the relative quality of plaintiff's and defendant's services. Also, there is no discussion of price or quality discrimination in the supply of either hospital or DME services.

Under certain conditions characteristic of health care markets, vertical integration can be an efficient alternative to arms-length market transactions. By contrast the number of vertical practices that could actually cause competitive harm is small. Unfortunately, judicial opinions dealing with vertical practices have often been limited to an examination of the impact on the plaintiff. This approach cannot distinguish between efficiency-enhancing and competition-reducing vertical practices. Under a well-reasoned antitrust policy, legal action must be limited to those few situations where a vertical practice creates, facilitates or enhances market power. As the *Key Enterprises* decision illustrates, the factual conditions that would cause competitive harm from vertical practices are not often present in the health care industry.

A more detailed treatment of this topic by EI Principal and Senior Vice President Barry C. Harris and Jones, Day, Reavis & Pogue partner Kathryn M. Fenton will appear in the Summer 1994 Antitrust Bulletin.

PATTERNS IN BANK MERGER REVIEWS

Antitrust intervention by the Department of Justice (DOJ) and the federal banking agencies, especially the Federal Reserve Board (FRB), has shaped consolidations of thousands of banks since 1990. Most of these mergers have involved relatively small organizations; however, several, such as the BankAmerica-Security Pacific and Chemical-Manufacturers Hanover mergers, have involved some of the country's largest banking organizations. Denials of certain applications, lawsuits, and many required divestitures affected both whether mergers occurred and the size of the resulting organizations, especially in local banking markets. Greater predictability about likely reaction to a bank merger, especially by DOJ, can be provided by identifying patterns as well as underlying sources of differences among these mergers.

Since 1990, all five of the suits filed by DOJ to enjoin mergers were resolved with consent decrees and divestitures. Several other cases became conditional approvals after applicants agreed to divestitures prior to the FRB's decision. These cases have important implications for banks considering expansion by acquisition. Some of the decisions appear to send conflicting messages. For example, BankAmerica-Security Pacific and Chemical-Manufacturers Hanover involved banking organizations of comparable size with significant operations in large metropolitan areas. In the former, DOJ and the FRB required divestitures in five states to grant approval, while the latter was approved without conditions. Similarly, Society-Ameritrust and Comerica-Manufacturers National involved organizations in metropolitan areas that were roughly comparable in market share and concentration numbers. The former required substantial divestiture to settle a DOJ suit, while the latter went unchallenged by DOJ after it was approved by the FRB.

One possible source of differences in outcomes is that DOJ uses a different product market definition method than the FRB. DOJ focuses on individual product markets (e.g., small business lending, middle-market business lending and certain retail accounts), while the FRB defines the market as the "cluster" of all banking services. Another source of differences concerns DOJ's inclusion in its market concentration measures of *only* those firms it regards as actual competitors or likely "uncommitted entrants," whereas the FRB's method includes all banks and thrifts, with thrifts being given a 50 percent weight. In a number of cases, DOJ excluded certain thrifts from business lending markets because they were not active lenders, resulting in market concentration measures greater than those produced by the FRB's method. DOJ has also excluded smaller commercial banks as competitors for middle-market business lending, again yielding higher concentration measures than the "all-

bank" level calculated by the FRB. These explanations, however, fail to account for differences at a single agency in decisions on apparently similar cases.

There is another aspect to DOJ's pattern of determining market participants that can produce these intra-agency differences in outcomes. In each case it reviews, DOJ considers the same classes of firms as possible market participants in its relevant product markets (e.g., thrifts and non-banks for small business lending). DOJ then uses market-specific facts to choose which particular firms actually to include in determining concentration. For example, DOJ may develop different market concentration measures in two markets with the same number of thrifts because all thrifts were considered actual competitors in one market but not in the other. Moreover, market concentration measures at DOJ may vary for two apparently similar markets if one market supports a finding that out-of-market banks are active lenders to middle-market firms but the other market does not. The common list of possible market participants lends predictability to the process; prediction of the possible outcome at DOJ depends on market-specific facts.

The second key pattern to DOJ's recent decisions is that entry or expansion of smaller incumbents can offset a competitive problem only where there is substantial evidence that sufficient entry would occur. Similar to the market participants pattern, DOJ appears to use a standard list of possible entry or expansion candidates (e.g., smaller incumbents, big banks with small in-market presence), but does not weigh these heavily unless facts support that the specific candidates can be relied upon to enter or expand sufficiently. Again, intra-agency differences in outcome can result from using a standard list of entry prospects, but making decisions based on market-specific or firm-specific facts.

The third pattern to DOJ's recent decisions is that divestiture of branches, deposits, and related assets to smaller incumbents or out-of-market banks can resolve many competitive concerns. Each of the lawsuits brought by DOJ was resolved by divestitures and many other transactions were approved based on divestiture commitments. Moreover, divestiture commitments made to satisfy DOJ appear to be sufficient to meet any concerns at the FRB. In examining divestitures required in cases in the last five years, it is clear that the agencies are seeking divestitures that will enable the purchaser to replace competition lost by merger.

Analyzing a specific transaction in the context of these three patterns and the relevant market facts can provide guidance to the likely enforcement decisions of DOJ and the FRB. If facts on market participants, entry, and expansion suggest that a particular merger will likely raise concerns at DOJ (and at the FRB), there is still the possibility that carefully crafted divestitures can resolve these concerns while maintaining the transaction's profitability.

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BALANCING EFFICIENCIES AND COMPETITION IN EVALUATING HOSPITAL MERGERS

Several recent hospital mergers reviewed by the Federal Trade Commission and the Department of Justice have involved the only two hospitals in a town or small city. Mergers of this type often yield significant cost savings from combining clinical services, reducing administrative overlap, and gaining efficiencies in ancillary services. While the *Merger Guidelines* acknowledge that real efficiencies can counter the potential anticompetitive effects of increased concentration, the role of efficiencies has not always been important in practice. A merger policy that fails to incorporate merger-related efficiencies may result in higher than necessary health care costs.

A large portion of the cost savings often results from clinical consolidations. In many regions, a significant decline in inpatient days has led to one or both of the merging hospitals providing specific clinical services at inefficiently low levels. Clinical consolidation produces cost savings because many of the costs associated with staffing a nursing unit are not directly related to the number of patients treated in that unit. While demand is typically sufficient to staff

general medical/surgical wards efficiently, the demand for other specific clinical services, such as obstetrics, pediatrics, emergency services and intensive care, may be significantly below efficient scales. Combining hospitals allows the rationalization of these below-scale clinical services.

The antitrust agencies have recognized the significance of these cost savings, but have often inquired whether similar savings could be realized by combining one of the merging hospitals with another hospital that presents a lower likelihood of reduced competition. An alternative hospital merger, however, will only produce the desirable cost savings if patients actually travel to the site of the consolidated service. Obstetrics, pediatrics, emergency services and intensive care services are typically local in nature. If patients are likely to travel to the site where the clinical service is consolidated, then it is likely the alternative merger partner should have been included in the original geographic market. In this case, the alternative merger may not offer relief from competitive concerns.

Another concern of the antitrust agencies is whether the specific underutilized services can be combined without combining all clinical services. The multi-product nature of hospitals, however, makes it highly unlikely that the specific underutilized services could be consolidated without combining most other clinical services. The supply-side aspects of a hospital's multi-product nature are closely related to cost savings from the administrative and ancillary services. The demand-side considerations, which are controversial, are illustrated by managed care plans' introduction of capitation and other mechanisms that shift risk bearing to providers. Under capitation each hospital is paid according to the number of managed care subscribers rather than according to the services rendered. Thus once the level of capitation payment is established, each has strong incentives to have patients treated at unaffiliated facilities. This problem is exacerbated when different services in the same physical facility have different ownership and thus different profit and loss consequences. In addition, hospitals are often reluctant to enter into agreements that would consolidate important clinical services at the site of a competitor. If hospitals are prevented from merging and are either unable or unwilling to consolidate certain underutilized clinical services, then it is unlikely that their costs would be reduced absent the failure of one of the hospitals.

Administrative savings from hospital mergers are also often significant. Most of these savings derive from the elimination of duplicative management and staff positions. To a large extent, the number of employees per hospital admission needed in these departments does not decline as quickly as do patient volumes. Consequently, these cost savings may only result from some form of consolidation. Nevertheless, the benefits of these savings seemingly have not generated much enthusiasm from the reviewing agencies, apparently because the agencies believe many administrative savings would result from a combination of one of the merging parties with another hospital. There is seldom any reason, however, to believe that such an alternative consolidation would occur. The same administrative savings would, however, ultimately occur if one of the merging hospitals failed. Of course, this would delay the savings until exit actually occurred, and the ultimate impact on competition would be the same as with a merger.

Finally, hospital mergers can achieve cost savings in the provision of ancillary services. These cost savings are usually small relative to clinical and administrative cost savings. Joint ventures are potentially helpful in allowing hospitals to increase the utilization of ancillary equipment, but may be imperfect substitutes for mergers as a method of achieving cost savings. Establishing governance procedures is difficult and hospitals often are concerned that their joint venture partner (and often closest competitor) will use the joint venture strategically to gain an advantage. Consequently, an antitrust enforcement policy that allows joint ventures in ancillary services does not guarantee that these joint ventures will actually occur.

As hospitals and other providers adjust to the changing health care environment, the antitrust agencies will continue to be faced with proposed mergers that promise cost savings but may potentially reduce competition. When analyzing these mergers, it is important that the agencies recognize that the failure to properly incorporate merger-related efficiencies into a merger policy may result in higher than necessary health care costs.

EI Principal and Senior Vice President Barry C. Harris and Senior Economist William P. Hall have worked on several hospital mergers including the recent Columbia-Galen and Columbia-HCA mergers and local mergers in Manchester, NH and Everett, WA.