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Why Hospital Merger Antitrust Enforcement Remains Necessary: A Retrospective on the Butterworth Merger*

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ABSTRACT: This Article analyses the impact of the hospital merger approved over the objections of the Federal Trade Commission ("FTC") in *FTC v. Butterworth Hospital*. That merger was approved, in large part, because of the nonprofit nature of the surviving entity, the likelihood of substantial capital and operational savings from the transaction, and the merging hospitals' agreement to abide by a "Community Commitment." Based upon their examination of the Grand Rapids Michigan market some three years after the merger, the authors conclude that although some savings have been realized, and although the merging parties have been diligent in following the terms of the Community Commitment, self-regulation is an inadequate substitute for competition. The authors also suggest that the decision was based on economic studies on the incentives of nonprofit hospitals that have been undermined by more recent research. The authors conclude that the self-regulatory approach in *Butterworth* should not be repeated and the FTC should consider challenging these cases in administrative litigation to clarify the economics and jurisprudence on mergers of nonprofit hospitals and the analysis of efficiencies.

* This Article is premised upon work conducted during the authors' tenure at the Federal Trade Commission, but it represents the personal views of the authors and does not necessarily reflect the views of the Federal Trade Commission or any of its Commissioners. The authors express their gratitude to Oscar Voss, Jack Kirkwood, Shane Woods, and David Pender and especially the staff and management of Spectrum Hospital for their extensive assistance.

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One of the more controversial issues in antitrust enforcement is the proper treatment of hospital mergers. The antitrust laws prohibit mergers that may substantially lessen competition. Under the law and the Merger Guidelines, fairly clear rules are provided for the analysis of mergers.[1] Underlying these rules is a policy preference for efficiency that comes from rivalry, a preference for internal growth over collaboration, and a strong concern over the aggregation of market power.

Applying these standards to hospital mergers over the past decade has been a difficult process with very mixed results. There was substantial hospital merger consolidation during the decade, and relatively few cases were challenged by the antitrust agencies.[2] Although the 1990s began with several successful challenges to hospital mergers by the federal antitrust agencies, during the latter half of the decade there was an unbroken record of litigation defeats, which were harmful to hospital merger enforcement specifically, and merger enforcement more generally.

In some cases, state antitrust enforcers declined to litigate, choosing instead to permit mergers based on promises by the merging parties to hold down prices or pass on prospective cost savings in the form of lower prices for consumers.[3] In these cases, the parties often agreed to a regulatory decree to be monitored by the pertinent state authority. After these decrees expired, the hospitals often increased prices, and private antitrust lawsuits were brought challenging the merger and other alleged anticompetitive conduct.[4]

Antitrust courts rarely approve the acquisition of market power or other anticompetitive conduct based on the promise not to increase prices. This Article addresses the only hospital merger in which a federal court took that approach: the merger between the Butterworth and Blodgett hospital systems in Grand Rapids Michigan.[5] The merger was unsuccessfully challenged by the Federal Trade Commission ("FTC") in 1996, even though the court found that a prima facie violation existed. The court permitted the merger based in large part on the entry of a decree proposed by the merging parties, known as the "Community Commitment," which regulates the merged firm's prices, efforts to reduce costs, and dealings with managed care entities. This Article, based on a study we conducted in early 2000, focuses on the implementation and efficacy of the Community Commitment, and examines whether the Commitment has been effective and whether the proposed efficiencies from the merger have been achieved.

We conclude that although the parties have abided with the terms of the Commitment and there has been the achievement of some efficiencies, the Commitment is not an adequate substitute for competition. We suggest that courts and regulators should not attempt to substitute regulation for competition. If a regulatory approach is adopted a court should impose an independent monitor of the decree, rather than permitting parties to "self-regulate" as in *Butterworth*. In addition, where the merging parties

also control a managed care entity, as in *Butterworth*, courts should consider divestiture of that entity to prevent problems of discrimination. Finally, because hospital mergers pose particularly complex economic questions on efficiencies and the treatment of nonprofit hospitals, we recommend that the FTC challenge future hospital mergers in administrative litigation.

I. Procedure of the Retrospective

Because of the unique nature of the relief chosen by the court in this case, we chose to reexamine the state of competition in the Grand Rapids hospital market three years after the merger.[6] Our fundamental question was whether the Community Commitment achieved its goals to prevent anticompetitive conduct, such as price increases, and guarantee that efficiencies of the merger would occur. We began the task by reviewing the court decision, court documents, and FTC internal documents. We requested various documents from the hospitals and other market participants and secured data on pricing and patient revenue by zip code, diagnosis related group ("DRG"),[7] and payor type. In March 2000, we visited Grand Rapids and interviewed community leaders, managed care health plan representatives, employers, and hospital representatives. We received extensive assistance from the merged parties and interviewed several employees and representatives of the Board of Trustees of the merged hospitals (now known as "Spectrum Health") and the Financial Advisory Committee established by the parties pursuant to the Community Commitment.

II. Overview of the Case

A. The Merger and the Litigation

The Grand Rapids metropolitan area is the second largest metropolitan area in Michigan, with just over one million people. At the time of the merger, there were four major hospitals in Grand Rapids: Blodgett Memorial Medical Center, Butterworth Hospital, Saint Mary's, and Metropolitan. Butterworth and Blodgett were the two largest hospitals, with 529 and 515 general acute beds, respectively. In addition to being the two largest hospitals, Blodgett and Butterworth were also the only two hospitals offering a full range of primary, secondary, and tertiary care.[8] Both hospitals were high-quality, well-functioning, and fiscally-sound operations prior to the merger. Saint Mary's was a 230-bed general acute care facility, and Metropolitan was an osteopathic hospital with about 238 general acute beds. Saint Mary's offered a more limited range of primary, secondary, and tertiary care than either

of the merging hospitals; Metropolitan provided only primary and secondary services.

The catalyst for the merger was community concern over a "medical arms race" between the two largest hospitals. Historically, Blodgett and Butterworth had been vigorous competitors. Both were profitable, efficient, and perceived as high-quality hospitals. Butterworth was in downtown Grand Rapids. Blodgett was located in a "landlocked" facility in a residential neighborhood that severely limited its ability to expand.[9] It decided to build a replacement facility, known as the "Beltline facility,"[10] at the cost of $187 million. Butterworth had similar expensive plans to expand. Concerned over what it described as the potential for a medical arms race and wasteful competition between Blodgett and Butterworth, a community commission recommended that the two hospitals consider merging as an alternative to expansion. After some consideration, an agreement was reached and the two hospitals agreed to merge in May 1995. Both hospitals cited the avoidance of capital expenditures and the achievement of significant operating efficiencies as primary factors motivating the merger.[11]

1. The Trial and Decision on the Merits

The FTC filed suit in federal court in the Western District of Michigan to enjoin the merger on January 23, 1996. After about three months of discovery, the district court held a five-day hearing on the merits.[12] On September 26, 1996, the court ruled in favor of the merging parties and denied an injunction to stop the merger.[13] The court held that the FTC had established its prima facie case, i.e., that the merger would substantially increase concentration in the relevant market.[14] The court upheld the FTC's claims that the relevant product markets were general acute inpatient hospital services and primary care inpatient hospital services, because alternatives, such as outpatient services, could not fully "substitute for some inpatient services in response to a small but significant increase in price of general acute care inpatient services."[15] Moreover, the court rejected the defendants' argument that employers and third-party payors could successfully oppose a price increase for primary and secondary care by steering patients away from the merged hospitals.[16]

The court also accepted the FTC's proposed geographic market of the "Greater Kent County" area, which included Grand Rapids and parts of seven other counties within a thirty-mile radius.[17] The market included the four Grand Rapids hospitals and five

smaller, primarily rural hospitals providing general acute care inpatient services.[18]

Finally, the court concluded that the proposed merger would "result in a significant increase in the concentration of power in the relevant markets and repose in the merged entity an undue share of the markets."[19] For general acute care inpatient hospital services, the merged entity would control 47% to 65% of the market depending on the unit of measurement (licensed beds, discharges, or inpatient revenue).[20] The merged hospitals likewise would control between 65% and 70% of the market for primary care inpatient hospital services.[21] Thus, the court concluded there was "no question" that the combined Butterworth/Blodgett would have "substantial market power"[22] and that "the FTC has established its prima facie case that the proposed merger would violate Section 7 of the Clayton Act."[23] The court, however, declined to enjoin the transaction because it agreed with the hospitals' contention that "even though competition may be lessened, the interests of consumers are . . . likely to be advanced rather than hurt."[24]

2. Defenses

Defendants presented several arguments to rebut a presumption of anticompetitive effects. First, the defendants contended that "empirical proof does not support the presumption that high concentration of market power among nonprofit hospitals results in price increases."[25] Defendants based this claim on studies by their economic expert, Dr. William J. Lynk, of nonprofit hospital pricing in California and Michigan, in which Dr. Lynk found that higher market concentration was associated with lower prices among nonprofit hospitals.[26] Defendants also relied on a study by Dr. Lynk comparing relative prices of "monopoly" services at both Butterworth and Blodgett with the prices for services for which the two hospitals competed prior to the merger. Dr. Lynk found that on services for which either Butterworth or Blodgett had a monopoly prior to the merger (such as burn treatment), prices were relatively lower than for prices on which Butterworth and Blodgett competed. Against the FTC position that market dominance is associated with higher prices,[27] the court found that the "unexpected empirical findings" cast doubt on the traditional presumption of merger law that a significant increase in market concentration would necessarily lead to higher prices.[28]

Defendants also argued that a hospital Board of Directors consisting of community business leaders would prevent price increases

at the merged entity because community leaders "have a direct stake in maintaining high quality, low cost hospital services."[29] Both hospitals' board chairmen had "testified convincingly that the proposed merger is motivated by a common desire to lower health care costs and improve the quality of care."[30] In response, the FTC asserted that "board members quickly develop institutional loyalty which may overcome their vigilance of community interests."[31] The court found the FTC's concern in this area to be unpersuasive and concluded that the hospitals would be unlikely to exercise their market power in a manner detrimental to consumers.[32]

Defendants claimed that the merger would not be anti-competitive because St. Mary's and Metropolitan would continue to compete with respect to primary and secondary care services.[33] St. Mary's, as further argued by the defendants, had the capacity to expand tertiary care services in the event of a unilateral price increase by the merged entity.[34] The court found these arguments less persuasive, and concluded that Saint Mary's and Metropolitan's ability to defeat a small price increase would be limited.[35]

Responding to the FTC's argument that the merger would produce anticompetitive reductions in discounts to managed care companies, the court questioned whether a leveling of discounts would negatively affect consumers.[36] Defendants argued that managed care discounts simply shift costs to those uninsured persons who purchase healthcare services directly, or are enrolled in commercial health plans, or commercial insurance products not entitled to managed care discounts.[37] The court supported this view, and found that "[s]uch selective price advantages [as managed care discounts] are hardly the sort of benefit the antitrust laws are designed to protect."[38]

B. Capital Avoidance and Efficiencies

The centerpiece of the defendants' claims was their argument that the merger would enable the merging hospitals to achieve efficiencies and significant cost savings.[39] There were two sources of efficiencies: avoiding the capital expenditures of building a new Blodgett facility, and operating synergies from combining the two hospitals.[40] Without the merger, the defendants claimed that they would have to build a new Blodgett facility at the cost of $187 million.[41] Prior to the merger, Butterworth, in turn, intended to renovate space on its existing campus with a baseline plan estimate of $73.9 million.[42] This plan included the renovation and upgrade of inpatient nursing units and support functions, the expansion of several programs (Neonatal Intensive

Care Unit, Emergency, Neuro-diagnostics, Endoscopy, Clinical Laboratory, and Outpatient Pharmacy), construction of a parking ramp and street bridge, and creation of a cardiology center.[43] In terms of synergies, the hospitals believed they could achieve substantial savings by eliminating duplicate facilities and services. The parties argued that the merger would lead to $68.5 million in operating efficiencies over the first five years of the merger (not described in detail by the court).[44]

The hospitals presented a "capital avoidance study," which suggested that the merger would result in significantly lower capital expenditures.[45] One approach, known as "Scenario 3A" suggested that the Butterworth campus would be used as the location for the majority of inpatient services, and the Blodgett facility as a comprehensive outpatient center with a small inpatient component, and the use of Ferguson (a small closed hospital used by Blodgett for administrative functions) for the new system's central offices.[46] The capital cost of Scenario 3A was estimated at $161.7 million.[47] Thus, the capital avoidance from implementing merger Scenario 3A instead of the baseline scenario was calculated to be $99.2 million (the cost of Butterworth's and Blodgett's baselines minus the cost of Scenario 3A).[48]

The FTC challenged the proposed efficiency claims on several grounds. It suggested that the capital avoidance estimates were inflated in some respects, that many of the operating efficiencies could be achieved through means short of a merger, and that one would need to balance the lost quality benefits of a new facility against these cost savings.[49] The FTC took the position that the total capital expense avoidance that would result from the merger would be "no more than $42 million" and that Butterworth's and Blodgett's operating efficiencies were "overstated by at least $32 million."[50]

The court began its analysis by posing the ultimate question: "[i]n order to overcome the presumption arising from the FTC's prima facie case that the proposed merger would substantially lessen competition, defendants must demonstrate that the intended acquisition would result in significant economies and that these economies ultimately would benefit competition and hence, consumers."[51] The court also cautioned that "[b]ecause measuring the efficiencies of a proposed transaction is inherently difficult and because both sides' estimates are clearly based in some measure on speculative self-serving assertions, . . . the Court finds it neither appropriate nor necessary to engage in a detailed evaluation of the competing views."[52] The court was persuaded

by the fact that the defendants' efficiency expert had done a far superior job in demonstrating efficiencies: "the Court notes the striking disparity in quality between the comprehensive studies done by defendants' experts, on the one hand, and the FTC's expert's critical analysis."[53] The court ultimately credited the Hospitals' experts more than the FTC's. But the judge never answered whether the proposed merger would benefit, or at least not substantially lessen, competition.

The court went on, however, to find that efficiencies "totaling in excess of $100 million" would result from the proposed merger.[54] Although the court's analysis is detailed and was based in part on the judge's observation of the facilities, it seemed deficient in several respects. The law and the Merger Guidelines ("Guidelines") require that efficiencies (1) be significant enough to overcome the potential anticompetitive effects of the merger; (2) are merger specific, that is cannot be achieved through less anticompetitive means; and (3) will be passed on to consumers.[55] The court's decision was deficient in each of these respects: it did not explain how it arrived at its estimate of efficiencies, scrutinize whether each claimed cost saving was truly merger-specific, or explain whether the efficiencies would be passed onto consumers in lower prices.

According to the Merger Guidelines, "[w]hen the potential adverse competitive effect of a merger is likely to be particularly large, extraordinarily great cognizable efficiencies would be necessary to prevent the merger from being anticompetitive."[56] However, the court did not analyze how or whether those efficiencies would measure up against the harm to competition in the market. Although the court did not explicitly address this issue, it implicitly addressed the issue of whether efficiencies would be passed on. The court reasoned that, as nonprofit institutions with "community boards," the hospitals would be guided by business leaders who "can be expected to bring real accountability to price structuring"[57] and by a "Community Commitment" that contained certain pledges regarding future price levels.[58] The court concluded further that the risk of above-normal margins that the merged entity was likely to maintain as a result of its market power would necessarily—in view of the hospitals' nonprofit character—be spent to improve the institution, and that such improvements "would be in the best interests of the consuming public as a whole."[59] Although it did not specifically conclude that efficiencies would be passed on, it appears that the court assumed that the community board and Community Commitment would provide sufficient protection

of consumers. This was an especially troubling assumption, given that the hospitals had recently enjoyed very high profit margins, which would seem to undermine the conclusion that their nonprofit character guaranteed that any savings would be passed on to consumers.

C. Community Commitment

Even though the FTC prevailed in establishing its prima facie case, the court held that the hospitals had successfully rebutted that case "by showing that increased market share does not convert into higher prices and profits automatically, in [the] case of non-profit hospitals, and that it was less likely to do so in [the case of Blodgett and Butterworth], in light of [the parties'] past history of community responsibility and willingness to extend a 'community commitment' to freeze prices."[60] The court then took the unique approach of compelling the parties to embody their commitments in an order and asked them to submit the commitment in the form of an order to be entered by the court.[61] The FTC declined to participate in this process.

The FTC opposed the Commitment for several reasons. Although such efforts are often well-intended, they otherwise have been consistently rejected by antitrust courts (most recently by the district court in *Cardinal Health*).[62] The reasons for that have been articulated in several decisions,[63] and are typically that: (1) "[t]he reasonable price fixed today may through economic and business changes become the unreasonable price of tomorrow;"[64] (2) a limit on prices does not assure that prices will decrease—and this is a significant concern in hospital markets in which competition was leading to increased discounts; and (3) a price cap does not protect against a loss of nonprice competition, such as for service or quality.[65] Nonetheless, the FTC's arguments did not prevail.

This Community Commitment consists of five distinct parts: (1) a freeze of list prices, also known as charges, (2) a limit on prices to managed care plans, (3) a margin limit, (4) increased funding of programs for the underserved and medically needy, and (5) governance requirements.[66]

Freeze on List Prices. The hospitals' "Charge Commitment" promised to freeze or control the rate of annual increase in charges for seven years post-merger.[67] In the first three years there would be no price increase.[68] In years four through seven, the merged entity would limit charge increases to no more than the annual percentage increase in the all-products Consumer Price Index ("CPI").[69]

Commitment to Managed Care. At the time of the merger, Butterworth owned a majority interest in the largest health maintenance organization ("HMO") in the market, Priority Health ("Priority").[70] Thus, at the time of the merger employers and other managed care providers raised concerns that post-merger Butterworth would favor Priority to the detriment of other managed care providers.[71] To address those concerns, the Community Commitment contained a "Commitment to Managed Care" to attempt to create a level playing field between Priority and the other managed care providers.[72]

The Commitment placed a ceiling on the price of hospital services paid by managed care companies.[73] Spectrum devised a three-tiered schedule for this portion of the Commitment, with the three largest existing HMOs (i.e., Grand Valley, Care Choices, and Blue Care Network) in the first category, joined by Spectrum's own Priority; existing managed care plans other than the four major HMOs in the second; and new managed care entrants in the third grouping.[74] The three large existing HMOs besides Priority would be offered new contracts with Spectrum with inpatient and outpatient hospital rates equal to the weighted average of the "current" rates paid to Blodgett and Butterworth by the HMOs, including Priority.[75] Priority would pay the same weighted average price as any of the other three HMOs.[76] Other existing managed care plans could choose to freeze their "current" contracts for three years post-merger with annual increases in the following four years limited to the increase in the regional all-products CPI.[77] Included in this group were Preferred Provider Organization of Michigan and Healthcare 2000.[78] Non-HMOs that chose not to freeze their contracts were not covered by the Commitment. Under the Commitment, new entrants can receive offers at a "discount commensurate with the incremental volume that the [plans could] deliver to the merged entity."[79] Finally, the Commitment to Managed Care included a capitation clause that required Spectrum to offer the same capitation risk agreement it received from any individual managed care provider to each of the other large HMOs.[80] The method by which Spectrum would set discount rates was not detailed in the Commitment.

Margin Commitment. Accompanying the pricing provisions, the Margin Commitment limited post-merger margins by setting the health system's margin target at the "five year rolling average total margin for the merged system that does not exceed the average of Moody's and Standard & Poors upper quartile total margins for other health systems nationally."[81] At the time of the order, the target margin was in the range of 7–8%, a number

below the operating margins of either hospital (but, as FTC staff observed in opposing the Community Commitment, well above average for the hospital industry).[82]

Governance. Under the Governance provision, the hospitals promised to reconstitute the Board of the merged entity to include local business representatives, physicians, and community members, to be reflective of the diversity in background, culture, community involvement and professional interests of Western Michigan. This provision also called for the establishment of a permanent Advisory Committee to counsel the Finance Committee of the merged hospitals' Board and the opening of the merged entity's budget and pricing process to the public.

III. Results of the Merger

As described below, the structure of the Grand Rapids market looked much the same in 2000 as it did in 1997. The market shares of the four major hospitals have not changed much, although Spectrum's share declined slightly. The most significant change is the change that did not occur—Spectrum did not rationalize the Blodgett and Butterworth facilities as originally planned.[83] Both Butterworth and Blodgett continue to exist as full service hospitals, and the plan to convert Blodgett into more of a long term care facility and consolidate secondary and tertiary services at Butterworth has not been carried out. The Blodgett facility continues to function much as it did several years ago—notwithstanding the arguments that it needed to be replaced, with or without the merger.

Competition increasingly takes place at the managed care level, but unlike the premerger environment, managed care providers can no longer "play" Butterworth and Blodgett off against each other to seek better prices and services. Grand Rapids has remained a market of modest managed care penetration: traditional "indemnity" insurance, in which a health plan pays for all care received by its enrollees, still accounts for over 50% of covered lives in grand Rapids. While strict forms of managed care such as capitation have not taken hold, PPO and POS plans are popular among patients and physicians, in keeping with national trends.[84] Most significantly, as described below, concerns have been raised that Priority Health has grown and increased market share at the expense of its managed care rivals.

Finally, although the merger plans did not involve physician groups, physician groups in many specialties have merged. Groups

formerly aligned separately with either Butterworth or Blodgett have merged and some of these groups have over 70% of the providers in individual specialties.

A. Spectrum's Post-Merger Performance

1. Implementation of the Community Commitment

The merged entity, now known as Spectrum Health, has implemented each of the five portions of the Commitment. Just before the Commitment was implemented, however, Blodgett increased prices by 3%.[85] Once it was implemented, Spectrum adhered to the price freeze and has continued to do so. Although the merger occurred in 1997, the facilities only merged their charge masters in September 2000.

In order to abide with the managed care provisions, Spectrum calculated a weighted average discount of 26.3% off charges to be offered to the four pre-existing HMOs; the discount was based on the rates paid by each of the HMOs at the time of the merger.[86] Spectrum further decided to offer all pre-existing, non-HMO managed care plans a discount rate of 14% off charges. Finally, Spectrum offered half the discount (or 7%) to any new managed care entrants.

Unlike orders adopted in other hospital merger cases, there are no provisions for compliance review by a government agency. Instead, Spectrum Health established an independent Finance Advisory Committee ("FAC") to monitor compliance with the order. The primary purpose of the FAC is to counsel the Spectrum Health Board's Finance Committee prior to adoption of the health system's budget. In addition, the FAC reports to the Grand Rapids community on Spectrum Health's adherence with the Community Commitment in an annual public meeting. To fulfill this function, the FAC contracts with an outside auditing firm for a yearly report on Spectrum Health's performance. The FAC contracted with Price Waterhouse Coopers ("PWC") in 1998 and 1999, and Deloitte & Touche in 2000. In preparing the report, the auditor is responsible for reviewing Spectrum Health's (1) managed care contracts for adherence with the Managed Care Commitment; (2) charge masters and bills for compliance with the Charge Commitment; (3) margin in keeping with the Margin Commitment; and (4) expenditures towards the Commitment to the Underserved, including the amount, accruals, and administrative cost percentage.[87]

For the year ending June 15, 1999, PWC found Spectrum Health in compliance with all five of the Commitment provisions. Two

findings were noted in the price freeze category. First, the Blodgett operating room supply charges, which are billed at actual cost plus a mark-up, are not included on the charge master. Thus, PWC noted that a price increase could have occurred between October 1997 and February 1998, a period for which no inventory list was available for cross check. In response, Spectrum Health management argued that any increases during this time period would be immaterial. Second, Spectrum Health adjusted the room rates at the Butterworth facility to a standard rate for a given category of room (Medical/Surgical, Pediatric, etc.), having previously billed rooms by acuity level (i.e., the more acute the illness, the higher the room rate). PWC found the new rates to be budget neutral. For the Commitment to the Underserved, PWC documented the expenditure or committal of $4 million through February 28, 1999, which annualized to the promised $6 million per year. No indications existed that "funding of pre-merger projects [was] reduced to meet the community commitment to the underserved through cost shifting."[88] Spectrum Health also kept its margin to 4.33% for fiscal year 1999 against a 1997 Moody's margin of 7.9%.[89] The PWC report made a finding of "no exceptions" with regards to the Commitment to Managed Care.

2. Spectrum Health Market Shares and Prices

Generally, the structure of the Grand Rapids hospital market has not changed significantly since the merger. The Grand Rapids market has shown a gain in total patient volume since 1997. Spectrum Health's volume has reflected this expansion, with increases coming primarily from outpatient service growth in the outlying areas. Despite a rise in volume, Spectrum Health's market share for all classes of payors as calculated from VHA Midnet data has decreased post-merger, with much of the reduction coming from primary care. The losses in market share based on discharges between 1996 and 1998 are as follows: all patients –0.7%; tertiary care patients –0.4%; secondary care patients –0.9%.[90] In comparison, our calculations show Spectrum Health's private payor market share increasing 0.4% from 1993 to 1998. The health system's share of the Kent County private payor market has decreased by 0.2%.

Accompanying its gain in patient volume, Spectrum Health's prices per admission and per day for privately insured patients have decreased since reaching highs in 1996. Blodgett and Butterworth combined saw a downward trend in price per day from 1993–1994; following the decrease, the per day rate at the two hospitals increased from 1994 to 1996, with a large leap between 1995 and 1996. A similar pattern holds for price per

admission, although the period from 1994 to 1995 saw a slight downward trend. This decrease turned in 1995 and continued upwards on a steep trajectory until 1996.

After a budgetary scare that resulted in pay reductions for a large portion of employees, Spectrum Health looks to be financially healthy. The latest reports show Spectrum Health has $630 million in reserves for the fiscal year ending June 30, 2000, and a current year margin in excess of $40 million. With its current financial health, Spectrum Health will restore 1999's employee pay cuts averaging 3% overall with a range of 1% to 15% that had affected 6,000 employees.[91]

B. Saint Mary's and Metropolitan Hospitals

Spectrum Health's losses in market share have translated into slight gains in share for Saint Mary's and Metropolitan. According to Spectrum Health data sources, both hospitals have captured greater market shares in secondary care specialties within Kent County since the merger.[92] Saint Mary's, the historical site for indigent patient care in Grand Rapids, has experienced a particularly marked increase in its volume of uninsured patients. For its insured patients, insurance companies reimburse Saint Mary's at rates far below those paid to Spectrum Health. Saint Mary's also has recently decided to stop taking new patients under Michigan's Medicaid HMO program.[93]

Our calculations show that both Metropolitan and Spectrum Health posted slight gains in private payor market share for all zip codes from 1997–98 (0.6% and 0.4%, respectively).[94] However, Saint Mary's showed a loss in private payor market share of 0.6% for the same period. Similar numbers hold true for the Kent County portion of the market, with the exception that Spectrum Health lost 0.2% market share for 1996–98.[95]

Metropolitan currently plays the same role of primary and secondary care facility as it did premerger. The hospital continues to hold capitated contracts with health plans under which it provides primary and secondary care services. For tertiary care, Metropolitan typically must refer enrollees to Spectrum Health. While the hospital's inpatient market shares have stayed the same since 1997, Metropolitan's volume has increased due to the hospital's construction of clinics in rural areas. As a result, Metropolitan is approaching its ideal patient volume of 130,000 lives per year; just a few years ago, that volume was only 70–80,000. The hospital reported a net income of $6.8 million on revenues of $150 million for the fiscal year ending September 30, 1998.[96]

Like Saint Mary's, Metropolitan launched several projects in 1997, including a joint venture with 130 physicians and a building plan of at least $10 million.[97] Metropolitan Health, Metropolitan's PHO, formed a "super PHO" involving six healthcare organizations and 450 physicians in October of 1998; the entity goes by the name of West Michigan Regional Delivery Network. During early 1999, Metropolitan also partnered with Borgess Hospital in Kalamazoo to share administrative duties and costs. The two hospitals have no plans to integrate on a clinical level. According to one analyst, the Metropolitan-Borgess joint operating agreement is a temporary endeavor aimed at better positioning Metropolitan for a merger with either Spectrum Health or Saint Mary's, with Saint Mary's being the more likely of the two partners. Without such a merger, Metropolitan "could cease to exist."[98]

C. Health Insurance

Although hospital prices and market shares in Grand Rapids have remained relatively stable since the merger, the same cannot be said for the managed care market. Over the past three years, Priority has moved into a more dominant position and currently accounts for more than 50% of the market. It is difficult to determine the cause for Priority's growth. On the one hand, Priority has expanded the types of managed care products it offers and has also grown geographically. Much of this growth is procompetitive, as Priority has become a more significant and innovative force in the market.

On the other hand, some employers and managed care providers raised concerns that Priority was growing because of actions by Spectrum Health to favor Priority. Our study was unable to determine whether there was a foundation to these allegations, although there was some evidence that other managed care providers have lost significant portions of their covered lives to Priority. Moreover, some employers suggested that prices, gauged in terms of premium costs from plan to employer or individual subscriber, have increased significantly across plans. In 1997, premiums increased 3% for most Grand Rapids employers, while large companies who self-insure were hit with rate hikes of up to 110%.[99] More recently, all Grand Rapids healthcare plans have increased premiums significantly, and there are some observations from employers and managed care experts that rates are increasing faster than in other markets in Michigan, perhaps even double those seen in other markets in the state. Indeed, some employers noted that their managed care costs have increased by over 10% per year since the merger.

IV. Efficiencies

The critical element of the court's decision was its perception that the merger would lead to substantial efficiencies, primarily though the rationalization of services between the Butterworth and Blodgett facilities, which the merging parties estimated would amount to $68.5 million over the first five years after the merger. After two and a half years, the results show a mixed picture.[100] The plan to rationalize the two facilities appears to have been abandoned and there has been limited consolidation of some specialties, far less than originally planned. There have been savings by streamlining some administrative functions, but some of these savings may not be merger specific. (We did not audit the specific estimated savings.) Overall, the current estimated savings are relatively modest, somewhat less than $30 million, some of which may not be merger specific.[101]

A. Plant and Equipment

The merger has proven harder and more costly to implement than Spectrum Health originally anticipated. Decreases in government funding have prompted Spectrum Health to shelve plans to build the new Blodgett facility for outpatient care. The land owned by Blodgett, previously earmarked as the site for the new facility, has remained empty. Neighbors have attempted to have the empty lot rezoned, claiming it is hurting residential property values.[102] In place of the new inpatient facility, Spectrum Health has sought to consolidate inpatient care at Butterworth and construct a new ambulatory surgery center. Spectrum Health's administration, however, considers both of these initiatives to be long term projects. Other building projects have added or are anticipated to add to Spectrum Health's capacity incrementally. Much of the hospitals' stated justification for the merger focused on the new facility and the benefits to be reaped from consolidation of services. Unfortunately, few of these benefits have come to fruition in the years since the merger and appear unlikely to materialize in the near future. A survey of current building projects follows.

Spectrum Health has begun a two-part expansion that eventually will add 131 licensed inpatient beds to the Butterworth campus, bringing total Butterworth capacity up to 660 beds. The first part of the plan consists of the approved fifty-bed South Tower facility. In the proposal phase as of April 2000, the second portion of the plan outlines a 250,000 square foot addition in which to house new intensive care services and consolidate Spectrum Health's cardiovascular services. One business news

article describes the tower as the largest project proposed by Spectrum Health since the 1997 merger.[103] Finally, as part of the outreach portion of the Community Commitment, Spectrum Health has spent $2.7 million on clinical facilities in low-income areas within the past two years.

In the area of medical equipment, Spectrum Health has made steps toward consolidation of neurosurgery with its recent purchase of new operating equipment. This purchase has enabled Spectrum Health to upgrade the quality and types of neurosurgery services provided at Butterworth. Spectrum Health has not identified or quantified other equipment purchases undertaken since the merger.

B. Medical Care

Program consolidation potentially could lead to substantial efficiencies; consolidation could permit the hospitals to reduce excess capacity while combining the expertise of two medical staffs to improve patient care. Spectrum Health's original merger plan called for the consolidation of most inpatient services at the Butterworth facility. While the health system has initiated the physical movement of some programs to Butterworth, complete consolidation of inpatient care is still at least five years down the road.[104] The hospital system calculates the overall expense reductions generated by program consolidation from September 1997 to August 1999 to be $1.55 million.[105]

There were several proposed consolidations of medical care programs. The original plan was to consolidate three specialties—Obstetrics, Pediatrics, and Cardiology—in Butterworth. Currently, Pediatrics is the only program for which that has occurred. The combination eliminated duplication of services by the two campuses. Furthermore, it removed the need for inconvenient transfers from Blodgett to Butterworth when pediatric patients require continuing or follow-up care not offered at Blodgett. Spectrum Health estimates the savings from pediatric consolidation at $800,000 per year.[106]

On the other hand, there are several limits to the projected consolidation at Butterworth. There are capacity limitations, and Butterworth currently operates close to capacity in many respects, leading to a diminution in service and greater waiting times on occasion. While certain specialty departments have been able to consolidate at Butterworth, Spectrum Health's President of the Medical Staff believes that switching Blodgett to a

primary care facility is untenable. Psychologically, the shift would be an insult to Blodgett's physicians. Practically, the conversion plan could not be carried out because of size constraints. Butterworth's high census would cause overuse of operating rooms, which in turn would produce problems with physician satisfaction and quality of patient care.[107]

Instead, the hospital has come up with a new plan for cardiology services. The complete cardiology staffs will join together at a new cardiology center planned for the Butterworth campus, which will open in late 2003 at a projected construction cost of $67.4 million.[108]

In the outpatient care area, several of Spectrum Health's programs have been consolidated. Spectrum Health has relocated cardiac rehabilitation to the Blodgett campus at a savings of $125,000 and has consolidated the congestive heart failure services on the Blodgett campus. In addition, Blodgett's outpatient diabetes education capacity has moved to Butterworth, producing a savings of $300,000 for plant and staff. Spectrum Health also claimed as expense reductions consolidation of programs in digestive disease ($500,000 savings) and poison centers ($125,000).

Changes in quality of care as a result of the merger are far more difficult to measure than capital expenditures and prices. On the one hand, debate still exists in the medical research community as to the proper indicia of "quality" to employ when assessing medical care. Moreover, there were little aggregate data available to us relating to medical outcomes, thereby preventing any meaningful analysis of patient care. We did hear anecdotally of complaints about reductions in service and greater delays from the merger.[109] Capacity seems to be strained at the Butterworth campus.[110] Anecdotally, as conveyed by the President of the Medical Staff, operating rooms are in short supply due to Butterworth's high post-merger census. Nursing shortages are also common. Butterworth has also experienced congestion in the critical care unit.

On the other hand, Spectrum Health's Downtown Campus was just listed as one of three Michigan hospitals in HCIA-Sachs' list of this years' 100 Top Hospitals; the Downtown Campus has made the list five years. The East Campus has made the list four years (including 1999). Additionally, *U.S. News & World Report* ranked Spectrum Health-Downtown Campus excellent in the Orthopedic and Respiratory Disease categories.[111]

C. Administration and Research

Spectrum Health's cited cost savings in nonclinical care areas include the following: (1) initiation of the Medical Education and Research Center; (2) development of a medical leadership program; (3) expansion of an obstetrical study; (4) administrative cutbacks; and (5) installation of a new payment system.

The Medical Education and Research Center is a joint project in conjunction with Saint Mary's, Michigan State University, Grand Valley State University, and Metropolitan. To the extent that the Center improves clinical knowledge and practice in Grand Rapids, it may be counted as a quality-enhancing efficiency. If, however, the Center would have opened absent the merger, its existence cannot be attributed to the merger and thus is not cognizable as an efficiency. We were unable to determine whether the Center would have been viable had Blodgett and Butterworth remained separate.

Like the Research Center, Spectrum Health's medical leadership program has the potential to improve patient care. Better coordination of care, as well as increased provider knowledge and skills, ultimately will lead to better patient care. These improvements may result from the combination and reorganization of medical staffs, and thus may be counted as merger-specific, substantial efficiencies. However, the courts have typically been skeptical of best practice efficiencies, because firms can often accomplish the same goals through less restrictive means.[112] In the present case as well, implementation of Spectrum Health's medical leadership program may not have been merger-specific.

D. Review of Efficiencies

The efficiency estimates presented at the time of the merger were for a five year period and our view is of course only a snapshot at year three. But at this point, Spectrum has achieved at best only a modest portion of those efficiencies. Based on the system's own estimates, operating efficiencies achieved are something less than $30 million. We believe that not all of these efficiencies are cognizable because many of them would have been achieved absent the merger. The central efficiency, consolidating specialties at Butterworth, occurred only to a limited extent. Only pediatrics has been wholly consolidated at Butterworth. The ability to consolidate additional specialties at Butterworth appears problematic both because of the preferences of the practicing physicians and because of the limited space at that facility, which already frequently operates very close to full capacity.

V. Anticompetitive Effects

The key concern over any merger, including this merger, would be whether the merged entity would utilize its market power to either increase prices or reduce output. In this case, assessing the competitive effects of the merger is a somewhat difficult task because hospital prices are rather complex.[113] The Community Commitment regulated the pricing of inpatient care; however, the vast majority of customers do not pay the "prices" charged by the hospital. Rather, the charges are discounted, especially through managed care arrangements. In addition, mergers can have an adverse effect on quality or service, which cannot be measured by the simple measurement of price. One additional complicating factor in this case arises from the fact that Spectrum Health owns the largest managed care provider in the market, Priority Health. Through this vertical relationship there is the potential for avoiding the price regulating effects of the decree.

A. Prices

The Community Commitment required no price increases for the first three years and Spectrum Health abided with that provision. The first phase of the Commitment ended on October 1, 2000 and the system immediately increased prices by 3.3%. Blodgett also had raised prices by 3% immediately before the Community Commitment price freeze in 1997.[114]

B. Managed Care Provisions: A Level-Playing Field?

A second major component of the Community Commitment consisted of the provisions to protect the other managed care providers by attempting to require the merged hospital to deal on a nondiscriminatory basis with Priority and the competing managed care firms. At the time of the merger, many community and business representatives were concerned with Spectrum Health's continued ownership of Priority. This relationship, they claimed, nearly guaranteed that Priority would receive preferential treatment from Spectrum Health in the form of more favorable reimbursement levels for hospital services. The Community Commitment recognized the possible anticompetitive effects posed by Spectrum Health's ownership of Priority. Indeed, the "level-playing field" portion of the Commitment sought to prevent Spectrum Health from favoring Priority.

Three years into the implementation of the Community Commitment, numerous parties, including some employers and public advocates questioned whether the Community Commitment

was truly effective and the managed care marketplace was truly level. Priority increased its market share, due in part to its expansion of products and geographic growth. Of course, much of this expansion is procompetitive to the extent Priority has expanded services or attained efficiencies of scope or scale.

However, rival managed care providers believed that their costs increased considerably due to the Commitment's set discounts and restraints on rate negotiation. Employers noted that premiums have increased by over 10% each year in the market. As significant may be the effect on entry into the managed care market. We heard complaints that the "regulatory" structure imposed by the Community Commitment increased barriers to entry and efforts by other managed care providers to enter the Grand Rapids market may have been forestalled.

The Community Commitment allowed pre-existing health plans several options regarding their contracts with Spectrum Health's campuses. Pre-existing HMOs could accept a weighted average of the premerger rates paid to Blodgett and Butterworth by all four HMOs, or freeze their existing contracts. Similarly, existing managed care plans other than the HMOs could freeze their existing contracts or negotiate a new contract with Spectrum Health. Each of these arrangements would be in place for three years following the merger, with rate increases in years four to seven limited to no more than the increase in the regional all-products CPI. New managed care plans would be offered a "discount commensurate with the incremental volume that the plan can deliver to the merged entity."[115]

The Community Commitment regulatory schema produced a healthcare environment in which several health plans believed that they were paying more in hospital reimbursement than they most likely would have been absent the merger. Prior to the merger, managed care plans could play Butterworth and Blodgett off against one another and that rivalry has been lost. Only Priority holds a capitated contract with the hospital system. If two separate hospitals still operated in Grand Rapids, multiple HMOs may have been able to negotiate differing capitation rates with the two entities. These rates would have been based on each plan's enrollee volume and ability to steer patients to a particular facility *as is intended by the concepts of managed care and capitation.*

Capitation is not the only insurance rate schema that could conceivably suffer under the decree's regulatory scheme. The uniform discount Spectrum Health offered to the other Grand

Rapids HMOs is significantly less than that held by many prior to the merger (and for some it was higher). For those plans that chose to freeze their premerger contracts for the first three years post-merger, the Commitment does not specify at what level they may recontract upon expiration of their current contracts. Rather, it promises to limit annual increases in rates. Plans thus may find their base discount severely diminished when they reenter negotiations. This problem has not occurred as of yet, but is a risk in the future.

There has been relatively little managed care entry in the Grand Rapids market since the merger. Both potential new entrants and others expressed concerns that the Community Commitment permits Spectrum Health to heighten barriers to the managed care market; determination of an entrant's discount rate is essentially left up to Spectrum Health by the open-ended language of the new entrant price provision. Spectrum Health currently offers new entrants a 7% discount off of charges.[116] Spectrum Health determined the new entrant rate by simply halving the 14% discount given to all non-HMOs in the market at the time of the merger. Such an offer stands in stark contrast to the 26% discount being offered to the four large HMOs, as well as the 40% Blodgett discounts enjoyed by several health plans prior to the merger.

Even if Spectrum Health were to calculate the discount rate for each new entrant based on that plan's potential volume leverage, a new entrant would still be highly dependent on Spectrum Health. Potential entrants universally said they could not effectively enter without a contract with Spectrum Health. New entrants thus may find themselves having to negotiate a deal with Spectrum Health before they establish an enrollment base. Without substantial numbers of enrollees, Spectrum Health need not give them a preferable rate, as is stated in the Community Commitment. Spectrum Health, in fact, has an incentive not to give them a favorable rate: doing so might mean taking market share away from Priority. While this discussion is hypothetical, no health plans have entered the Grand Rapids area since the merger, several are positioned to exit, one potential entrant failed, and at least one potential entrant is believed to have failed.

Ultimately, even if Spectrum Health has abided with every aspect of the level playing field provisions, the provisions themselves may place rivals of Priority at a competitive disadvantage and increase barriers to entry. Moreover, there is no independent agency to monitor compliance with these provisions. Ultimately, whether these provisions succeed or fail, creating, monitoring,

and enforcing an order that attempts to prevent vertical discrimination is a tremendously difficult process. The Community Commitment appears to be deficient in failing to provide a mechanism to address these problems.

C. Services

As noted earlier, the merger has resulted in some consolidation of services, which in turn has led to some reduction of convenience. Other concerns have arisen from the closure of the Blodgett campus urgent care centers. These closings especially have impacted some employers who rely extensively on an affordable and convenient source of urgent care. Prior to the merger, employers were able to secure discounted rates for services, special billing arrangements for services received in the emergency room after regular urgent care center hours, and coordination of follow-up care. These types of contracts ended when Spectrum Health closed Blodgett's urgent care centers.

Some employers claimed that, as a result, employees needing urgent care after hours have been directed to other facilities by Spectrum Health staff, where they have often experienced long waits and lower quality treatment. Neither Saint Mary's nor Metropolitan has an urgent care center. Thus, for these employers, the only option outside of the Spectrum Health system is to use a twenty-four-hour occupational medical care center. Unfortunately, these facilities do not provide a continuum of care.

D. Consolidation of Physician Groups

Sometimes mergers have unanticipated results in related markets. That seems to be the case in Grand Rapids, where soon after the merger, many of the physicians providing hospital-based specialty services merged to form near monopolies within specialties.[117] In most specialities prior to the merger, there were typically at least two major physician groups, one affiliated with Butterworth and one affiliated with Blodgett. After the merger, many of the provider groups merged. Some of the managed care providers described the specialties (anesthesiology, pathology, radiology, and emergency care) as operating like "cartels." Many of these groups account for more than 60–70% of the market and they have proven especially resistant to price reductions. Some groups have threatened to terminate contracts unless they receive more favorable terms. Other groups have refused to negotiate long term contracts.

Other specialties have merged as well. For example, Blodgett and Butterworth's two cardiology groups merged financially and administratively in conjunction with pending physical and clinical consolidation at the new cardiac center. The combined group now includes twenty-five out of thirty-two Grand Rapids cardiologists (or 78% of the market). One purchaser expressed additional concern about possible monopolistic consolidation in neurology.

E. Entry

The potential for Spectrum Health to exercise market power could conceivably be limited by the ability of other hospitals to enter the market or for the remaining incumbents—Saint Mary's or Metropolitan—to expand services. New entry is highly unlikely. As the court recognized "[t]he Grand Rapids community is already served by sufficient inpatient hospital bed capacity[,] and authorization for construction of a new general acute care hospital in the area is not likely to be granted under Michigan's 'certificate of need' laws."[118] Therefore, the entry points of interest with respect to the Blodgett-Butterworth merger are at the levels of tertiary hospital services and health plan products.[119] Saint Mary's or Metropolitan could conceivably add services to counterbalance a Spectrum Health exercise of market power. Likewise, another health plan may enter Grand Rapids and provide an alternative to Priority Health. However, the likelihood of entry in the market is slim.

Metropolitan, because of its osteopathic tradition and focus on primary and secondary care, does not have the desire or ability to enter the market for tertiary services in Grand Rapids. Saint Mary's is better positioned to introduce tertiary service programs that compete with Spectrum Health. Nevertheless, providing new tertiary services would require approval from Michigan's CON program and could be opposed by Spectrum Health.[120] Such approval is unlikely if Spectrum Health has already entered the market; in addition, approval may take several years.

F. Conclusions on Competition

Spectrum Health has made a diligent and sincere effort to abide with the Community Commitment. It has taken its provisions seriously and pursued its obligations in a business-like fashion. It deserves credit for the establishment of the Financial Advisory Committee and its efforts to monitor the compliance with the commitment. Moreover, Spectrum Health recognizes its obligations to the

community and both seeks input from and provides information on compliance with the Commitment on a regular basis. In addition, it has expanded the Board of Directors to include a wider diversity of community and business leaders.

Yet the commitment of any firm to limit price increases or otherwise constrain the post-merger exercise of market power does not adequately substitute for the benefits of continued competition, whether the commitments are voluntary or are embodied in a binding consent order negotiated with a state attorney general. This case suggests how regulatory relief can be an inadequate substitute for competition. The court order has produced a healthcare environment in which several health plans believe that they are paying more in hospital reimbursement than they most likely would have absent the merger. Only Spectrum Health's own HMO holds a capitated contract with the hospital system. If two separate hospitals still operated in Grand Rapids, multiple HMOs may have been able to negotiate differing capitation rates with the two hospitals. These rates would have been based on each plan's enrollee volume and ability to steer patients to a particular facility as intended by the concepts of managed care and capitation. Instead, the regulatory order appears to have significantly dampened the opportunity for entry in the market for capitated health plans.

VI. Final Observations

We close by addressing four issues raised by this litigation: (1) the treatment of the nonprofit nature of the hospitals; (2) governance of the hospital; (3) whether capital avoidance should be treated as an efficiency; and (4) structuring regulatory relief.

A. Treatment of the Nonprofit Nature of the Hospitals

The linchpin of the rejection of the competitive concerns in Butterworth was the "undisputed" premise, put forth by the defendants, that "empirical proof does not support the presumption that high concentration of market power among nonprofit hospitals results in price increases."[121] The defendants based this premise on two papers by Dr. William Lynk, which suggested that increased concentration among nonprofit hospitals does not lead to higher prices.[122] At the time of the trial, these were the only published, empirical studies addressing the subject.

In the first paper, Dr. Lynk argued that community representation on a nonprofit hospital's board of directors will force that hospital to act as a consumer cooperative.[123] This implied that a

nonprofit hospital would set competitive prices irrespective of whether it possessed market power. While this theory of nonprofit behavior is theoretically plausible, other theories of nonprofit hospital behavior, which predict that nonprofit hospitals would exploit market power, are equally plausible. For instance, hospital administrators may seek perquisites such as fancy offices,[124] or a hospital's physician staff members may operate the hospital to maximize their own welfare.[125] In the second paper, Dr. Lynk used data for California hospitals in 1989 to empirically test the proposition that nonprofit hospitals will not exploit market power.[126] Specifically, the paper examined the relationship between the price that a nonprofit hospital sets and its market share in the county in which it is located.[127] Here, Dr. Lynk found that this relationship is negative, which led him to conclude that nonprofit hospitals do not exercise market power.[128]

In response to the *Butterworth* decision, at least four papers have reexamined the premise that nonprofit hospitals do not exercise market power. These papers seriously undermine Dr. Lynk's conclusions. The first three papers[129] are similar to Lynk's study in that they use cross-sectional data to examine the relationship between the price that a nonprofit hospital sets and some measure of its market power. These three papers differ, however, in that each applies a slightly different methodology to examine this relationship. Using these different methodologies, each of these papers finds that nonprofit hospitals tend to set higher prices when they possess market power. At a minimum, these papers suggest that Lynk's results are not robust and thus should not be relied upon in court proceedings.

The fourth paper[130] examines the results of a merger in which a for-profit hospital was acquired by a nonprofit: Dominican Santa Cruz's acquisition of AMI Community Hospital, which created a monopoly in Santa Cruz, California.[131] Using price data from 1986 to 1996, this paper found that prices at Dominican Santa Cruz increased substantially (over $1,000 per admission) following the acquisition.[132] Because Dominican Santa Cruz was a nonprofit hospital, the authors of this study conclude, "mergers involving not-for-profit hospitals are a legitimate focus of antitrust concern."[133]

These studies cast doubt on the results of Dr. Lynk's analysis. Such doubt warrants further investigation of pricing behavior among nonprofit hospitals and suggest that courts should be much more hesitant to follow the precedent set by *Butterworth*. Cases such as *Butterworth* are almost unprecedented in antitrust jurisprudence in

permitting an otherwise illegal combination because of the nonprofit nature of the surviving entity. Courts should analyze this issue with greater precision and more readily grant injunctions against nonprofit mergers that stand to confer market power.

The FTC can play a critical role in developing the jurisprudence on the treatment of nonprofit hospitals. Unlike the Antitrust Division of the Department of Justice, the FTC can challenge mergers in an administrative process before an Administrative Law Judge. This permits a more careful examination of economic and legal issues than can be achieved in federal court litigation, where the time constraints are extreme. Of course if a case is litigated administratively, the parties can consummate the merger prior to final resolution and there is the threat that a consolidated hospital system could not be unscrambled if the FTC ultimately prevailed. However, as this merger demonstrates, consolidation is often a very slow process and so the FTC may be in a position to fully restore competition even if the administrative litigation is not completed for two or three years. In this case, the two hospitals have not fully consolidated, and a divestiture could have been effective even three years after the merger. There is a significant need for clarification of the law and economics in this area and FTC administrative litigation may be the best approach for resolving these issues.

B. Governance Structure

The court also relied on the belief that the hospital would operate benignly because of its governance structure. The court noted that the merged hospital would be "comprised of community business leaders who have a direct stake in maintaining high quality, low cost services" and who would bring "real accountability to price structuring."[134] Thus, the court appeared to reason that these individual board members would restrain the ability of the hospital to exercise market power.

In fact, in accordance with the Community Commitment, Spectrum Health expanded its Board of Directors to include more community members and employers. We interviewed several members of the board, but did not study their role in depth. Many of the members are community leaders and businesspersons who have a direct stake in low-priced, high-quality healthcare. Some members spend a large portion of their time on hospital related issues. Others are employers who have a direct stake in controlling hospital costs.

Some commentators, such as Professor Thomas Greaney, are critical of the suggestion that an independent board can adequately police and restrain potential anticompetitive conduct.[135] According to Professor Greaney, members of the board of a nonprofit entity rarely involve themselves in day-to-day business decisions like pricing policies and discounting practices.[136] Moreover, even when a sufficient number of outside directors undertake supervision responsibilities, it is well established that they are compelled to act in the interest of the corporation on whose board they serve. Thus, an outside director may not have the ability to compel a hospital to focus on the interests of consumers for lower prices. As Professors Areeda and Hovenkamp have observed, a "nonprofit firm is more likely to be organized or managed in such a fashion as to make it less aggressive in cutting costs."[137] For example, while community involvement may make a hospital "responsible" to the community in its pricing decisions, it is just as likely to give the hospital a diverse agenda of costly—perhaps politically motivated—projects and activities that provide little benefit in proportion to their costs. In that case, competition acts as an essential discipline for which good intentions are rarely a sufficient substitute.

C. Treatment of Capital Avoidance as an Efficiency

This case also poses the question of whether the proposed capital avoidance of not having to build the new Blodgett facility or expand Butterworth should be considered an efficiency.[138] Typically, capital avoidance is not considered an efficiency, in part, because the antitrust laws have a strong preference for internal growth.[139] For example, if two firms are efficient and they propose to merge to avoid building a new factory, the savings from avoiding building the factory are not cognizable. Competition and society will be better off though the expansion of capacity.

Of course, hospitals pose a more difficult question. Hospital facilities are very expensive and society may not necessarily benefit from expansion. Excess capacity, which the antitrust laws often seek to protect in other markets, may raise hospital costs and prices that are eventually borne by consumers. Thus, a plausible assertion that a merger could reduce future excess capacity and costs is something that should be considered in hospital merger analysis. Concerns over excess capacity have led states to control expansion and entry through certificate of need laws. In this particular case, the merger was largely motivated by the concerns of community leaders to avoid a "medical arms race."

In *Butterworth*, the FTC presented several reasons for rejecting the capital avoidance claim, primarily because it was questionable whether the new hospital would actually be built and the amounts involved were speculative. The FTC presented extensive evidence that, absent the merger, managed care would likely encourage economizing on new facilities, forcing Blodgett to do without a new facility or at least reduce any "gold plating."[140] That argument seems to have been strengthened by post-merger experience. Before the merger, Blodgett argued that replacing its facility was essential so the choice for accommodating Blodgett's patient load was between (a) building a brand-new Blodgett, or (b) adding onto Butterworth, plus building a small satellite hospital where the brand-new Blodgett would have gone. But three years later, Blodgett remains open with very little of its patient load moved to Butterworth. All of this highlights the speculative nature of projections of future major capital expenditures in hospital markets, and the dubious likelihood that hospitals will be forced to make major capital expenditures in the face of an uncertain and potentially hostile reimbursement environment.

As a general matter, when should the avoidance of capital expenditures be considered an efficiency? If capacity expansions effectively reduce variable cost, the elimination of capacity expansions through merger could be, under some circumstances, an increase, not a reduction, in variable cost. In this situation, the capital cost reductions should not be cognizable. But what if the acquiring firm also had a facility at or near the same location that offered the same services and could accommodate not only its current patient draw, but also could accommodate the number of additional patients that would have been served at the new facility? If that were the case, then the avoidance of capital expenditures might reduce the future average variable cost of operating the assets of both firms. Then the avoidance of capital expenditures should be an efficiency. On the other hand, if the acquiring firm had no such facility, then the elimination of the new capacity should not be considered a reduction in variable cost. Instead, it should be viewed as an anticompetitive effect.

What if both firms are efficient but possess excess capacity? If the market were competitive prior to the merger, it would make no sense for one hospital to build additional capacity—when it and its rival already had excess capacity—unless the expansion would provide benefits to consumers that exceeded the capital costs. Under these assumptions, the elimination of the expansion through merger would automatically harm consumers and capital avoidance should

be a noncognizable efficiency. That would seem to have been the case in *Butterworth*.

D. Regulatory Review

As Professor Greaney observed, acceptance of the Community Commitment as an adequate safeguard against anticompetitive harm was "remarkable in several respects."[141] First, the court was effectively engaging in rate regulation in a setting in which it had no evidence or information or projections about future prices, cost, or quality changes in the hospital industry. Rate regulation of hospitals, even when performed by adequate administrative agencies, has not proven effective. Second, the Community Commitment provided no assurance that consumers would not be harmed by the diminution of nonprice aspects of care, such as quality, waiting times, and levels of service. Third, the parties were left to regulate themselves, rather than being subject to the oversight of a state department of health or state attorney general. Fourth, there is no mechanism for enforcing the decree. In cases brought by state attorneys general under state law, there is typically a provision for the attorney general to enforce breaches of the decree. Overburdened federal courts may find it quite difficult to engage in the difficult and specialized task of effectively overseeing such a regulatory decree.[142]

Finally, a regulatory decree is not forever. Although a decree may limit price increases during its duration, once the price regulatory provisions expire the parties are free to increase prices. In some of the cases where the states adopted a regulatory approach, this is precisely what the merged parties did at the end of the decree. A merger is forever, and a regulatory decree can at best just delay the exercise of market power created by the merger.

Assuming that a court permits the consummation of a merger based on a promise to "self-regulate" (i.e., control prices), how could it improve on the approach taken in this case? First, vertical concerns such as the issue of the relationship between the merged hospital and its managed care affiliate may be impossible to police. A preferable approach would be including structural provisions in subsequent orders in which such vertical concerns are raised. Second, independent review plays a critical role in assuring adherence with order provisions. Courts should appoint a third party to conduct a review of the merging parties' compliance with the provisions of its order. The FTC has used this type of "monitor trustee" successfully in many merger orders. An independent review would provide a more transparent evaluation of

the merger; it would also relieve the merging parties of the burden of conducting costly and time-consuming studies to measure their compliance with the court order.

Managed care markets stand to be particularly impacted by a hospital merger, as in Grand Rapids. Majority ownership of a purchaser of health services by the provider of services has obvious implications for patient channeling and preferential payment schedules. Thus, we recommend that merging hospitals be required to divest their ownership interest in any health plan when the merged entity would enjoy market power both in hospital services and health insurance. Ownership falling under this description may exist in the form of:

- a single hospital with majority ownership merging with another hospital with no previous ownership interest, for which the merger would produce new market power in hospital services and preserve existing market power in insurance;

- two hospitals with ownership interest in the same plan merging to create new market power in both hospital services and insurance; or

- two hospitals with ownership interest in different plans, in which the plans stood to merge as well, merging to create new market power in hospital services and insurance.

Depending on the degree of ownership and other market conditions, courts may opt to require full or partial divestiture by one or both of the parties.

VII. Conclusion

The decision in *Butterworth* is unique in its use of a quasi-regulatory decree as a substitute for competition. Although we believe that the management of Spectrum Health and the members of the Financial Advisory Committee should be credited for their efforts to adhere to the decree, we think it inevitably must fall significantly short of its goals. First, there is no administrative agency (or its equivalent) to perform the ongoing regulatory oversight of Spectrum Health. Unlike other efforts to substitute regulation for competition, this decree lacked the supervision of an independent authority such as the state department of health or a state attorney general. Second, the relationship between Spectrum Health and Priority invariably creates problems of

needing to prevent self-dealing or discrimination, and the opportunity for avoiding the price controls in the decree. When this type of relationship is present, a regulatory decree becomes even more difficult to effectively implement. That is why federal antitrust agencies prefer structural relief (i.e., requiring divestiture) when facing problems arising from self-dealing.[143] In this situation, courts or administrative agencies should either require the divestiture of the managed care entity or simply block the merger.

Third, Spectrum Health's experience on achieving efficiencies shows the substantial difficulty, often recognized in other industries, in achieving the efficiencies proposed in a merger.[144] In this case, the parties' proposed efficiencies excluding capital avoidance were well over $60 million over a five-year period. In the three years since the merger, no more than $30 million in savings has been achieved, some of which is probably not merger specific. Although part of the difficulty in achieving efficiencies may be due to exogenous factors, such as the decrease in reimbursement under the Balanced Budget Act, this suggests that courts should be very cautious in evaluating proposed efficiency claims. The fact that this case incorporated efficiency claims that were unusually well documented, substantiated, and the subject of lengthy study, and that Spectrum Health has devoted tremendous time and energy to achieving these savings shows that courts generally should be skeptical of these types of claims.

The analysis of these mergers will continue to be a problem for antitrust regulators and the courts. The fact that many of these mergers have led to litigation post-merger challenging substantial price increases suggests that neither a lax merger policy, nor efforts at regulating price increases are an adequate substitute for competition. We believe the FTC should consider the use of administrative litigation to help clarify the law and economics of hospital competition, providing a sound platform for future hospital merger enforcement. The issues of efficiencies and the nonprofit status of hospitals need particular attention.

Ultimately, this case documents the viewpoint that regulation serves as a poor alternative to continuing competition. One commentator suggested: "The opinion opens new vistas for antitrust analysis of hospital mergers by crediting the nonprofit status of the merged hospital and the parties' prospective commitments as a basis for overcoming the presumption of illegality."[145] Our review suggests that this is an experiment in substituting self-regulation for competition that should not be repeated.

Endnotes

[1] *See* U.S. DEP'T OF JUSTICE & FEDERAL TRADE COMM'N, 1992 U.S. MERGER GUIDELINES, *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,104, at 20,569 (Apr. 8, 1997) [hereinafter GUIDELINES].

[2] *See* Robert Pitofsky, *FTC Chairman Pitofsky Outlines Merger Approval Guidelines* (visited Mar. 22, 2001) <http://www.useu.be/ISSUES/pitof0217.html>; Joe Sims, *A New Approach to the Analysis of Hospital Mergers*, 64 ANTITRUST L.J. 633 (1996). *See generally* United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997); Federal Trade Comm'n v. Butterworth Health Corp., 946 F. Supp. 1285, 1302 (W.D. Mich. 1996), *aff'd in unpublished opinion*, 1997-2 Trade Cas. ¶ 71,863 (6th Cir. 1997); Federal Trade Comm'n v. Freeman, 911 F. Supp. 1213, 1224 (W.D. Mo.), *aff'd*, 69 F.3d 260 (8th Cir. 1995), United States v. Carilion Sys., 707 F. Supp. 840, 846 (W.D. Va.), *aff'd*, 892 F.2d 1042 (4th Cir. 1989).

[3] *See* Erwin A. Blackstone and Joseph P. Fuhr, Jr., *The Shift from Federal Antitrust Enforcement to State Regulation*, 33 J. HEALTH L. 103 (2000). In some cases where the states have imposed regulatory relief, there is evidence that these mergers have led to benefits for consumers. *See* Peter Johnson, *Survey: Benefits Prices Less than State Average*, GREAT FALLS TRIB., Nov. 16, 2000, at A1. In other cases states have had to lift regulatory provisions when the anticipated revenues have diminished. *See* Barbara Kirchheimer, *S.C. System Can't COPA with Limits*, MODERN HEALTHCARE 18 (Nov. 27, 2000). As a general matter hospital mergers often fail to deliver anticipated efficiencies efficiencies. *See* Jennifer Steinhauer, *Hospital Mergers Stumbling as Marriages of Convenience*, New York Times March 14, 2001 at A1.

[4] *See, e.g.*, Shannon P. Duffy, *Antitrust Suit Against Hospital Gets Green Light*, THE LEGAL INTELLIGENCER, Apr. 23, 2001 (reporting on *HealthAmerica Pennsylvania Inc. v. Susquehanna Health Sys.*, in which the Middle District of Pennsylvania declined to dismiss allegations that merged hospital system illegally tied physician service contracts to contracts for hospital services).

[5] *Butterworth*, 946 F. Supp. 1285. For the purposes of this Article, the merged entity is referred to as "Spectrum." Any references made to the hospitals in their premerger state utilize the names "Blodgett" and "Butterworth," as do references to the post-merger separate physical facilities for simplicity. Spectrum refers to the facilities post-merger as the "Downtown Campus" (Butterworth) and the "East Campus" (Blodgett).

[6] We performed the task as members of the Office of Policy and Evaluation in the Bureau of Competition of the FTC, and were assisted by an economist, John Simpson, from the Bureau of Economics. All the interviews we conducted and information we gathered is strictly confidential.

[7] DRGs are medical groupings, each representing "a class of patients who are deemed medically comparable and who require approximately equal amounts of health care resources," DRG are used by Medicare and Medicaid to determine reimbursement levels for hospitals. *See* VISTA Monograph: Administrative and Financial, Veterans Health Administration (visited July 27, 2000) <http:// www.va.gov/About_VA/ORGS/VHA/vista/admin/drgg.htm>.

[8] Blodgett could refer to Butterworth or some other hospital for a small subset of tertiary services.

[9] There was limited parking space and the facility was located two and one-half miles from a freeway, which limited access for emergency vehicles.

[10] *See Butterworth*, 946 F. Supp. at 1300. Blodgett had planned on constructing a replacement facility at a site already acquired by the hospital. Blodgett's baseline replacement facility plan included, in addition to the new facility,

the "bundling of related services into physician spaces/institutes (Primary Care Center, Digestive Disease Institute, Cancer Institute, Cardiovascular Institute, Orthopedic Institute, and Neuroscience Institute)," 314 inpatient beds, Research/Poison and Patient Service Centers, and a 1,000 space parking structure. The cost of the baseline plan for this scenario was estimated by the hospitals' trial expert to be $187.0 million.

[11] *See Butterworth*, 946 F. Supp. at 1300.

[12] *Id.* at 1288.

[13] *Id.* at 1302.

[14] *Id.* at 1294.

[15] *Id.* at 1290.

[16] *Butterworth*, 946 F. Supp. at 1291.

[17] *Id.*

[18] *Id.* Defendants argued that the FTC should be required to meet the "'90/90 strong market'" threshold outlined in *FTC v. Freeman Hosp*ital, 911 F. Supp. 1213, 1218 (W.D. Mo.), *aff'd*, 69 F.3d 260 (8th Cir. 1995). On this point, the court held that the area proposed by FTC staff at least came close to those thresholds, and in any event "it is inappropriate to evaluate the strength of a proposed market simply on the basis of an arbitrary percentage cutoff"; instead, the definition of a geographic market "must be pragmatic, based on consideration of all relevant data." *Butterworth*, 946 F. Supp. at 1291.

[19] *Butterworth*, 946 F. Supp. at 1294. Additional evidence suggested that other factors would exacerbate the anticompetitive effects of the merger and place the relevant market under the control of a truly dominant firm: the two other Grand Rapids hospitals offered a more limited range of services and had a reputation for lower quality of care, entry barriers were significant, and the merging partners had announced their intention to reduce certain managed care discounts and increase others post merger and institute "standard managed care rates."

[20] *Id.* at 1294.

[21] *Id. See* GUIDELINES, *supra* note 1, at 20,573-75. Market concentration may be measured by determining the market shares of industry leaders or by calculating the Herfindahl-Hirschman Index ("HHI"). The HHI is calculated by squaring the individual market shares of all firms in the market and adding up the squares. A merger that results in an HHI over 1800 indicates a highly concentrated market; it is presumed that mergers producing an increase in the HHI of more than 100 points in such markets are likely to create or enhance market power or facilitate its exercise. In this case, the post-merger HHIs for general acute care inpatient services were calculated at 2767 to 4521 points, reflecting an increase of between 1064 and 1889 points. For primary care inpatient services, the post-merger HHI rose to between 4506 and 5079 points (an increase of from 1675 to 2001 points). *See Butterworth*, 946 F. Supp. at 1294.

[22] *Butterworth*, 946 F. Supp. at 1302.

[23] *Id.* at 1294.

[24] *Id.* at 1302.

[25] *Id.* at 1295.

[26] *See id.* at 1295.

[27] *See Butterworth*, 946 F. Supp. at 1296.

[28] *Id.* at 1295. As one commentator has noted, the "empirical studies proved outcome determinative." The defendants effectively switched the burden of proof back to the government and from the court's view required the government to show that "proof about anticompetitive effects" was not just theoretical but "factual." Since this burden was impossible to carry, the FTC

lost. Michael S. Jacobs, *Presumptions, Damn Presumptions and Economic Theory: The Role of Empirical Evidence in Hospital Merger Analysis,* 31 IND. L. REV. 125, 139. In more recent cases, courts have rejected efforts to require the government to show likely anticompetitive effects with certainty in the fashion required in *Butterworth. See* FTC v. H.J. Heinz Co., 2001 U.S. App. LEXIS 7735 (D.C. Cir. Apr. 27, 2001).

[29] *Butterworth*, 946 F. Supp. at 1296.
[30] *Id.* at 1297.
[31] *Id.*
[32] *Id.* at 1297.
[33] *See id.*
[34] *Id.*
[35] *Butterworth*, 946 F. Supp. at 1298.
[36] *Id.* at 1299.
[37] *Id.*
[38] *Id.*
[39] *See Id.* at 1300.
[40] *See Butterworth*, 946 F. Supp. at 1300.
[41] *See id.*
[42] *See id.*
[43] *See id.*
[44] *See id.* at 1302.
[45] *See id.* at 1300-01
[46] *Butterworth*, 946 F. Supp. at 1300.
[47] *See id.*
[48] *See id.* at 1301-02.
[49] *See id.*
[50] *Id.* at 1301.
[51] *Butterworth*, 946 F. Supp. at 1301.
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] *See id.* at 1300.
[56] GUIDELINES, *supra* note 1, at 20,573-13.
[57] *Butterworth*, 946 F. Supp. at 1297.
[58] *See id.* at 1298.
[59] *Id.* at 1301.
[60] *Id.* at 1285.
[61] *See id.* at 1303.
[62] FTC v. Cardinal Health, Inc., 12 F. Supp. 2d 34, 62 (D.D.C. 1998). For a description of the law on this issue, see Richard Parker & David Balto, *The Merger Wave: Trends in Merger Enforcement and Litigation,* 55 BUS. LAWYER 351, 367-68 (1999).
[63] *See* Parker & Balto, *supra* note 62, at 367-68.
[64] United States v. Trenton Potteries Co., 273 U.S. 392, 397 (1927).
[65] *See Butterworth*, 946 F. Supp. at 1298.
[66] For the full text of the Community Commitment, see *Butterworth*, 946 F. Supp. at 1304-07. The Commitment to the Underserved consists of an annual $6 million budgeted item for direct funding of community based clinics, immunization and preventive care, and health education programs. Policies for use of the fund were to "be determined using formal community input, including stakeholder representation, from existing community groups and committees including Healthy Kent 2000, the Kent County Health Department, neighborhood groups, and others." *See id.* at 1307.
[67] *Butterworth*, 946 F. Supp. at 1305.

[68] *See id.*
[69] *See id.* at 1304.
[70] *Id.* at 1305.
[71] Although there was testimony at trial about these concerns, the FTC did not allege in its complaint that the merger would lead to this type of harm.
[72] *See Butterworth*, 946 F. Supp. at 1305.
[73] *See id.*
[74] *See id.*
[75] *See id.*
[76] *See id.*
[77] *See Butterworth*, F. Supp. at 1305.
[78] *See id.*
[79] *Id.*
[80] *See id.* at 1306 ("If any of the four large health maintenance organizations mentioned above seeks to enter into a capitation risk agreement with the merged entity . . . the merged entity will offer a uniform capitation rate to each of these large HMOs so long as the plans utilize the same uniform underwriting criteria (e.g., community rating versus experience rating) with respect to the covered population and provide an actuarially appropriate number of covered lives.").
[81] *Id.* at 1306.
[82] *Id.*
[83] Part of the problem for Spectrum was that the Balanced Budget Act of 1997 significantly reduced reimbursement for hospitals and has diminished the ability of all hospitals to expand and invest in new products. With large cutbacks in Medicaid/Medicare reimbursement, all Grand Rapids hospitals have had to look for ways to cut costs and improve efficiency. Thus, the plans to rationalize the two facilities have been put on hold.
[84] In a capitated arrangement between a health plan and hospital, the health plan pays a set monthly per enrollee dollar amount to the hospital for hospital-based care. The hospital is then responsible for managing costs among its patients. Some Health Maintenance Organizations ("HMO"s) offer an indemnity-type option known as a Point of Service plan ("POS"), which allows enrollees to refer themselves outside the plan and still receive some coverage. This is in contrast to a strict HMO, which requires enrollees to select a primary care "gatekeeper" and only see participating specialists upon referral by the gatekeeper. Finally, a Preferred Provider Organization, or "PPO," is a form of managed care plan in which enrollees may select physicians from a health plan's panel at a reduced out-of-pocket rate as compared to non-panel physicians. "Choice"-oriented PPO and POS products have seen the greatest share of recent managed care growth nationwide. *See generally* Susan M. Marquis & Stephen H. Long, *Trends in Managed Care and Managed Competition, 1993-1997*, 18 HEALTH AFFAIRS 75, 75-88 (1999) (citing J.R. Gabel & K. Hurst, *Health Benefits in 1998: Executive Summary* (KPMG Peat Marwick 2000)).
[85] *Dear Community Leader* (Spectrum Health) Nov. 17, 1999.
[86] Spectrum Health Agreed Upon Procedures Report, Coopers & Lybrand L.L.P.
[87] *Id.*
[88] Spectrum Health Agreed Upon Procedures Report, Coopers & Lybrand L.L.P.
[89] The Moody's figure is for health systems with an Aa Bond rating.
[90] Spectrum Health System Executive Summary: Inpatient Marketshare [sic] and Opportunity Analysis Based on 1998 Discharges.
[91] *Hospital Officials Expect to Finish Year in the Black*, ASSOCIATED PRESS STATE & LOCAL WIRE, June 9, 2000, at 1.
[92] *Id.*

[93] Chris Meehan, *Saint Mary's Closes Doors on Medicaid*, GRAND RAPIDS PRESS, Mar. 1, 2000, at A1.

[94] *Relative Market Shares Between Saint Mary [sic], Metropolitan and Spectrum Hospitals (Private Payors, All Zip Codes, Less DRGs 391, 324-338, 462) Years 1993-1998*, Bureau of Economics.

[95] *Id.*

[96] For a discussion of mergers and alliances in the Grand Rapids area, see David Hoekman, *Mergers, Alliances Signal New Era in Health Care*, GRAND RAPIDS BUS. J., Dec. 28, 1998, at B6.

[97] David Czurak, *Change Marks Health Care Market*, GRAND RAPIDS BUS. J., Dec. 29, 1997, at 3.

[98] Michael Casey, *Consolidation on the Rise in Western Michigan*, MED. INDUSTRY TODAY, Feb. 26, 1999. Mr. Casey is an analyst for Medical Data International, a healthcare consulting group operating out of California.

[99] Czurak, *supra* note 97, at 3.

[100] See the *Appendix* on p. 170 for a full list of Spectrum Health's claimed expense reductions and volume/revenue increases from September 1997 to August 1999. We did not audit or verify the amounts of the cost savings. There were also potential savings from avoiding the cost of building the new Blodgett facility, but as shown elsewhere, these savings arguably are not cognizable.

[101] Under the antitrust laws, efficiencies are cognizable only if they are "merger-specific," i.e., they cannot be achieved by other means less restrictive of competition. *See, e.g.*, FTC v. H.J. Heinz Co., 2001 U.S. App. LEXIS 7735 (D.C. Cir. Apr. 27, 2001); FTC v. Cardinal Health, Inc., 12 F. Supp. 2d 34, 62 (D.D.C. 1998); FTC v. Staples, Inc., 970 F. Supp. 1066, 1090 (D.D.C. 1997); United States v. Mercy Health Servs., 902 F. Supp. 968, 987 (N.D. Iowa 1995); United States v. Ivaco, Inc., 704 F. Supp. 1409, 1425 (W.D. Mich. 1989); United States v. Rockford Mem'l Corp., 717 F. Supp. 1251,1289 (N.D. Ill. 1989). As to merger specificity, many cost savings in plants or facilities could have been achieved through more limited joint ventures. Hospital mergers pose difficult problems of measuring efficiencies. *See* Erwin A. Blackstone and Joseph P. Fuhr, Jr., *Rural Hospital Mergers, Antitrust Policy and the Ukiah Case*, 23 J. HEALTH POL., POL'Y & L. 949 (1998).

[102] David Czurak, *Spectrum Gets Parking Ramp OK, Stern Reminder*, GRAND RAPIDS BUS. J., Sept. 27, 1999, at 8.

[103] David Hoekman, *Spectrum Health Plans Construction of Nine-Story Tower*, GRAND RAPIDS BUS. J., Apr. 10, 2000, at 7.

[104] Interview with Terry O'Rourke, Former Spectrum Health Chief Executive Officer (Mar. 2, 2000).

[105] Memorandum from Terry O'Rourke, to Spectrum Board (Aug. 19, 1999).

[106] *Id.*

[107] Interview with Dr. Ronald VanderLaan, Spectrum Health Medical Staff President (Mar. 3, 2000).

[108] *Medical Alley Taking Shape Along College Avenue Corridor*, GRAND RAPIDS BUS. J., Apr. 10, 2000, at B9.

[109] We also heard concerns about a lack of convenience due to the merger. At trial the parties suggested the merger would make facilities more accessible to patients. However, some patients cannot be seen at their traditional campus due to volume constraints. Their physicians must arrange for a colleague to cover their patients at the other facility, with the result that the patients cannot be seen by their traditional provider.

[110] Blodgett's current occupancy rate is approximately equal to premerger levels. Butterworth's census, however, has risen; the system has also experienced an overall increase in patient volume (though not market share). Spectrum Health may be directing patients to Butterworth, the higher priced facility, or patients may simply be more likely to seek care at Butterworth after the merger.

[111] *See Best Hospitals, Alphabetic Listings*, U.S. News and World Report Online (visited Mar. 23, 2001) <http://www.usnews.com/usnews/nycu/health/hosptl/hospalph.htm#S>; Best *Hospitals Honor Roll*, U.S. News and World Report Online (visited Mar. 23, 2001) <http://www.usnews.com/usnews/nycu/health/hosptl/honroll.htm>. *See also Top 100 Award Ninth for Both Campuses*, Spectrum Health Web Site (visited Mar. 26, 2001) <http://www.spectrum-health.org/info/news/top1002000.asp>.

[112] *See United States v. Mercy Health Servs.*, 902 F. Supp. 968 (N.D. Iowa 1995) ("best practices" efficiencies not cognizable because could be achieved by less restrictive means). For the general analysis of efficiency claims, see Parker & Balto, *supra* note 62, at 364-67.

[113] It is important to recognize that hospital charges do not necessarily bear much relationship to the price ultimately paid by managed care plans. In fact, list charges are almost never paid by any but the smallest of health plans. Instead, payments can take many forms. In some cases (including some of the managed care plans in Grand Rapids at the time of the merger), payments were based on discounted charges. The level of discount is negotiated between the hospital and the plan. Whether an increase in charges would then cause an increase in payments depends on whether the plan would renegotiate the effective discount. Similarly, effective prices to plans can increase without any change in charges if the hospital negotiates a lower discount off those charges. In other cases, plans may negotiate rates that are entirely independent of charges, for example per-diem rates or DRG-based rates. In that case, an increase in charges has no effect on payments. Similarly, restrictions on the hospital's charges in no way protect the plan from higher prices since those restrictions do not preclude the hospital from negotiating a higher per-diem rate.

[114] Price increases potentially could have been effectuated by shifting volume between the two hospitals. Prior to the merger, the hospital campuses operated under two separate charge masters and the charge masters only merged in 2000. This was a potential concern up until the merger of the charge masters. We did find that Blodgett's census (70% annual occupancy) was typically less than that at Butterworth (80-85% annual occupancy), which illustrates that Butterworth, the larger of the two facilities, receives the majority of Spectrum Health's patients.

[115] *Butterworth*, 946 F. Supp.1285, 1305.

[116] Interview with Michael Freed, Spectrum Health CFO. According to Freed, Spectrum Health set the 7% discount rate by halving the 14% discount given to all non-HMOs in the market at the time of the order.

[117] The FTC Staff has no information on the Spectrum Health physician joint ventures' levels of financial and/or clinical integration.

[118] *Butterworth*, 946 F. Supp. at 1297.

[119] Saint Mary's and Metropolitan already compete with Spectrum Health in primary and secondary care services.

[120] Certificate of Need statutes require hospitals or other healthcare facilities to seek advance approval by state agencies for most hospital expansions and major equipment purchases. The intent of CON laws is to contain healthcare costs by avoiding overcapacity.

[121] *Butterworth*, 946 F. Supp. at 1295. This holding was directly contrary to the treatment of the nonprofit status in the Seventh and Eleventh Circuits. *Compare* United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990) ("We are aware of no evidence and the defendants present none, only argument that nonprofit suppliers of goods or services are more likely to compete vigorously than other profit making suppliers.") *and* FTC v. University Health, Inc., 938 F.2d 1206, 1224 (11th Cir. 1991) ("The non-profit status of the acquiring firm will not, by itself, help a defendant

overcome the presumption of illegality that arises from the government's prima facie case.") *with* United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997) *and* United States v. Carilion Health Sys., 707 F. Supp. 840 (W.D. Va.), *aff'd mem.*, 892 F.2d 1042 (4th Cir. 1989).

[122] Dr. Lynk also did an empirical study of the difference in prices between monopoly and competitive services between Butterworth and Blodgett and a control market, Chicago, and suggested based on that study that prices were not necessarily higher under a monopoly. The court did not appear to rely on that study.

[123] William J. Lynk, *Property Rights and the Presumptions of Merger Analysis*, 39 ANTITRUST BULL. 363 (1994).

[124] For an extreme example, see Monica Langley, *A Nonprofit Hospital Finds Hospital Executives Were Making the Profit*, WALL ST. J., Nov. 20, 1996, A1.

[125] *See* Mark Pauly & Michael Redisch, *The Not-for-profit Hospital as a Physician's Cooperative*, 63 AM. ECON. REV. 87 (1973).

[126] William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J. L. & ECON. 437, 442 (1995).

[127] *Id.* at 446.

[128] *Id.* at 454.

[129] David Dranove & Richard Ludwick, *Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis*, 18 J. HEALTH ECON. 87 (1999); Emmett B. Keeler et al., *The Changing Effects of Competition on Non-Profit and For-Profit Hospital Behavior*, 18 J. HEALTH ECON. 69 (1999); John Simpson & Richard Shin, *Do Nonprofit Hospitals Exercise Market Power?*, 5 INT'L J. ECON. BUS. 141 (1996).

[130] Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers*, 48 J. INDUS. ECON. 63 (2001).

[131] We were unable to perform a similar study for Grand Rapids because of data limitations.

[132] Vita & Sacher, *supra* note 130, at 79.

[133] *Id.* at 82.

[134] *Butterworth*, 946 F. Supp. at 1297.

[135] Thomas L. Greaney, *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*, 23 AM. J.L. & MED. 191, 217 (1997).

[136] *Id.*

[137] Phillip Areeda & Herbert Hovenkamp, ANTITRUST LAW, ¶ 261c, at 267 (1997).

[138] In *Butterworth* the court seemed to credit some of the capital avoidance as a cognizable efficiency, but it did not specify the precise amount.

[139] *See, e.g.*, Areeda & Hovenkamp, *supra* note 137, ¶ 973b.

[140] The FTC also claimed that elimination of the planned expansion would hinder the quality improvements that would flow from a better facility. Efficiencies that stem from a reduction in quality or consumer choice arguably are not cognizable. *See* Robert Pitofsky, *Efficiencies in Defense of Mergers*, 7 GEO. MASON L. REV. 485, 486-87 (1999) ("Efficiencies must not arise from anticompetitive reductions in output, service, or other competitively significant categories such as innovation.").

[141] Greaney, *supra* note 135, at 218.

[142] *See generally* Blackstone and Fuhr, *supra* note 3; Jacobs, *supra* note 28.

[143] *See, e.g.*, Parker & Balto, *supra* note 62, at 398-400.

[144] Some studies show that firms often fail to accomplish the projected cost savings from a merger. *See generally* KPMG, UNLOCKING SHAREHOLDER VALUE: THE KEYS TO SUCCESS, MERGERS AND ACQUISITIONS: GLOBAL RESEARCH REPORT (1999) (stating that 83% of mergers failed to add to shareholder value); Joseph Brodley, *Proof of Efficiencies in Mergers and Joint Ventures*, 64 ANTITRUST L.J. 576 (1996); Craig W. Conrath & Nicholas A. Widnell, *Efficiency Claims in Merger*

Analysis: Hostility or Humility?, 7 GEO. MASON L. REV. 685 (1999) (describing cases where efficiency claims failed to be achieved). Some recent reports suggest that hospitals also have a spotty record in achieving efficiencies. *See* Jennifer Steinhauer, *Hospital Mergers Stumbling as Marriages of Convenience*, N.Y. TIMES, Mar. 14, 2001, at A1.

145 Greaney, *supra* note 135, at 212.

APPENDIX
Efficiencies: Expense Reductions

Category	Item	Savings
Expense Reductions		
	Consultants	$2,200,000
	Physician Contracts and Stipends	$1,300,000
	Program Consolidations	$1,550,000
	Bond Refinancing	$350,000
	Dues, Affiliations, Network	$720,000
	Travel, Telephone, Misc.	$860,000
	Advertising	$270,000
	Recognition Gala/Dinner	$400,000
	Catering	$200,000
	P.H. Medicaid Costs	$1,000,000
	Med+ Centers	$1,000,000
	Continuing Care Group	$300,000
	Ask-A-Nurse	$500,000
	Supplies/Services/Contracts	$950,000
	Other-Various Items	$1,400,000
Workforce Changes		
	Management Consolidation, 97–98	$3,000,000
	V.N.A., 97–98	$1,100,000
	Senior Management Restructuring, early 99	$1,000,000
	Priority Health	$2,000,000
	Hospital Payroll Salary Reduction (Hosp. staff, exec. mgmt. & dir., physicians)	$8,000,000
	Cancel FY'99 ICP Program	$900,000
	Total:	$29,000,000

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