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**ALLOWING LARGE HOSPITALS TO MERGE:
*UNITED STATES v. LONG ISLAND JEWISH
MEDICAL CENTER***

*Kenneth E. Yeadon**

INTRODUCTION

In October 1997, a federal district court allowed the two largest, most prestigious hospitals on Long Island, New York, to merge.¹ In *United States v. Long Island Jewish Medical Center*² the court rejected the Federal Trade Commission's attempt to prevent the merger of Long Island Jewish Medical Center and North Shore Health Systems under Section 7 of the Clayton Act.³

The Federal Trade Commission (FTC) enforces the Clayton Act.⁴ The Clayton Act forbids mergers where a reasonable probability exists that the firms could force prices above competitive levels, and thereby

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¹See *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 149 (E.D.N.Y. 1997).

²See *id.*

³See 15 U.S.C. § 18 (1994 & Supp. III 1997) (stating that "[n]o person engaged in commerce or in any activity affecting commerce shall acquire, directly or indirectly, the whole or any part of the stock [of another person] . . . [w]here the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly").

⁴See 15 U.S.C. § 21 (1994 & Supp. III 1997). Congress vested authority in five federal agencies to enforce the Clayton Act: the Interstate Commerce Commission for common carriers regulated by that agency; the Federal Communications Commission for common carriers regulated by that agency; the defunct Civil Aeronautics Board; the Federal Reserve Board for banks; and the Federal Trade Commission for activities not covered by the other four agencies. See *id.* See also *FTC v. University Health, Inc.*, 938 F.2d 1206, 1214 (11th Cir. 1991) (holding that nonprofit hospitals fell under the FTC's jurisdiction to enforce the Clayton Act because no other agency listed in Section 11 regulated the hospitals).

“hurt consumers.”⁵ Historically, courts granted practically every hospital merger injunction requested by the FTC.⁶ Recently, several courts refused to grant injunctions mainly because economic conditions in the healthcare industry warranted the mergers.⁷ These mergers appear to violate the Clayton Act by providing the merged hospitals with enough market power to profitably increase prices.⁸ In cases like *Long Island Jewish Medical Center*, however, the government’s antitrust strategies did not address changes in the healthcare industry.

This article reviews the decision in *Long Island Jewish Medical Center*, and discusses the reasons behind the government’s loss in the case. A background into antitrust law and recent changes in the healthcare industry is provided first.

BACKGROUND

Changes in the healthcare industry affect the application of antitrust law to hospital mergers. This section provides background into antitrust law, notes the changes in New York State’s health care industry, and introduces the merging hospitals.

The Clayton Act

Section 7 of the Clayton Act outlaws mergers that “substantially lessen competition, or tend to create a monopoly.”⁹ Congress passed the Clayton Act in 1914, in reaction to the Supreme Court’s interpretation of the

⁵United States v. Rockford Mem’l Corp., 898 F.2d 1278, 1282-83 (7th Cir. 1990).

⁶See *University Health, Inc.*, 938 F.2d at 1225 (vacating the district court’s denial of a preliminary injunction); *Rockford Mem’l Corp.*, 898 F.2d at 1286 (affirming the district court’s grant of a preliminary injunction); *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1393 (7th Cir. 1986) (affirming the district court’s grant of a preliminary injunction); *FTC v. Columbia Hosp. Corp.*, 1993-1 Trade Cas. (CCH) ¶ 70,209 (M.D. Fla. May 5, 1994) (granting a preliminary injunction without opinion).

⁷See *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1303 (W.D. Mich. 1996) (merging hospitals successfully rebutted the FTC’s *prima facie* case by showing that increased market share does not automatically translate into higher prices and profits). See also *FTC v. Freeman Hosp.*, 69 F.3d 260, 272 (8th Cir. 1995) (holding that the FTC failed to establish the requisite relevant market); *United States v. Mercy Health Serv.*, 902 F. Supp. 968, 975 (N.D. Iowa 1995), *vacated as moot* 107 F.3d 632, 634 (8th Cir. 1997) (holding that the FTC failed to establish the requisite relevant market; hospitals subsequently abandoned merger plans).

⁸See *Mercy Health Serv.*, 902 F. Supp. at 975 (meeting the requirements of Section 7 requires that the government show a reasonable probability that the proposed transaction will substantially lessen competition in the future).

⁹See 15 U.S.C. § 18 (1994 & Supp. III 1997).

Sherman Act.¹⁰ Congress had enacted the Sherman Act to reel in railroad cartels and oil and tobacco trusts.¹¹ The Supreme Court fulfilled these objectives, but made proving a Sherman Act violation too difficult.¹² Today, Section 7 is understood to forbid mergers likely to “hurt consumers, as by making it easier for the firms in the market to collude, expressly or tacitly, and thereby force price[s] above or farther above the competitive level.”¹³

The government establishes a prima facie case under Section 7 by demonstrating with reasonable probability¹⁴ that the merged entity will possess a large percentage of the relevant market,¹⁵ and may raise prices above competitive levels.¹⁶ The government bears the burden of proof and must (1) define the relevant product market; (2) define the relevant geographic market; and (3) prove that the merger will result in anticompetitive conditions and an increase in prices above competitive levels for a significant period of time.¹⁷

The term “relevant markets” describes the markets in which the merging parties currently compete.¹⁸ Relevant markets include product markets and geographic markets. A product market includes potential

¹⁰See *Rockford Mem'l Corp.*, 898 F.2d at 1282 (responding to the United States Supreme Court's opinion in *Standard Oil Co. v. United States*, 221 U.S. 1 (1911), the drafters of the Clayton Act identified particular anticompetitive practices and forbade those practices upon a showing, not that they would, but merely that they might, lessen competition substantially).

¹¹See *id.*

¹²See *id.*

¹³*Id.* at 1282-83.

¹⁴See *Fruehauf Corp. v. FTC*, 603 F.2d 345, 351 (2nd Cir. 1979) (requiring a reasonable probability of a substantial impairment of competition by an increase in prices above competitive levels to render a merger illegal under Section 7). See also *United States v. Falstaff Brewing Corp.*, 410 U.S. 526, 555 (1973), *mandate conformed to United States v. Falstaff Brewing Corp.*, 383 F. Supp. 1020 (D.R.I. 1974) (satisfying Section 7 requires more than remote possibilities).

¹⁵See *Fruehauf Corp.*, 603 F.2d at 351. See also *United States v. Marine Bancorporation*, 410 U.S. 602, 618 (1974) (determining the relevant product and geographic markets necessarily predicates finding whether a merger contravenes Section 7).

¹⁶See *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 363 (1963). See also *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 392 (1956) (holding that price and competition are so intimately intertwined that any discussion must treat them as one. Price cannot be conceivably controlled without power over competition, or vice-versa. An intention to monopolize is presumed when a monopolist has power over price and competition.)

¹⁷See *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 137 (E.D.N.Y. 1997).

¹⁸Joe Sims, *Symposium: Perspectives on Efficiencies and Failing Firms in Merger Analysis: A New Approach to the Analysis of Hospital Mergers*, 64 ANTITRUST L.J. 633, 637 (1996) [hereinafter *Sims*]. See also *infra* pp. 91-93.

suppliers readily able to offer consumers a suitable alternative to the defendant hospitals' services.¹⁹ A product market should exclude suppliers offering products too different from that of the defending hospitals.²⁰ The geographic market covers that geographic area to which consumers can practically turn for alternative sources of the product and in which the defending hospitals face competition.²¹

Proving a merger's anticompetitiveness involves a two-step analysis.²² First, with reasonable probability, will the merged entity possess enough market power to profitably increase prices above competitive levels for a substantial period of time?²³ Second, considering that increased market share and leverage, will the merged entity reduce the quality of services offered?²⁴ Alternatively, the government establishes a prima facie showing that the merger will result in anticompetitive effects by demonstrating that the merged entity will possess an undue share of the relevant market.²⁵

Defendants may rebut the government's prima facie case with evidence that the intended merger would create significant efficiencies in the relevant market.²⁶ The merger's increased efficiencies must enhance and not hinder competition.²⁷ The defendants must show that the merger, and not any other factor, will generate significant economies.²⁸ Further, these economies must be shown to ultimately benefit consumers.²⁹ As part of this analysis, the not-for-profit status of merging hospitals will be considered if supported by evidence that the status inhibits anticompetitive effects.³⁰

¹⁹See *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1290 (W.D. Mich. 1996).

²⁰See *id.*

²¹See *id.*

²²See *Long Island Jewish*, 983 F. Supp. at 142.

²³See *id.* See also *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1078 (D.D.C. 1997) (preventing Staples, an office supply superstore, from merging with Office Depot because Staples, as the only remaining office superstore, could raise prices without fearing the effects of competition).

²⁴See *Long Island Jewish*, 983 F. Supp. at 142.

²⁵See *id.* at 145.

²⁶See *FTC v. University Health, Inc.*, 938 F.2d 1206, 1222 (11th Cir. 1991).

²⁷See *United States v. Country Lake Foods, Inc.*, 754 F. Supp. 669, 680 (Minn. 1990).

²⁸See *University Health, Inc.*, 938 F.2d at 1223.

²⁹See *id.*

³⁰See *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 146 (E.D.N.Y. 1997). See also *infra* pp. 94.

Courts are suspicious of the efficiencies defense.³¹ To sustain the defense, defendants must clearly demonstrate that the proposed merger will create a net economic benefit for health care consumers.³² To this end, alleged efficiencies are often speculative, and vigorously disputed.³³ In addition, whether the merger's efficiencies actually trickle down to consumers is difficult to measure.³⁴

Given this background into antitrust law, the next section discusses conditions in New York's health care industry that encouraged Long Island Jewish and North Shore Health Systems to merge.

The Healthcare Industry in New York State

The New York healthcare industry has experienced significant changes over the past ten to twenty years.³⁵ Predominantly, the industry has seen the entry of managed care health organizations (MCOs), a surplus of hospital beds, and decreasing government funding from Medicare and Medicaid.³⁶ This section provides an overview of these changes.

State and local governments began encouraging MCOs to insure citizens in the 1980's and early 1990's.³⁷ By that time, governmental entities realized that many citizens could not afford the cost of medical

³¹See *Sims*, *supra* note 18.

³²See *Long Island Jewish*, 983 F. Supp. at 147.

³³See *id.*

³⁴See *id.*

³⁵See *id.* at 127.

³⁶See *id.* at 127-29.

³⁷See *Long Island Jewish*, 983 F. Supp. at 127. Hospital professionals distinguish among the types of care various facilities provide based on the sophistication of services rendered, and the seriousness and complexity of the illnesses treated. See *United States v. Carilion Health Sys.*, 707 F. Supp. 840, 844 (W.D. Va. 1989) (discussing that service levels include primary, secondary, tertiary, and acute care. Hospital offering primary care services prevent, detect, and treat diseases. The primary care level includes obstetrics, gynecology, internal medicine, and general surgery. Primary care hospitals usually own diagnostic equipment to perform X-rays and laboratory analysis. Secondary care involves more sophisticated treatment than primary care. This service level includes cardiology, respiratory care, and physical therapy. This level features more sophisticated diagnostic equipment and laboratory capabilities than primary care. Tertiary care acts to arrest disease already in progress. This level usually includes heart surgery and cancer treatments like chemotherapy. The quality of diagnostic equipment and laboratory capabilities is higher than primary and secondary care. Acute care requires hospitalization, and cannot be provided on an outpatient basis. While a significant number of problems can be treated on an inpatient or outpatient basis, reasonable doctors differ as to whether inpatient or outpatient treatment is most appropriate. Because outpatient care is less expensive, insurance carriers generally structure their reimbursement policies to encourage patients to use outpatient service.)

care or insurance.³⁸ A MCO is an organized system of health care that, for a defined group of people, provides insurance, payments, and health care services.³⁹ Because MCOs insure a vast number of people, MCOs exert great leverage in pressuring physicians and hospitals to provide quality care at reasonable prices.⁴⁰ Recognizing that inpatient hospital care is by far the most expensive cost of medical care, MCOs developed and promoted inpatient care alternatives.⁴¹

Previously, MCOs did not market in New York because the State set the rates charged by hospitals.⁴² In New York's regulated market, MCOs' negotiation advantage gained from representing so many patients carried little weight.⁴³ Because the State set rates, little incentive existed to find alternatives to expensive inpatient costs.⁴⁴

New York patients utilized inpatient hospital care for lack of alternatives.⁴⁵ This system created the most hospital dependent health care system in the United States.⁴⁶ The average hospital stay was significantly longer than in almost every other major metropolitan area.⁴⁷ In response, New York hospitals created the capacity to service the market, but could barely meet demand.⁴⁸ While New York supplied nine beds per capita, occupancy sometimes exceeded one hundred percent.⁴⁹

In the late 1980s, New York's legislature began to loosen the regulatory grip on health care.⁵⁰ A form of the MCO, the health maintenance organization (HMO), was allowed to negotiate rates with hospital providers.⁵¹ Still, other types of MCOs remained subject to regulation, were forced to pay the higher state regulated rates, and held little economic incentive to compete in the state.⁵² The legislation had

³⁸See *Long Island Jewish*, 983 F. Supp. at 127.

³⁹See *id.*

⁴⁰See *id.*

⁴¹See *id.*

⁴²See *id.*

⁴³See *Long Island Jewish*, 983 F. Supp. at 127.

⁴⁴See *id.*

⁴⁵See *id.*

⁴⁶See *id.*

⁴⁷See *id.*

⁴⁸See *Long Island Jewish*, 983 F. Supp. at 127.

⁴⁹See *id.*

⁵⁰See *id.*

⁵¹See *id.*

⁵²See *id.*

little impact because HMO's were only a small percentage of the hospitals' business.⁵³

On January 1, 1997, New York deregulated hospital rates.⁵⁴ Now, all MCOs are free to negotiate prices, greatly accelerating their penetration of the New York marketplace.⁵⁵ Anticipating deregulation, hospitals were already working with MCOs.⁵⁶

An effect of MCOs was to reduce hospital prices.⁵⁷ Industry experts predicted that prices would fall even farther because hospitals need the patients controlled by MCOs.⁵⁸ MCOs have also created surplus hospital beds.⁵⁹ Focusing on costs, MCOs have encouraged outpatient treatments and shorter hospital stays when possible.⁶⁰

Hospitals have experienced financial pressure from the changes in the industry.⁶¹ In addition to having to negotiate for decreased rates with MCOs, Medicare and Medicaid payments are decreasing.⁶² Efforts to balance the federal budget have focused on trimming payments to health care providers.⁶³ Over the next six years, Medicare payments to the hospitals will be reduced by \$44 billion.⁶⁴ All hospital rates for Medicare are frozen, without regard to inflation.⁶⁵

Given this understanding of economic conditions in New York's health care industry, the next section introduces the merging hospitals.

⁵³See *Long Island Jewish*, 983 F. Supp. at 127.

⁵⁴See *id.*

⁵⁵See *id.*

⁵⁶See *id.* On April 30, 1996, a Long Island Jewish report stated that "to date, the hospital has active agreements with over 35 managed care entities. In confirmation of the effectiveness of its strategy of managed care contracting, inpatient discharges for managed care members for the first three months of 1996 has surpassed by 35% such activity for all of 1995. See *id.*

⁵⁷See *id.* at 128.

⁵⁸See *Long Island Jewish*, 983 F. Supp. at 129.

⁵⁹See *id.*

⁶⁰See *id.*

⁶¹See *id.*

⁶²See *id.*

⁶³See *Long Island Jewish*, 983 F. Supp. at 129.

⁶⁴See *id.* at 128 (beginning in 1997, over a five-year period, Long Island Jewish will lose more than \$88 million and North Shore Manhasset will lose \$87 million in Medicare and Medicaid payments).

⁶⁵See *id.*

The Hospitals

North Shore Health Systems and Long Island Jewish Medical Center (Long Island Jewish) are large institutions located fairly close to one another.⁶⁶ North Shore Health Systems owns nine hospitals: one in Queens County, five in Nassau County, two in Suffolk County, and one on Staten Island.⁶⁷ North Shore Health System's major hospital is North Shore Manhasset, and is located in the northwesterly portion of Nassau County.⁶⁸

Long Island Jewish is two miles away from North Shore Manhasset in the most easterly portion of Queens County.⁶⁹ Long Island Jewish is comprised of three institutions: Long Island Jewish, a 450 bed acute care adult facility; Schneider's Children's Hospital, a 150 bed acute care facility; and Hillside Hospital, a 220 bed psychiatric ward.⁷⁰ Long Island Jewish is also an academic teaching center affiliated with the Albert Einstein School of Medicine.⁷¹

Long Island Jewish faces competition in each area of practice. The primary competitors of Long Island Jewish in the psychiatric field are the Nassau County Medical Center and Elmhurst Hospital in Queens.⁷² In pediatrics, Long Island Jewish competes with almost every hospital on Long Island who has inpatient pediatric services.⁷³ This includes Winthrop University Hospital (Winthrop Hospital) in Nassau, New York Hospital of Queens, Good Samaritan Hospital in Suffolk, and the Manhattan hospitals.⁷⁴

Long Island Jewish is committed to treating all patients who walk through the door, regardless of their ability to pay or their source of reimbursement.⁷⁵ The profile of the patient population at Long Island Jewish, categorized by the type of payer, is: thirty percent Medicare, twenty percent Medicaid, twenty percent classic indemnity insurance carriers, and thirty percent various type of managed care insurance

⁶⁶See *id.* at 126.

⁶⁷See *id.* at 125.

⁶⁸See *Long Island Jewish*, 983 F. Supp. at 125.

⁶⁹See *id.*

⁷⁰See *id.* at 126.

⁷¹See *id.*

⁷²See *id.*

⁷³See *Long Island Jewish*, 983 F. Supp. at 126.

⁷⁴See *id.*

⁷⁵See *id.*

carriers.⁷⁶ Fifty percent of the Long Island Jewish patient population resides in Queens, thirty percent in Nassau, and the balance in Suffolk, Manhattan, and Westchester.⁷⁷

North Shore Manhasset is an academic teaching hospital affiliated with the New York University School of Medicine.⁷⁸ The patient profile at North Shore Manhasset is forty percent Medicare and Medicaid and thirty percent managed care, which increased from fifteen percent several years ago.⁷⁹ The rest of the patients have commercial insurance companies or are self-payers.⁸⁰

North Shore Manhasset has a tradition of community assistance. The hospital's clinics opened on the same day as the hospital.⁸¹ Additionally, prior to the introduction of Medicaid in 1966, North Shore Manhasset's attending physicians were committed to treating the poor without charge.⁸² Today, this tradition has evolved into 150 to 200 hospital administered outreach programs, in which North Shore Manhasset personnel go into the community to address health problems and advise on preventative medicine.⁸³

Both hospitals offer similar levels of service. Approximately eighty to eighty-five percent of the services provided by North Shore Manhasset and Long Island Jewish are primary/secondary services. All community hospitals in Queens and Nassau also provide these services.⁸⁴ The remaining services are for tertiary care.⁸⁵ The hospitals' reputations, however, distinguish them from all other hospitals in the vicinity.⁸⁶

The CEO of United Health Care stated that North Shore Manhasset and Long Island Jewish are "must have" hospitals for that company.⁸⁷ United Health Care is the third largest health care insurer in the United States covering 25 million persons and 1.1 million New Yorkers.⁸⁸ The

⁷⁶See *id.*

⁷⁷See *id.*

⁷⁸See *Long Island Jewish*, 983 F. Supp. at 126.

⁷⁹See *id.*

⁸⁰See *id.*

⁸¹See *id.*

⁸²See *id.*

⁸³See *Long Island Jewish*, 983 F. Supp. at 126.

⁸⁴See *id.* at 127.

⁸⁵See *id.*

⁸⁶See *id.*

⁸⁷*Id.* at 130.

⁸⁸See *Long Island Jewish*, 983 F. Supp. at 130.

CEO stated that United could not build a marketable network on Long Island if the company had to drop one of the hospitals from the plans offered to customers.⁸⁹

Winthrop Hospital is a large teaching facility in Nassau County on Long Island.⁹⁰ While Winthrop was ranked one of the "100 Best Hospitals" in the United States by U.S. News & World Report, Winthrop cannot match the prestige of Long Island Jewish and North Shore Manhasset.⁹¹ Insurers need Jewish Medical Center or North Shore Manhasset to build a strong network.⁹²

SUBJECT OPINION

The FTC requested preliminary and permanent injunctions under Section 7 of the Clayton Act⁹³ to prevent North Shore Health Systems and Long Island Jewish from merging.⁹⁴ With the merger pending, the federal district court expedited the case and refused to grant a permanent injunction.⁹⁵ While the court addressed a total of six issues,⁹⁶ the government lost the case on the first issue, the relevant product market.⁹⁷ The following sections address each issue.

Relevant Product Market

The government started with the burden of proving that the merged hospitals would possess a large percentage of the relevant product market.⁹⁸ The government lost the case on this issue because the court refused to accept the government's definition of the relevant product market.⁹⁹ The government defined the relevant product market as anchor hospitals providing primary and secondary services.¹⁰⁰ Anchor hospitals possess prestigious reputations, broad-ranging and highly sophisticated

⁸⁹See *id.*

⁹⁰See *id.* at 131.

⁹¹*Id.*

⁹²See *id.* at 132.

⁹³See 15 U.S.C. § 18 (1994 & Supp. III 1997).

⁹⁴See *Long Island Jewish*, 983 F. Supp. at 125.

⁹⁵See *id.* at 126.

⁹⁶See *id.* at 125.

⁹⁷See *id.* at 140.

⁹⁸See *id.*

⁹⁹See *Long Island Jewish*, 983 F. Supp. at 140.

¹⁰⁰See *id.*

services, and high-quality medical staffs.¹⁰¹ The court disagreed with the government's argument, finding the relevant product market as general acute care inpatient hospital services.¹⁰²

The premise of the government's argument was that North Shore and Long Island Jewish's reputation distinguished them from all other hospitals on Long Island.¹⁰³ While many other hospitals offered similar services and comparable quality, North Shore and Long Island Jewish's reputations as premier hospitals placed them in the anchor hospital market.¹⁰⁴ On Long Island, the anchor hospital market included only three institutions: North Shore Manhasset, Long Island Jewish, and Winthrop Hospital.¹⁰⁵

The court found the government's characterization of the relevant product market which included only anchor hospitals, as unnecessarily restrictive, given the number of hospitals in the area that offered the same services as Long Island Jewish and North Shore Health Systems.¹⁰⁶ The majority (85%) of the hospitals' business was from primary and secondary care, and many other hospitals on Long Island deliver similar acute inpatient care services.¹⁰⁷ For the same reason, the court was not convinced that North Shore's and Long Island Jewish's reputation, or cachet, determined where consumers went for healthcare.¹⁰⁸ The court found that reputation demonstrated where patients currently went, not where patients could practically go for acute care inpatient services.¹⁰⁹

The court observed that the government's anchor hospital argument was doomed anyway because another hospital of similar size and

¹⁰¹ *See id.*

¹⁰² *See id.*

¹⁰³ *See id.*

¹⁰⁴ *See Long Island Jewish*, 983 F. Supp. at 140.

¹⁰⁵ *See id.*

¹⁰⁶ *See id.* (citing *United States v. Grinnell Corp.*, 384 U.S. 563, 590-91 (1966) (Fortas, J., with Stewart, J., dissenting) (criticizing narrow market definitions tailored only to those activities in which defendants engage; relevant markets include alternative sources of, and substitutes for, defendants' products reflecting "commercial realities").

¹⁰⁷ *See id.* at 41 (competing hospitals include Winthrop Hospital, Nassau County Medical Center, ten general acute care hospitals in Queens County, and eight general acute care hospitals in Nassau County).

¹⁰⁸ *See id.*

¹⁰⁹ *See Long Island Jewish*, 983 F. Supp. at 138-39.

reputation, Winthrop Hospital, was available.¹¹⁰ Winthrop, a teaching facility providing primary, secondary, and tertiary health care services, qualifies as an anchor hospital.¹¹¹ The court went on to address the rest of the issues to complete the record.

Relevant Geographic Market

The relevant geographic market turned on the availability of alternative sources for health care consumers, should the merged hospitals increase prices.¹¹² The parties based their arguments on different geographic markets that included permutations of Nassau, Queens, Western Suffolk County, and Manhattan.¹¹³ The court heard evidence that patients prefer to receive health care treatment near their homes.¹¹⁴ Evidence further demonstrated that many Queens, Nassau, and Suffolk residents traveled to Manhattan for certain tertiary treatments.¹¹⁵ Reviewing this evidence, the court found two geographic markets.¹¹⁶

The first geographic market was for primary and secondary care.¹¹⁷ These services constituted eighty-five percent of the hospitals' activities.¹¹⁸ This market included only Queens and Nassau; Manhattan and Western Suffolk County hospitals were considered too far away to provide reasonably suitable alternative care.¹¹⁹ The second geographic market was for tertiary care.¹²⁰ This market included Manhattan, Queens, Nassau, and Western Suffolk County.¹²¹

¹¹⁰*See id.* at 140 (noting that the government's own economist testified that Winthrop Hospital offered the same services as Long Island Jewish and North Shore Manhasset. The court also observed that U.S. NEWS & WORLD REPORT ranked Winthrop Hospital as one of the top 100 hospitals in the United States).

¹¹¹*See id.*

¹¹²*See id.* at 140 (defining the relevant geographic market as the area in which consumers can practically find alternative healthcare sources; therefore, the defendant hospitals face competition in these areas).

¹¹³*See id.*

¹¹⁴*See Long Island Jewish*, 983 F. Supp. at 141.

¹¹⁵*See id.*

¹¹⁶*See id.*

¹¹⁷*See id.*

¹¹⁸*See id.*

¹¹⁹*See Long Island Jewish*, 983 F. Supp. at 141 (noting the presumption that hospital consumers prefer to receive care near their homes).

¹²⁰*See id.*

¹²¹*See id.*

Anticompetitive Effects of the Merger

Determining the anticompetitive effects of the merger involved a two-step analysis.¹²² The first step asked whether, with reasonable probability, the merged entity would have enough market power to profitably increase prices above competitive levels for a substantial period of time.¹²³ The second step asked whether the merged hospitals, given increased market share and leverage, might reduce the quality of care, treatment, and medical services rendered.¹²⁴

The hospitals satisfied the first step by convincing the court that the merger would not likely cause a price increase.¹²⁵ The government argued that the hospitals would raise prices twenty percent.¹²⁶ In their defense, the hospitals presented testimony directly controverting that argument.¹²⁷ That testimony was supported with evidence about New York's health care economy.¹²⁸ Health care rates, including hospital prices, were steadily falling in the wake of deregulating New York's health care industry.¹²⁹ Additionally, the hospitals had agreed with the State not to raise prices for at least two years after merging.¹³⁰

The government did not establish a *prima facie* case¹³¹ because the court held that the merged hospitals would not possess an undue share of the relevant market.¹³² In 1994, excluding newborns, Long Island Jewish had 7.7 percent of the Queens inpatient discharges and North Shore had 11.8 percent of the Nassau inpatient discharges.¹³³ In 1995, in Queens, Nassau, and Suffolk, 12.9 percent of the patients came from the merging hospitals, with 87 percent of the patients in other hospitals.¹³⁴

¹²²See *id.* at 143. But see *United States v. Vail Resorts, Inc.*, 62 F.R. 5037 (1997) (holding that, in a proposed merger between ski resorts owning all the available ski lifts in the relevant market, the merger would result in anticompetitive effects because the merged resorts could unilaterally raise prices without the risk of losing skiers to a competitor).

¹²³See *Long Island Jewish*, 983 F. Supp. at 143.

¹²⁴See *id.*

¹²⁵See *id.*

¹²⁶See *id.* at 144.

¹²⁷See *id.* at 143.

¹²⁸See *Long Island Jewish*, 983 F. Supp. at 144.

¹²⁹See *id.* (noting that this was due to a combination of empty hospital beds, and MCOs' ability to negotiate).

¹³⁰See *id.* at 145.

¹³¹See *id.*

¹³²See *id.*

¹³³See *Long Island Jewish*, 983 F. Supp. at 145.

¹³⁴See *id.*

Furthermore, approximately 50 percent of revenues came from Medicare and Medicaid patients.¹³⁵ This is significant because the government, not the hospitals, sets those prices.¹³⁶ Of the remaining 50 percent, MCOs provide many of the patients.¹³⁷ At trial, MCOs testified in favor of the merger stating that they would seek out other available hospitals if there were a price increase.¹³⁸

The government also lost on the second step of the anticompetitive analysis.¹³⁹ Credible evidence did not exist to show that the merged hospitals would not attempt to reduce costs or result in any disincentives to reduce services to or treatment of patients.¹⁴⁰ In defense, the hospitals put forward the principal reasons behind the merger: advancing high quality patient treatment, fostering physician education and training, pursuing medical research, and avoiding duplication resulting in lower costs.¹⁴¹

The Effect of the Not-for-Profit Status of the Hospitals

A not-for-profit status does not exempt hospitals from antitrust law.¹⁴² The court considered not-for-profit status to the extent that other evidence demonstrated the status inhibited anticompetitiveness.¹⁴³

¹³⁵ See *id.*

¹³⁶ See *id.*

¹³⁷ See *id.*

¹³⁸ See *Long Island Jewish*, 983 F. Supp. at 145.

¹³⁹ See *id.* at 142.

¹⁴⁰ See *id.*

¹⁴¹ See *id.*

¹⁴² See *id.* at 145.

¹⁴³ See *Long Island Jewish*, 983 F. Supp. at 145. See also *FTC v. Butterworth*, 946 F. Supp. 1285, 1296 (W.D. Mich. 1996) (holding that nonprofit status could be a relevant consideration if supported by other evidence that anticompetitive effects would not result; offered testimony included the chairman of the hospital's board of directors with whom the merger idea originated); *FTC v. Freeman Hosp.*, 69 F.3d 260, 271 (8th Cir. 1995) (considering merging hospitals' status as nonprofit entities); *United States v. Carilion Health Sys.*, 707 F. Supp. at 840, 849 (W.D. Va. 1989) (discussing the merging hospitals' nonprofit status as indicative of the merger's reasonableness because the hospitals' boards of directors included business leaders who could be expected to demand that the merger's cost savings would reduce hospital charges, which are paid in many cases by employers, either directly or through insurance carriers).

Neither hospital showed any intent to act in an anticompetitive manner.¹⁴⁴ While the court emphasized the “proven good intentions of the Board members,” those good intentions were adjudged fleeting.¹⁴⁵ Inevitably, the hospitals’ boards will change members and the current boards’ assurances will no longer carry any weight.¹⁴⁶ Therefore, the court did not rely on the hospitals’ not-for-profit status in allowing continuation of the merger.¹⁴⁷

Alleged Efficiencies Resulting from the Proposed Merger

Analyzing the expected efficiencies to result from the merger require a two-step analysis.¹⁴⁸ First, whether the defendant hospitals clearly demonstrated that the proposed merger itself would, in fact, create a net economic benefit for the health care consumer.¹⁴⁹ Second, whether those savings would be passed on to consumers.¹⁵⁰ The burden of proof rested with the hospitals to show that the actual merger, rather than any other factor, resulted in significant economies and that these economies ultimately benefitted the consumer.¹⁵¹

The court was amenable to the idea that the merger created a net economic benefit for the health care consumer.¹⁵² Both sides had proposed a wide range of possible cost savings.¹⁵³ Reviewing the

¹⁴⁴See *Long Island Jewish*, 983 F. Supp. at 145 (noting that good intentions are evidenced by the fact that board members work for free, and provide million of dollars in free medical care to persons in need. Profits are funneled back into the community in the form of new programs and facilities).

¹⁴⁵*Id.*

¹⁴⁶See *id.*

¹⁴⁷See *id.*

¹⁴⁸See *id.* at 147.

¹⁴⁹See *Long Island Jewish*, 983 F. Supp. at 147.

¹⁵⁰See *id.* at 149.

¹⁵¹See *id.* at 147. As stated in the Horizontal Merger Guidelines of the United States Department of Justice and the FTC (Revised 4/8/97), Section 4.0: “Efficiencies generated through mergers can enhance the merged firm’s ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products. The Merger Guidelines acknowledge that the realization of efficiency benefits often is the impetus for merger transactions.” See *id.*

¹⁵²See *id.*

¹⁵³See *id.* The hospitals’ expert estimated the merger to result in annual operating cost savings of \$92 million, and a one-time capital savings of \$78 million. The savings were to come from eliminating management, administrative, and clinical employees, saving money on capital expenditures, economies in purchasing medical supplies, the consolidation of information systems, and reducing the hospitals’ enormous laundry bills.

proposals, the court selected a middle number, \$25 million to \$30 million, for the projected savings in operating expenditures.¹⁵⁴ Regarding capital savings, the court found both parties' projections too speculative.¹⁵⁵

The court also agreed that the merger would result in benefits to consumers.¹⁵⁶ Noting the hospitals' not-for-profit status, the court found that the hospitals were genuinely committed to helping their communities.¹⁵⁷ Additionally, the hospitals agreed with the State to pass on to local communities costs savings of \$100 million during the five-year period beginning January 1998.¹⁵⁸ This agreement guaranteed the surrounding communities a minimum of \$50 million.¹⁵⁹ The court concluded that, with reasonable certainty, the efficiencies gained in the merger would ultimately result in benefits to consumers.¹⁶⁰

Entry

Lastly, the court noted the growth in the health care market on Long Island.¹⁶¹ A new hospital located within seven miles of Long Island Jewish, New York Hospital Queens, was under construction at the time of the merger.¹⁶² Additionally, other hospitals continued to merge and expand on Long Island.¹⁶³ The entry of new hospitals into the relevant market led the court to conclude that Long Island Jewish and North Shore could not increase prices above competitive levels and expect to continue to attract patients.¹⁶⁴

The government's expert estimated annual operating savings of \$6.3 million, and reduction in capital expenditures of \$800,000. The savings in capital expenditures related mostly to a reduction in depreciation charges. *See id.*

¹⁵⁴*See Long Island Jewish*, 983 F. Supp. at 148.

¹⁵⁵*See id.*

¹⁵⁶*See id.* at 149.

¹⁵⁷*See id.*

¹⁵⁸*See id.*

¹⁵⁹*See Long Island Jewish*, 983 F. Supp. at 149.

¹⁶⁰*See id.*

¹⁶¹*See id.*

¹⁶²*See id.*

¹⁶³*See id.*

¹⁶⁴*See Long Island Jewish*, 983 F. Supp. at 149.

ANALYSIS

The government brought this case with good reason. These two hospitals offer the best medical treatment on Long Island. The government argued that combined, the hospitals could raise prices and still attract patients.¹⁶⁵ Evidence presented at trial demonstrated that large institutional users need these hospitals in their health care portfolios.¹⁶⁶ Testimony from executives for the Long Island Railroad explained that their union considers accessibility to hospitals an important consideration in collective bargaining.¹⁶⁷ The union's membership found access to North Shore Manhasset, Long Island Jewish, and Stony Brook an integral part of any collective bargaining agreement.¹⁶⁸

The government argued that the size and importance of Long Island Jewish and North Shore Manhasset distinguished them from all other hospitals on Long Island offering similar services.¹⁶⁹ By combining into a single entity, Long Island Jewish/North Shore Manhasset could unilaterally raise prices.¹⁷⁰ The government, however, fought existing case law in making this argument.

In hospital merger cases, a consensus exists among courts on the relevant product market.¹⁷¹ That consensus hold that the relevant product

¹⁶⁵*See id.*

¹⁶⁶*See id.* at 131.

¹⁶⁷*See id.*

¹⁶⁸*See id.* Much testimony at trial addressed the government's contention that Long Island Jewish and North Shore Manhasset are in a hospital class by themselves. The CEO of United Health Care, the third largest insurer in the United States covering 1.1 million New Yorkers, referred to Long Island Jewish and North Shore Manhasset as "must have hospitals" needed to build a marketable network on Long Island."

A senior vice president for MagnaCare, an MCO, testified that in order to operate on Long Island "you have to have one of these facilities in [your] network." *See id.* Reputation mattered to MagnaCare's customers. MagnaCare conceded that Winthrop Hospital possessed the same services and quality of services as Long Island Jewish and North Shore Manhasset, but that Winthrop lacked a comparable reputation.

The administrator for District Council 37 Health and Security Plan and Trust, the negotiator of health care packages for approximately 300,000 active workers and 100,000 retirees, stated that an arrangement for the plan's members "could not [be] conceiv[ed] . . . without those two hospitals." *See id.* Finally, Cigna Healthcare of New York testified that without either Long Island Jewish or North Shore Manhasset, "Cigna would probably lose its current clients and not be able to market to a whole other population in the area." *See id.* at 130.

¹⁶⁹*See Long Island Jewish*, 983 F. Supp. at 138.

¹⁷⁰*See id.*

¹⁷¹*See* Thomas L. Greaney, *Night Landings on an Aircraft Carrier: Hospital Mergers and Antitrust Law*, 23 AM. J.L. & MED. 191, 199 (1997).

market is the cluster of services consisting of acute care inpatient services.¹⁷² Acute care inpatient services are services that must be performed at a hospital.¹⁷³ Because outpatient substitutes are not available for these procedures, a check is not available to limit the price of those procedures.¹⁷⁴

Since 1989, five courts have followed this line of reasoning. In 1995, the Eighth Circuit in *FTC v. Freeman Hospital* held that the relevant product market was acute care inpatient services.¹⁷⁵ In that case, the government sought to enjoin the merger of the two largest acute care hospitals in the three-hospital town of Joplin, Missouri.¹⁷⁶ In 1991, the Eleventh Circuit in *FTC v. University Health, Inc.*, defined the relevant product market as inpatient services offered by acute care hospitals in the vicinity of Augusta, Georgia.¹⁷⁷ In Augusta, Georgia, five hospitals already competed in the vicinity.¹⁷⁸

In 1990, the Seventh Circuit in *United States v. Rockford Memorial Corporation* affirmed the district court's holding that the market consisted of the inpatient services offered by acute care hospitals in the vicinity of Rockford, Illinois.¹⁷⁹ In 1995, the federal district court for the Northern

¹⁷²*See id.*

¹⁷³*See id.*

¹⁷⁴*See id.* (discussing that in addition to the relevant product market, courts have arrived at three more general consensus. First, the geographic market is primarily local due to the emergency nature of some care, and the preference of people to be hospitalized near their families and homes. Second, applying the rule of presumptive illegality, courts consider a broad range of factors that may support or undermine inferences to be drawn from market concentration and market share evidence. These factors include the not-for-profit status of hospitals in the market, the presence of sophisticated buyers, excess capacity, entry restrictions and the heterogeneity of service offerings. Third, most courts evaluate the proposed efficiencies attributable to the merger; however, significant differences exist in the way they assign proof burdens and otherwise weigh the importance of purported cost savings.

¹⁷⁵*See* *FTC v. Freeman Hosp.*, 69 F.3d 260, 263 (8th Cir. 1995) (ruling from the bench, the district court denied the government a temporary order restraining the hospitals from merging stating that "I don't think you've got any business being in here. I don't see how the Federal Trade Commission can claim there is a lack of competition when there [are] four of five hospitals in the area, and reducing it by one is not going to wipe out competition. . . . It looks to me like Washington D.C. once again thinks that they know better what's going on in Southwest Missouri. I think they ought to stay in D.C.").

¹⁷⁶*See id.* at 262.

¹⁷⁷*See* *FTC v. University Health, Inc.*, 938 F.2d 1206, 1211 (11th Cir. 1991) (noting that the two merging hospitals did not compete in eleven acute service categories, but did compete in nineteen major diagnostic categories).

¹⁷⁸*See id.*

¹⁷⁹*See* *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1286 (7th Cir. 1990).

District of Iowa in *United States v. Mercy Health Services* held that the relevant product market was acute care inpatient services offered by the two merging hospitals.¹⁸⁰ In 1989, in *United States v. Carilion Health Systems* an advisory jury found that the relevant product market was acute inpatient hospital services and certain outpatient health care services provided by various clinics.¹⁸¹

In holding that the relevant product market is restricted to acute inpatient hospital services, courts are limiting the relevant product market. In fact, the government generally agrees with this determination.¹⁸² The FTC publishes policy statements on the agency's position regarding hospital mergers.¹⁸³ The policy statements encourage a market definition under which there is a core of services delivered locally that requires the facilities and services of an acute care institution.¹⁸⁴ Physicians are viewed as key to any possible patient movement; therefore, agency review is limited to analyzing hospitals to which the physicians who utilize competing hospitals would likely refer or admit patients.¹⁸⁵ Thus, the resulting geographic area tends to be small.¹⁸⁶

The merger guidelines influenced the courts in establishing this consensus. Unfortunately for the government in *Long Island Jewish Medical Center*, the merger guidelines worked to the government's disadvantage. In a large market like Long Island, many hospitals offer acute inpatient services. This case involved the merger of two very large hospitals in an area filled with hospitals. Physicians using competing hospitals could transfer patients or recommend that patients go to a variety of hospitals other than Long Island Jewish or North Shore Manhasset.

The government did have an alternative strategy. That strategy involved distinguishing Long Island Jewish from all other acute service providers by the hospitals' reputation.¹⁸⁷ The government argued that the relevant product market was limited to anchor hospitals offering primary

¹⁸⁰See *United States v. Mercy Health Serv.*, 902 F. Supp. 968, 976 (N.D. Iowa 1995).

¹⁸¹See *United States v. Carilion Health Sys.*, 707 F. Supp. 840, 842 (W.D. Va. 1989).

¹⁸²See *Sims*, *supra* note 18, at 637.

¹⁸³See *id.*

¹⁸⁴See *id.*

¹⁸⁵See *id.*

¹⁸⁶See *id.*

¹⁸⁷See *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 138-39 (E.D.N.Y.

and secondary services.¹⁸⁸ This argument was premised on limiting the market to as few hospitals as possible. In this case, the market would be limited to three hospitals: Long Island Jewish, North Shore Manhasset, and Winthrop Hospital.¹⁸⁹

Courts have also rejected this argument before. In essence, courts are interested in where consumers can go, not where consumers currently go for hospital care.¹⁹⁰ This reputation, or cachet argument was rejected in *FTC v. Freeman Hospital*.¹⁹¹ There, the court stated that “placing too much emphasis on the allegedly superior range of services available at Joplin Hospital could ultimately lead to a blurring of the product market” because the market would need to extend to any prestigious hospital in the area.¹⁹²

In addition, the reputation argument arguably applies only to tertiary services. Tertiary services can be scheduled in advance. Therefore, a patient may not mind driving in to Manhattan for chemotherapy, or, like in *FTC v. Freeman Hospital*, driving from Joplin, Missouri, to Kansas City. North Shore Manhasset and Long Island Jewish, however, devote eighty to eighty-five percent of their services to providing primary and secondary care.¹⁹³ A patient seeking primary care for an ailment like a gunshot wound gladly receives treatment at Long Island Jewish, but likely would accept care from a lesser institution, like Winthrop Hospital.

Alternatively, the court could have rejected this argument because Manhattan is only fifteen miles away from Long Island Jewish and North Shore Manhasset.¹⁹⁴ A patient concerned with reputation can go to these “very big, very famous, and very attractive” hospitals including New York Hospital, Columbia, Sloan-Kettering, and Beth Israel.¹⁹⁵

The government’s case failed because too many hospitals exist in the Long Island area that offer the same services as Long Island Jewish and

¹⁸⁸*See id.*

¹⁸⁹*See id.* at 141.

¹⁹⁰*See* *FTC v. Freeman Hosp.*, 69 F.3d at 260, 269 (8th Cir. 1995).

¹⁹¹*See id.*

¹⁹²*Id.*

¹⁹³*See* *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 127 (E.D.N.Y. 1997).

¹⁹⁴*See id.* at 141.

¹⁹⁵*Id.*

North Shore Manhasset.¹⁹⁶ In a market with a shrinking hospital population, an abundance of empty hospital beds, and negotiated reduced rates, hospitals are compelled to consolidate, merge, or affiliate in order to increase the quality and scope of their services and, most importantly, to decrease costs.

IMPACT

In large markets like New York or Chicago, government attempts to enjoin hospital mergers are likely to be unsuccessful. The law regarding relevant markets has solidified to include all deliverers of acute care services within the vicinity of the merging hospitals.

Proving an antitrust violation in a large market with many hospitals will be a difficult task. Any attempt to distinguish certain large hospitals based on reputation will likely fail because courts analyze where consumers can go, not where they currently go. Prestige today does not necessarily translate into continued prestige tomorrow.

In the largest markets, the government may have to pass on pursuing antitrust actions against merging hospitals. This realization will not last forever. In New York, a large number of acute care deliverers currently exist as a result of years of dependence on inpatient care.

As mergers continue, the number of hospitals will decrease. As this occurs, large hospitals may unilaterally increase prices. Then, the government must step-in to mitigate anti-competitiveness. Due to market conditions today, however, many of the largest metropolitan markets are too saturated with hospitals to allow the government to win an antitrust case.

CONCLUSION

The government will likely continue to attempt to enjoin hospital mergers in large metropolitan markets. These attempts, however, will continue to fail. So long as excess capacity is present, the relevant markets will include too many hospitals to enjoin the mergers.

¹⁹⁶*See id.* (competing hospitals include Winthrop Hospital, Nassau County Medical Center, ten general acute care hospitals in Queens County, and eight general acute care hospitals in Nassau County).

