The FTC Staff's Prescription: Wrong for Healthcare in West Michigan

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ABSTRACT: In the fall of 1997, two Grand Rapids, Michigan hospitals merged to become Spectrum Health. The FTC unsuccessfully tried to enjoin the merger in federal court by contending that the merger would substantially lessen competition. The court approved both the merger and Spectrum Health's Community Commitment, a decree that regulated Spectrum Health's prices, efforts to reduce cost and dealings with managed care entities. More than two years after the merger, the FTC staff, with the assistance of Spectrum Health, conducted a post-merger review. The immediately preceding Article in this issue is a report of that post-merger review written by two of the former FTC staff members who were involved in it. This Article, written by one of the Hospital's attorneys, responds to the comments made by the former staff members on the court's "experiment in substituting self-regulation for competition."

In September of 1997, following a failed attempt to obtain a preliminary injunction, and the dismissal of the Federal Trade Commission's ("FTC") Part III Administrative Proceeding, two Grand Rapids, Michigan hospitals—Blodgett Memorial Medical Center ("Blodgett") and Butterworth Health Corporation ("Butterworth")—merged to become Spectrum Health.[1] Two years later, the FTC's Office of Policy and Evaluation of the Bureau of Competition asked hospital representatives to participate in voluntary interviews and to provide information for purposes of a post-merger review.[2]

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Spectrum Health representatives agreed to participate in this voluntary, non-enforcement process. In the Spring of 2000 (two and a half years following the merger), FTC representatives arrived in Grand Rapids to conduct interviews of a variety of Spectrum Health representatives, as well as representatives of other healthcare providers, businesses, and the community at-large. The interviews at Spectrum Health included members of the hospital's board, administrative staff, physician leadership, and the chair of the community-based Financial Advisory Committee ("FAC").[3] Much of the FTC's post-merger inquiry focused on market share, price information, efficiencies, and Spectrum Health's compliance with its "Community Commitments."[4] The immediately preceding article, *Why Hospital Merger Antitrust Enforcement Remains Necessary: A Retrospective on the Butterworth Merger,* in this issue of the *Journal of Health Law,* is a report of the FTC staff's post-merger review findings, authored by the two former staff members primarily responsible for that review.[5] As such, the article notes that it represents "only the personal views of its authors."[6]

The FTC staff's article, for the most part, reiterates the points made by the agency during its court challenge to the proposed merger, rather than reflect on the consummated merger as it stands today. The FTC staff continues to reject the federal judge's prescient post-hearing finding[7]:

> [B]ased on the unique facts and circumstances that have come to light in these proceedings, the Court is firmly convinced that the health care consuming public in both the immediate Grand Rapids area and greater Kent County, and in West Michigan as a whole, and indeed, the public interest in general, are best served by allowing defendants the freedom to pursue the proposed merger.[8]

In their article, the FTC staff members hold fast to the FTC's focus on the narrow issue of the possible (indeed, entirely speculative) negative impact of the merger on managed care providers, continuing to ignore that which the court would not—that consumers on the whole benefit from the merger, both in terms of reduced costs and in terms of improved quality of care.[9] Because the purpose of the antitrust laws is to benefit consumers, the FTC staff should not continue to elevate the abstract notion of competition, particularly when it negatively impacts consumers.[10] The FTC staff members are most critical of the Community Commitments, but produce no evidence that the merging parties

have violated those commitments. Indeed, the staff concedes the existence of overwhelming evidence that Spectrum Health has adhered to the Community Commitments as it promised.[11] Importantly, the staff's article does not even mention that prior to and during the litigation, the hospitals offered the FTC several opportunities to play an enforcement role with respect to the Community Commitments, something the FTC summarily rejected.[12] Having refused to play a more constructive role, such criticism constitutes vague and unsubstantiated innuendo.

During the court proceedings, the FTC focused on the proposed merged entity's projected market share and theorized that the entity would exercise its market power to increase prices.[13] The FTC discounted the hospitals' rebuttal evidence concerning merger-related efficiencies and the hospitals' Community Commitments.[14]

In fact, the court's predicted outcomes proved correct. As the FTC staff concede, rather than increase, Spectrum Health's market share for inpatient services has decreased. In the first two post-merger years, the combined hospitals realized almost half of the operating efficiencies they anticipated saving over a five-year period.[15] Repeated independent audits by respected accounting firms have confirmed that Spectrum Health has lived up to its Community Commitments—passing the benefits of the merger on to the communities it serves.[16] In short, Spectrum Health has lived up to its promises to limit price increases and margins, as well as its promises to substantially increase its financial commitment to the underserved and to establish a governance structure reflective of the community as a whole.

I. The Current Landscape

The FTC staff digests the "results of the merger" as follows: (1) market shares have not changed much; (2) Spectrum Health has not yet "rationalized the Blodgett and Butterworth facilities as originally planned"; (3) "concerns have been raised that Priority Health [an HMO owed by Spectrum Health and two other "out of market" hospital systems] has grown and increased market share at the expense of its managed care rivals"; and (4) "physician groups in many specialties have merged."[17]

The FTC's staff members' views result from the FTC's historic theoretical construct, a short visit to Grand Rapids just two and a half years post-merger, and a review of the federal district court's opinion and various documents.[18] But, understandably, the authors' short visit and review of a few selected documents are

not adequate to produce a totally accurate "retrospective" of the Blodgett-Butterworth merger.[19] It is not possible in this short commentary to respond to the entire "retrospective" article in depth. Instead, the following is a brief, factual response to the staff's digest of the "results of the merger" and commentary on its recommendations and conclusions.

II. Market Share

During the court proceedings, the FTC's expert testified that the merged hospitals would dominate the inpatient acute and primary care markets.[20] But post-merger data provided to the FTC shows that rather than increase, the hospital's market share for inpatient services decreased 2% from 1997 to 1999, while Saint Mary's and Metropolitan Hospital's aggregate inpatient market share increased 1.8%.[21] Under these circumstances it is difficult to argue that Saint Mary's and Metropolitan cannot compete with Spectrum Health. They appear to be doing precisely that, and quite successfully.

III. The Efficiencies Case

In discussing the court's ruling on the efficiencies likely to be gained by the merger, the FTC staff is mistaken in its conclusion that "the judge never answered whether the proposed merger would benefit, or at least not substantially lessen, competition."[22] The judge first articulated the standard that he applied to the evidence—that "defendants 'must demonstrate that the intended acquisition would result in significant economies and that these economies ultimately would benefit competition and, hence, consumers.'"[23] Following the judge's analysis of the facts and expert witness testimony, and after considering information obtained by the judge during his own tour of the facilities, the court concluded that, absent the merger, the "medical arms race would continue, at great expense to defendants and ultimately to consumers," because Blodgett would build its new hospital and Butterworth would "just as surely proceed" with renovation, upgrade, and expansion plans "in order to compete with Blodgett's brand new, state-of-the-art facilities."[24] The court then concluded that "capital expenditure avoidance and operating efficiencies, totaling in excess of $100 million" was "a substantial amount . . . that would, in view of defendants' nonprofit status and the Community Commitment, invariably be passed on to consumers."[25] Thus, contrary to the staff's representation, the court did "answer the question" by focusing on consumer benefit—the interest that the antitrust laws were designed to protect.

In fact, the capital avoidance efficiencies have turned out to be larger than anticipated because Spectrum Health did not build the small additional facility it originally contemplated it would have to build as a result of the merger.[26] The FTC staff overlooks these savings to consumers.[27]

Significantly, there was no evidence presented during the court proceedings to refute the evidence that, absent the merger, Blodgett was fully committed and had reserved the funds necessary to build a new replacement hospital.[28] However, the FTC staff reverts to arguments previously rejected by the court—that absent the merger, managed care providers would have forced Blodgett to either forego building the replacement hospital "or at least to reduce any 'gold plating.'"[29] Yet, as the staff acknowledges at the outset of its article, the desire to avoid the capital expenditure for a replacement hospital was one of the main motivating forces behind the merger.[30] In short, during the litigation, the hospitals demonstrated that the projected capital avoidance efficiencies associated with the merger were significant and the court justifiably credited a large amount of the efficiencies.

The FTC staff also asserts that the court did not "explain," "scrutinize," or "analyze" the efficiencies' case to the FTC's satisfaction, but rather assumed that the hospital's nonprofit status and the Community Commitment would ensure that savings would be passed on to consumers.[31] And, the staff questions this "troubling assumption," because both Blodgett and Butterworth's operating margins were in the upper quartile of health systems rated by Moody's and Standard & Poors.[32] But, the court did not simply make assumptions. Dr. William J. Lynk, a hospital expert witness, had conducted three studies of nonprofit hospital pricing (including a study relating directly to the two merging hospitals and a study that dealt with price and hospital concentration in Michigan). Dr. Lynk's studies provided strong evidence "that market concentration among nonprofit hospitals [in Michigan] is not correlated with higher prices, but with lower prices."[33] The FTC's expert acknowledged that correlation.[34] That testimony was corroborated in this case by evidence of past hospital board conduct, the Community Commitments, and the fact that both hospitals had historically maintained below average prices while realizing above average margins.[35] The court noted that the FTC offered no evidence that would even suggest, much less establish, that the historically high operating margins at either Blodgett or Butterworth had produced funds that were wasted or misspent.[36] Notably, the Community Commitments themselves demonstrated that savings would be passed on to consumers. One of the

Community Commitments froze and then limited prices and another added $6 million in services to the medically underserved.[37]

IV. Efficiencies—Two Years Post-Merger

The court's analysis of the likely efficiencies and their benefit to consumers has been borne out by the post-merger experience. Spectrum Health's post-merger operating savings during the first two years totaled nearly $30 million, not "relatively modest, somewhat less than $30 million" in two and a half or three years, as mentioned by the FTC staff members at various places in the article.[38] Moreover, some of the savings are "annual" savings that will continue and result in higher aggregate numbers in the future.[39] Additionally, the operational savings estimates of $68.5 million were over a five-year period, as were plans to fully implement program consolidation.[40] As program consolidation continues, resultant merger-related savings will increase.

The FTC staff's suggestion that some of the savings might not be "merger specific"[41] is inaccurate. Clearly, the elimination of duplicate management personnel and consolidation of services would not have occurred absent the merger. There is no dispute that Blodgett and Butterworth were head-to-head competitors in the "medical arms race" premerger.[42] Although both hospitals participated in joint ventures and affiliations with other area healthcare providers, neither hospital did so with the other premerger. Furthermore, the only premerger joint venture in which all the local hospitals participated accomplished nothing and was abandoned.

Data provided to the FTC during its post-merger review reflect the realization of the merger-related efficiencies predicted in the court's findings.[43] Spectrum Health is providing healthcare at below 1996 premerger cost levels even in the face of undisputed increases in the cost of pharmaceuticals, supplies, technology, and construction; those savings inure to the benefit of consumers.

V. Managed Care Post-Merger

Finding "remarkably little employer opposition" to the proposed merger, during the court proceedings, the FTC focused on its "hypothesis that [Blodgett and Butterworth's] enhanced market power would enable them to stem the growing influence of managed care organizations."[44] The court rejected this part of the FTC's case as "artificially and misleadingly narrow."[45]

In its article, the FTC staff continues its narrow focus on the same limited set of managed care organizations (HMOs) that supported the FTC's case against the merger five years ago. But the staff's narrow focus on these HMOs misses the mark now as it did in 1996, although there is one difference. As the article notes, the FTC did not allege in its complaint to enjoin the merger that the merged entity "would favor Priority [Health] to the detriment of other managed care providers."[46] Presumably, the agency did not make that allegation because there was insufficient evidence to support it. Now, in the continuing absence of evidence to support that allegation, the FTC staff should not conclude that it is appropriate to 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."[47]

There are several problems with the staff's divestiture recommendation, particularly if it purports to emanate from the facts associated with this merger. First, allegations (purportedly expressed by Priority Health's competitors) that Priority Health has grown because of "actions by Spectrum Health to favor Priority [Health]" are wholly unsubstantiated—a fact that the staff admits in its article.[48] The staff alleges (without factual support) that "Priority Health has moved into a more dominant position in the market and currently accounts for more than 50% of the market."[49] This "market" is not defined in the article, but if the product market is HMOs, the allegation is untrue. Market share data shared with the staff demonstrate that Blue Care Network has almost three times the number of members as Priority Health. If the product market is managed care, PPO enrollment has increased significantly in West Michigan (as it has elsewhere), diluting HMO market share. That being said, enrollment data from the Michigan Insurance Bureau shows that HMO enrollment in Michigan increased from 23.5% of the population in 1997 to 27% in 1999. Moreover, data provided to the staff during the post-merger review show that 80% of Priority Health's growth over the past three years is attributable to the introduction of new products and acquisition of a northern Michigan HMO, growth which the FTC staff acknowledges is "procompetitive."[50]

Second, the "retrospective" article alleges (again, without factual support) that "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."[51] But evidence from Michigan Insurance Bureau rate filings and HMO annual reports contradicts these

observations.[52] In any event, if Priority Health's premiums were too high (which they are not), then Priority Health would presumably lose market share to its competitors, the opposite of the staff's contention. Surely, substantial managed care competition continues to exist, and even the staff does not claim collusion between Priority and its clearly unfriendly rivals.

Third, in the section of the staff's article entitled "Anticompetitive Effects," the staff without support goes on at length citing the "beliefs" of Priority Health's "rival managed care providers" and would be rivals concerning their costs and inability to get as favorable treatment from Spectrum Health as Priority Health has allegedly received.[53] The staff's conclusions regarding the effect of the merger on Priority Health are speculation, apparently relying entirely on purported concerns expressed by Priority Health's competitors rather than on facts. Even the language of this portion of the FTC's article is replete with the words "may," "believe," and "could," while at the same time acknowledging that alleged theoretical "favoritism" has "not occurred" to date and the "discussion is hypothetical."[54]

Fourth, the allegation that "several health plans believed that they were paying more in hospital reimbursement than they most likely would have been absent the merger" because of the "Community Commitment regulatory schema," shows the frivolous nature of the competitors' allegations.[55] In the absence of the self-imposed price freeze contained in the Community Commitment, it is more likely that these managed care providers (along with all other purchasers of hospital services) would have paid significantly more in hospital reimbursement.[56] In fact, if Spectrum Health had increased its costs commensurate with the CPI from 1997 to 2000, its costs per adjusted admission (adjusted for outpatient volume) would have been $7794 rather than $7226 (resulting in a difference of $40.3 million for fiscal year 2000 alone).

Fifth, the alleged concerns expressed by "potential new entrants and others"[57] that the "Community Commitment permits Spectrum Health to heighten barriers to the managed care market"[58] are unsubstantiated and without merit. The Community Commitment provided that any new entrant would be treated the same as a new entrant is likely to be treated in any market—"offered a discount commensurate with the incremental volume that the plan [could] deliver to the merged entity."[59] But Spectrum Health has done better than that by new entrants. Without requiring a new entrant to show the volume it can deliver, new

entrants are being offered a 7% discount.[60] That lowers the "barriers" to new entrants rather than heightens them. The fact that there have been several new PPO and Medicaid HMO entrants to the market in West Michigan (as is true throughout the state and nationwide) is further evidence that the merger has not resulted in heightened barriers to entry by managed care providers.[61]

The FTC staff's conclusion that managed care providers have been disadvantaged because of the merger is not supported by the facts, which undercuts their divestiture recommendation in cases where the merging hospitals "enjoy market power both in hospital services and health insurance."[62] Moreover, there is no evidence in this case that there has been any "patient channeling or preferential payment schedules" with respect to Priority Health and Spectrum Health.[63] Indeed the evidence is just the opposite. As the staff notes, Spectrum Health's "market share for *all* classes of payors as calculated by VHA Midnet data has decreased post-merger."[64] Moreover, as two different independent auditors, which have repeatedly reviewed Spectrum Health's compliance with all of its Community Commitments (including the managed care commitment), have found, Spectrum Health has lived up to its promises "with no exceptions."[65]

The FTC staff's regulatory prescription for the perceived but unfounded ills associated with not-for-profit hospital ownership of not-for-profit HMOs also fails to recognize that consumer costs could increase through such divestiture. Under the staff's scenario, a not-for-profit, community-based HMO would surely be acquired by a for-profit health plan because of the high capital investment required to establish and operate an HMO. Because their shareholders demand it, for-profit HMOs are motivated to maximize their return on investments. Because for-profit HMOs' administrative costs plus net income are frequently higher than not-for-profit HMOs (facts that are easily demonstrated in this case by comparing Priority Health to its for-profit HMO competitors), consumers would suffer by paying higher premiums.

But increased premiums are not the only consumer disadvantage that would result from divestiture. As its numerous recent awards demonstrate, Priority Health's consumer service and consumer satisfaction outrank that of its competitors. Priority Health has been recognized in *U.S. News & World Report*, as one of America's "Best HMO's," by being listed on that periodical's "Honor Roll" of top forty managed care plans.[66] For 2000-2001, Priority Health also received five "Best in Class" ratings (more than any other

HMO) from HIAG (Health Information Action Group, a consortium of business coalitions operating in a five state region).[67] So too, in the 2000-2001 *Consumers Guide to Health Maintenance Organizations*, published by HIAG, Priority Health received all four-star ("significantly above average") or five-star (highest 10%) ratings, as well as the highest total ranking as compared to all other ranked HMOs.[68] In 2000, the National Committee for Quality Assurance ("NCQA") awarded Priority Health its highest possible three year accreditation of "Excellent," because Priority Health's "service and clinical quality meet[s] or exceed[s] NCQA's rigorous requirements for consumer protection and quality improvement [and] HEDIS results are in the highest range of national performance."[69] Finally, in the fall of 2000, the Alliance for Health and Value Improvement Partners published the results of its comprehensive study (in which thirteen of Michigan's sixteen commercial HMO's participated), ranking Priority Health as the leading performer in each category measured.

VI. Physician Practice Consolidation

The "retrospective" says that one of the "results of the merger" is that physician "[g]roups formerly aligned separately with either Butterworth or Blodgett have merged, and some of these groups have over 70% of the providers in individual specialties."[70] Spectrum Health does not control the business dealings or plans of independent physicians, much less their decisions to merge. Physician consolidation in West Michigan began prior to this merger and continues not only with physicians who practice at Spectrum Health, but also with physicians practicing at other area hospitals. In short, it is difficult to understand how the FTC staff can imply that Spectrum Health is responsible for the specter of purported anticompetitive conduct by these independent actors.

It is true that physicians who once had privileges at one or the other, but not both Blodgett and Butterworth, now have privileges at Spectrum Health pursuant to revised Medical Staff By-laws. In addition, integration of clinical services is proceeding. The result of integrating clinical services has been (and will continue to be) improved patient care through the implementation of "best practices."

Indeed, just as Priority Health has received recognition and numerous awards for the services it renders, so too has Spectrum Health. In its July 17, 2000 edition, *U.S. News & World Report* ranked Spectrum Health as one of "America's Best Hospitals," with special recognition of its excellence in gynecology, heart,

hormonal disorders, and orthopedics care.[71] HCIA-Sacks recognized Spectrum Health-Butterworth Campus as one of three Michigan hospitals on its most recent "100 Top Hospitals" list.[72] SMG Marketing Group's most recent "Top 100 Integrated Healthcare Networks" ratings includes Spectrum Health.[73] And, in acknowledgement of the success of its Community Commitment to the underserved, the American Hospital Association recently named Spectrum Health as one of three national finalists for the Association's prestigious award honoring community service (the 2001 Foster G. McGaw Award).[74]

VII. Conclusion

The post-merger reality reflects Blodgett and Butterworth's premerger objectives of combining two historically successful hospitals to reduce costs and prices, and improve services to consumers. The process of integrating services and facilities is continuing, as the long term merger plans envisioned. Spectrum Health continues to deliver on the promises made in its Community Commitments—the self-imposed, voluntary pledges given as court enforceable assurances that the merged entity would achieve efficiencies that would be passed on to consumers in the form of low cost, high quality services.

Spectrum Health froze its prices for the first three post-merger years and its fourth year price increase did not exceed the all-products CPI. Additionally, Spectrum Health has lived up to (and with respect to new entrants has exceeded) its commitments to managed care providers;[75] while Priority Health has introduced new products and managed care overall has grown in West Michigan.[76] Spectrum Health has also lived up its margin commitment; while the average upper quartile Moody's–S&P hospital margins were 7.7% in 1998 and 6.7% in 1999, Spectrum Health's margins were 7.5% in 1998 and 3.3% in 1999. Spectrum Health has increased funding and improved services to the medically underserved.[77] And, the Spectrum Health Board, as promised, is comprised of community business leaders and consumers of healthcare services who are actively involved in assuring that the health system contains prices and improves services.

The other acute care hospitals in Grand Rapids have increased their market share vis-a-vis Spectrum Health and each of those hospitals continues to improve its services and facilities. While not government regulated, respected independent auditors and the independent community-based Finance Advisory Committee have confirmed each year that Spectrum Health has lived up

to each of its Community Commitments. In the process, Spectrum Health and its subsidiaries have been recognized by respected, professional organizations and journals for their excellence.[78] Clearly, at least in this case, self-regulation and community promises have resulted in lower costs and higher quality of care.

In short, this "experiment in substituting self-regulation for competition,"[79] as the "retrospective" article characterizes the Blodgett-Butterworth merger, is working. Consumers are demonstratively benefiting from this merger as costs are contained and resources previously committed to the premerger medical arms race are being invested in improving the quality of healthcare services. The FTC's staff's conclusions reflect its theories and the admitted speculation of unidentified managed care competitors of Priority Health rather than the factual data provided to it during its post-merger review. At least in the case of this merger and the Western Michigan community, an analysis of the post-merger facts suggests that the FTC's prescription is bad medicine.[80]

Endnotes

[1] David Balto & Meleah Geertsma, *Hospital Merger Retrospective: Blodgett-Butterworth, Grand Rapids MI*, 34 J. Health L. 129, 131 (2001).
[2] *Id.* at 132.
[3] *Id.* Spectrum Health staff also provided the FTC with a list of the community members of the FAC and the community members of the Community Commitment Advisory Committee and invited the FTC to interview those individuals as well.
[4] *Id.*
[5] *See generally* Balto & Geertsma, *supra* note 1.
[6] *Id.* at 129 n.*.
[7] *Id.* at 131-32.
[8] FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1303 (W.D. Mich. 1996), *aff'd in unpublished opinion*, 1997-2 Trade Cas. ¶ 71,863 (6th Cir. 1997).
[9] Balto & Geertsma, *supra* note 1, at 149-52.
[10] Indeed, during the preliminary injunction hearing, the FTC actually argued that the government's opposition to the merger would be appropriate even if the merger resulted (as this one did) in lower costs and higher quality of care. 4 Tr. 53:15-53:23.
[11] Balto & Geertsma, *supra* note 1, at 153-54.
[12] *Butterworth*, 946 F. Supp. at 1307.
[13] *Id.* at 1294.
[14] The staff's article criticizes the Consent Decree, which embodies the Community Commitments as "self-regulated," rather than policed by some government selected, court appointed third party. Balto & Geertsma, *supra* note 1, at 159-60. The purpose of Community Commitments was to provide further assurance that the merged entity would not exercise its market power in a manner detrimental to consumers. But the FTC's position during the court proceedings was "all or nothing"—its only position was that the merger should not go forward. Indeed, it refused any opportunity to make

input to the Consent Degree. In their August 14, 1995, White Paper and August 31, 1995, Position Paper (both of which were provided to the FTC well before it initiated its action to enjoin the merger), Blodgett and Butterworth set forth their Community Commitments. *Butterworth*, 946 F. Supp. at 1304-07. The hospitals offered to make their Community Commitments binding, in the form of a court order, both prior to and during the preliminary injunction hearing. The FTC refused these offers. *Id.* at 1307. In the end, the hospitals signed the Consent Decree; again, the FTC refused to be a party to the decree.

[15] *See* Balto & Geertsma, *supra* note 1, at 145, 148. The staff's article inconsistently refers to "modest" savings of "somewhat less than $30 million" over a period of two and a half years or three years (depending on which section of the article is read). That characterization is inaccurate, as demonstrated by their *Appendix*, which shows savings approaching $30 million in the first two years. *Id.* at 170.

[16] Balto & Geertsma, *supra* note 1, at 141-42.

[17] *Id.* at 140.

[18] *See id.* at 132.

[19] The lack of factual support for many of the authors' theoretical conclusions is borne out by frequent use of speculative words such as "may," "might," and "believe," as well as admissions that some are purely "hypothetical." *See Butterworth*, 946 F. Supp. at 1301.

[20] *Id.* at 1294.

[21] *See* Balto & Geertsma, *supra* note 1, at 142-43. The FTC successfully argued to the court that outpatient services were not adequate substitutes for inpatient care services for purposes of defining product markets. *Butterworth*, 946 F. Supp. at 1290-91.

[22] Balto & Geertsma, *supra* note 1, at 137.

[23] *Butterworth*, 946 F. Supp. at 1300 (quoting Federal Trade Comm'n v. University Health Inc., 938 F. 2d 1206, 1223 (11th Cir. 1991)).

[24] *Id.* at 1301.

[25] *Id.* Significantly, while the staff now criticizes the court's conclusion that merger-related efficiencies would exceed $100 million, during the proceedings, the FTC conceded an estimated $77.5 million in merger-related efficiencies. *Id.*

[26] Balto & Geertsma, *supra* note 1, at 145.

[27] "Scenario 3A" (the "rationalization" of the Blodgett and Butterworth facilities) was always one of several options being considered as part of the post-merger facilities' plans; not the only option. As the Community Commitment notes, "the clinical/operational consolidation activities and facilities plan may be adjusted to reflect community needs and opportunities to improve clinical services and patient access as the healthcare delivery environment continues to change." *Butterworth*, 946 F. Supp. at 1309.

[28] The Blodgett replacement hospital would not have increased capacity, as suggested by the staff. Moreover, during the proceedings, the hospitals did not take the position that replacement of the Blodgett facility was imminently necessary, whether or not there was a merger, as the staff now contends. The nonmerger scenario "Blodgett replacement hospital" was just that—a new hospital designed to compete with Butterworth and to house and care for Blodgett's patients. The hospital envisioned under merger Scenario 3A was not a replacement for Blodgett; instead under Scenario 3A, a single combined inpatient hospital would operate at the Butterworth site, the new Beltline facility would be used only for outpatient and short stay inpatient services, and the Blodgett site would be conveyed to a third party. *Butterworth*, 946 F. Supp. at 1309.

[29] Balto & Geertsma, *supra* note 1, at 158.
[30] *Id.* at 133.
[31] *Id.* at 137.
[32] *Id.* at 138.
[33] *Butterworth*, 946 F. Supp. at 1297.
[34] *Id.*
[35] *Id.*
[36] *Id.* In reaching his conclusion, the judge who presided over the week-long hearing considered multiple briefs, more than 900 exhibits submitted by the parties and toured the hospitals. The judge (who actively participated in the proceedings by asking questions of various witnesses) also exercised his discretion in sorting through expert testimony. *Id.* at 1288, 1301. The court could not help but notice "the striking disparity in quality between the comprehensive studies done by the [hospitals'] experts on the one hand, and the FTC's expert's critical analysis." *Butterworth*, 946 F. Supp. at 1301. One great disparity noted was the fact that the hospitals' experts were members of "multi-disciplinary teams who spent as much as four months in Grand Rapids inspecting the hospital facilities and conducting hundreds of interviews . . . [while the] FTC's expert admitted he had not been to Grand Rapids in over 20 years." *Id.* The FTC's expert conducted no "independent capital avoidance and efficiencies studies," instead he "merely critiqued" the studies done by the hospitals' experts. *Id.*.
[37] *Id.* at 1305, 1306.
[38] *See* Balto & Geertsma, *supra* note 1, at 170 (Appendix).
[39] Examples of annual savings include the $1.55 million savings from program consolidation that occurred from September 1997 to August 1999–pediatrics ($800,000 annually), digestive disease ($500,000 annually), cardiovascular ($125,000 annually) and poison center services ($125,000 annually). Additionally, $1 million a year in both plant and operation savings is being realized by Spectrum Health's closure and consolidation of duplicative urgent care centers—actions that would not have been taken absent the merger. *See* Balto & Geertsma, *supra* note 1, at 146-47.

[40] *See Butterworth*, 946 F. Supp. at 1301, 1308-09.
[41] Balto & Geertsma, *supra* note 1, at 145.
[42] *Id.* at 133.
[43] *Id.* at 161, 170.
[44] *Butterworth*, 946 F. Supp. at 1299.
[45] *Id.* at 1300 n.5.
[46] Balto & Geertsma, *supra* note 1, at 139 & n.71.
[47] *Id.* at 160.
[48] *Id.* at 144.
[49] *Id.*
[50] *Id.*
[51] *Id.*
[52] From 1995 to 2000, premiums in Grand Rapids increased 7.4%, while premiums in Northwest Michigan increased 9.4%, premiums in Southwest Michigan increased 13.6%, premiums in Northeast Michigan increased 7.7% and premiums in Southeast Michigan increased 9.4%. Winchester Consulting/Medical Advantage Group, Michigan HMO 2000 Rate Filing Analysis.
[53] Balto & Geertsma, *supra* note 1, at 149-52.
[54] Moreover, to the extent that facts are allegedly relied upon to support its conjecture, the "facts" are inaccurate or misleading. For example, the article erroneously asserts that "[p]rior to the merger managed care plans could play Butterworth and Blodgett off against one another [in bidding for discount

contracts] and that rivalry has been lost." *Id.* at 150. But the undisputed evidence showed that Butterworth had no HMO contracts with providers other than Priority Health, and that discounts at Blodgett had decreased over the preceding 5 years. 4 Tr. 70:13-70:16, 3 Tr. 281:8-281:10. Thus, the staff's speculation that "multiple HMOs *may* have been able to negotiate different capitation rates with the two entities" without the merger is not supportable. *Id.* (emphasis added). And, despite the allegation that "40% Blodgett discounts [were] enjoyed by *several* health plans prior to the merger" (*Id.* at 151 (emphasis added)), the evidence at the preliminary injunction hearing showed that only *one* health plan had a 40% discount contract with Blodgett and that plan had been told by Blodgett that it would be reduced by 20%, with or without the merger. 1 Tr. 300:20-301:12, 3 Tr. 280:23-281:1. Otherwise, the evidence showed that Blodgett had no contract with Priority Health and that the discounts in its contracts with the other three large HMOs ranged from zero to 30%, depending upon the service rendered. 1 Tr. 84:10-84:20.

[55] Balto & Geertsma, *supra* note 1, at 150.

[56] Charges likely would have been increased (as at other hospitals in Michigan and nationwide) to offset losses due to decreases in government funding. Moreover, increased HMO costs and premiums are more a result of consumers' demands for "high tech" services and soaring prescription prices than inpatient hospital services (which make up a relatively small component of HMOs' costs). Indeed, during the proceedings, the FTC's HMO witnesses testified that the inpatient hospital component accounts for only 20-25% of the costs of managed care plans.

[57] Balto & Geertsma, *supra* note 1, at 151.

[58] *Id.*

[59] *Butterworth*, 946 F. Supp. at 1305.

[60] Balto & Geertsma, *supra* note 1, at 151.

[61] Indeed, the trend toward PPOs over commercial HMOs in West Michigan tracks the nationwide trend. *See* Laura Benko, *Shake, Rattle, and Disenroll: Membership Erodes as HMOs Exit Markets, but Profits Begin to Stabilize*, MODERN HEALTHCARE, Feb. 5, 2001, at 94.

[62] Balto & Geertsma, *supra* note 1, at 160.

[63] *Id.*

[64] *Id.* at 142 (emphasis added).

[65] *Id.* at 141-42.

[66] Joseph P. Shapiro, *America's Top HMOs*, U.S. NEWS & WORLD REP., Oct. 5, 1998, at 70.

[67] *Priority Health Ranks Top in Newly Released HMO Consumer Guide* (visited Apr. 1, 2001) <www.priority-health.com/whats_new/honors.htm>.

[68] *2000-2001 Consumer Guide to Health Maintenance Organizations* (visited Apr. 1, 2001) <www.hiag.org/qat/hmo.htm>.

[69] *NCQA's Health Plan Report Card* (visited Apr. 1, 2001) <http://hprc.ncqa.org>.

[70] Balto & Geertsma, *supra* note 1, at 140-41. Elsewhere in the article, merged physician group are described by the staff as "near monopolies." *Id.* at 152. And "[s]ome of the [unidentified] managed care providers described the specialties (anesthesiology, pathology, radiology and emergency care) as operating like 'cartels'" *Id.* To the extent that the FTC's article implies that consolidation by independent practitioners creates antitrust problems, those alleged monopolistic affiliations could be challenged by the government. In any event, it is clear that the Hospitals' merger did not require consolidation of physician groups.

[71] *U.S. News & World Report Best Hospitals: Alphabetical Listing* (visited Apr. 1, 2001) <www.usnews.com/usnews/nycu/health/hosptl/hospalph.htm>.

[72] *See* Ed Lovern, *Reaping Healthy Profits*, MODERN HEALTHCARE, Dec. 11, 2000, at 36. *See also The 100 Top Hospitals: National Benchmarks for Success - 2000* (visited Apr. 1, 2001) <www.100tophospitals.com/winners/national00/benchmarks.htm>.

[73] *See* Vince Galloro, *Putting the Patient First*, MODERN HEALTHCARE, Feb. 19, 2001, at 18. *See also, Top 100 Integrated Healthcare Networks* (visited Apr. 1, 2001) <www.modernhealthcare.com/top100integrated.php3>.

[74] *Spectrum Health Award Recognizes Service Efforts*, GRAND RAPIDS PRESS, Jan. 4, 2001, at A21.

[75] *Butterworth*, 946 F. Supp. at 1304.

[76] *See supra* text accompanying note 51.

[77] *See supra* text accompanying note 37.

[78] *See supra* text accompanying notes 71-74.

[79] Balto & Geertsma, *supra* note 1, at 161.

[80] The staff's concluding sentence is that "the FTC should consider use of administrative litigation to help clarify the law and economies of hospital competition." Of course, that is a decision only the FTC can make. However, it should be noted that the FTC initiated and then abandoned administrative proceedings following its unsuccessful federal court action in this case.