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Tom Campbell
Baker & McKenzie LLP

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The Federal Trade Commission's ("FTC's") retrospective challenge to the merger of Evanston Northwestern Healthcare Corporation ("ENH") and Highland Park Hospital ("HPH") stands out as one of the agency's major antitrust enforcement initiatives in health care over the last several years. Tried before an FTC Administrative Law Judge ("ALJ") in 2005, the case produced several departures from antitrust orthodoxy. This article explores how these departures may affect the trials of future hospital mergers that are challenged.

THE MURIS MISSION

The goal of this prosecution was to reassert the agency's authority to challenge hospital mergers that threaten competition and to validate new approaches the agency devised to analyze the competitive effects of a merger. The usual justification for a hospital merger challenge is that Managed Care Organizations ("MCOs"), such as Health Maintenance Organizations ("HMOs"), will no longer be able to obtain competitive bids when two hospitals merge. However, the theory that prices will inexorably rise and consumers will be injured has not always carried the day when hospital mergers have been challenged and put to the test in a courtroom. On November 7, 2002, after the FTC and Department of Justice ("DOJ") lost seven straight hospital merger challenges,[1] the FTC Chairman at the time,

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* Tom Campbell is a partner in Baker & McKenzie LLP's Chicago office where he specializes in the litigation of antitrust matters and business disputes. Mr. Campbell frequently writes and speaks on antitrust developments. This paper is based in part on a presentation made to the Illinois Association of Healthcare Attorneys 24th Annual Health Law Symposium, held at the Chicago Marriott Downtown, October 4, 2006. The author thanks Roxane Busey and William J. Lynk for helpful comments.

1. *In re* Adventist Health Sys., 117 F.T.C. 224 (1994) (where the author was counsel of record, at trial and on appeal); FTC v. Freeman Hosp., 1995 MO W.D. 71,037, 911 F. Supp. 1213 (W.D. Mo. 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995) (where the author was counsel of record, at trial and on appeal); FTC v. Tenet Health Care Corp., 186 F.3d 1045 (8th Cir. 1999); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997);

Tim Muris, announced that the FTC was conducting a retrospective study of consummated hospital mergers and developing a task force to screen merger case targets and develop new theories for trying them.[2]

The transaction chosen to improve the enforcement record was the merger of ENH and HPH, a surprising choice considering the FTC staff had many consummated hospital mergers from which to choose and the structural argument was not compelling: after all, Chicago and its suburbs are rife with hospitals.[3] The FTC and DOJ agencies have previously been unsuccessful in less populated areas where there are fewer hospitals.[4] However, the ENH transaction did provide a record showing that the merged hospital raised prices after the merger, a troublesome fact supporting an inference of competitive injury that would prove difficult to rebut.[5] The FTC Complaint Counsel succeeded in persuading the FTC ALJ that the merger was anticompetitive and that he should order a divestiture.[6] However, the proof relied on to compel that result departed from previously accepted standards in a number of ways, as did the theory of how competition would be injured. In a bizarre twist, the ALJ grounded his decision on the structural case, not on the proof offered to show direct anticompetitive effects: the price increases.[7]

Commentators have criticized the Initial Decision of the ALJ condemning the merger, issued on October 20, 2005,[8] for being unconvincing and analytically flawed.[9] That decision has been appealed to the full Commis-

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FTC v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997); United States v. Mercy Health Servs., 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997); California v. Sutter Health Sys., 130 F. Supp. 2d 1109 (N.D. Cal. 2001).

2. Timothy J. Muris, FTC Chairman, Everything Old is New Again: Health Care and Competition in the 21st Century, Remarks Before the Seventh Annual Competition in Health Care Forum (November 7, 2002), at 19, http://www.ftc.gov/speeches/muris/murishealthcarespeech0211.pdf.

3. John T. Cusack, L. Edward Bryant & Steven S. Shonder, *A Dose of Bad Medicine: The Federal Trade Commission's Attempt to Break Up Evanston Northwestern Healthcare*, 32 J. HEALTH CARE FIN. 1 app. a at 32-36 (2006).

4. *See Adventist Health Sys.*, 117 F.T.C. at 242, 247; *Freeman Hosp.*, 911 F. Supp. at 1217; *Tenet Health Care Corp.*, 186 F.3d at 1047; *Butterworth Health Corp.*, 946 F. Supp. at 1288; *Mercy Health Serv.*, 902 F. Supp. at 971.

5. Evanston Northwestern Healthcare Corp., F.T.C. No. 9315 at 200 (Oct. 20, 2005) (initial decision), http://www.ftc.gov/os/adjpro/d9315/051020initialdecision.pdf [hereinafter Initial Decision].

6. *Id.* at 206.

7. *See id.* at 200-01.

8. *Id.* at 255.

9. *See* Barry C. Harris & David A. Argue, *FTC v. Evanston Northwestern: A Change from Traditional Hospital Merger Analysis?*, Antitrust Magazine, Spring 2006, at 34, 35; Cusack et al., *supra* note 3.

sion[10] and has been briefed and argued.[11] As of the date of this article's publication, the Commission has not yet issued a decision.[12] Moreover, after the Commission issues a decision, there may still be an appeal to one of the United States Courts of Appeals.[13] Nevertheless, the novel approaches used in prosecuting this case will undoubtedly remain weapons in the arsenal of the enforcers and will be employed again in future prosecutions, making it timely to consider how to deal with these approaches now.

THE CONVENTIONAL/UNCONVENTIONAL COMBO

In 1999, ENH consisted of Evanston Hospital, which had 411 staffed beds, and Glenbrook Hospital, which had 143.[14] ENH merged with HPH, which had 157 beds.[15] The transaction was not challenged at the time.

ENH and HPH had been part of the Northwestern Healthcare Network, which had received clearance under the Hart-Scott-Rodino Act in 1993.[16] Prior to consummating their merger on January 1, 2000, ENH and HPH confirmed with the FTC Pre-Merger Notification Office that they did not need to seek additional clearance under the Act for their merger because they were already deemed to be under common control.[17]

The FTC filed its challenge to the merger in 2004.[18] The case was tried before an ALJ who issued his Initial Decision on October 20, 2005.[19] The parties argued the appeal to the full Commission on May 17, 2006.[20]

The FTC's Complaint consisted of two primary theories as to why the

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10. Evanston Northwestern Healthcare Corp., Notice of Appeal, F.T.C. No. 9315 (Oct. 26, 2005) (notice of appeal), http://www.ftc.gov/os/adjpro/d9315/051026enhnotofappeal.pdf.

11. Evanston Northwestern Healthcare Corp., F.T.C. No. 9315 (Dec. 20, 2005) (respondent's appellate brief), http://www.ftc.gov/os/adjpro/d9315/051220enhappealbrief.pdf; Evanston Northwestern Healthcare Corp., F.T.C. No. 9315 (Feb. 10, 2006) (answer and cross appeal), http://www.ftc.gov/os/adjpro/d9315/060210ccattachmntpursuantrule.pdf.

12. *See* Evanston Northwestern Healthcare Corp. F.T.C., No. 9315, http://www.ftc.gov/os/adjpro/d9315/index.htm (for most recent status of this case).

13. Federal Trade Commission Act, 15 U.S.C. § 45(c) (2000).

14. Initial Decision, *supra* note 5, at 5-6.

15. *Id.* at 7, 14.

16. Hart-Scott-Rodino Antitrust Improvements Act, 15 U.S.C. § 18a (2000); Evanston Northwestern Healthcare Corp., F.T.C. No. 9315 at 85-86 (Jan. 12, 2006) (respondent's corrected appeal brief), http://www.ftc.gov/os/adjpro/d9315/060112enhappealbriefcorrected.pdf.

17. *See id.* at 197.

18. Evanston Northwestern Healthcare Corp., F.T.C. No. 9315 (Feb. 10, 2004) (admin. compl.), http://www.ftc.gov/os/caselist/0110234/040210emhcomplaint.pdf [hereinafter Administrative Complaint].

19. Initial Decision, *supra* note 5.

20. Evanston Northwestern Healthcare Corp., F.T.C. No. 9315 (April 20, 2006) (notice scheduling oral argument), http://www.ftc.gov/os/adjpro/d9315/060420notschedoralargu.pdf.

transaction was illegal.[21] Although Count One of the Complaint used a conventional approach, Count Two of the Complaint was novel.[22] The conventional approach is to demonstrate that a transaction will lead to undue concentration in the market for a particular product in a particular geographic area, which supports an inference that the transaction will substantially lessen competition.[23] According to the FTC Merger Guidelines, that lessening of competition can occur in one of two ways: (1) facilitating collusion among the remaining competitors ("coordinated effects") or (2) exercising market power by a single firm ("unilateral effects").[24] At trial, if the government shows the requisite undue concentration, then the burden shifts to the defendant to rebut the inference that the transaction will injure competition.[25] Thus, the conventional approach focuses on the structure of the market.

In Count One, the Complaint alleged that the product market was inpatient acute care hospital services "sold to private payers."[26] This was a narrower product market than those used in prior hospital merger cases, which typically included *all* inpatient services (*i.e.*, including services reimbursed by Medicare).[27] In fact, the Complaint narrowed the product market even further by alleging that it excluded "tertiary" services (*e.g.*, sophisticated services provided by highly specialized providers such as open heart surgery and transplants).[28] The scope of the product market affects the size of the geographic market, and a market including tertiary services would be larger than one excluding these services. By eliminating tertiary care from the product market definition, the Complaint Counsel could argue for a narrower geographic market that, as the discussion below shows, would increase the FTC's chances of success. However, Complaint Counsel ulti

21. Administrative Complaint, *supra* note 18, at 3-7.

22. Evanston Northwestern Healthcare Corp., F.T.C. No. 9315 at 1-2 (May 17, 2005) (decision and order), http://www.ftc.gov/os/adjpro/d9315/050520do.pdf.

23. United States v. Baker Hughes, Inc., 908 F.2d 981, 982 (D.C. Cir. 1990).

24. FTC Horizontal Merger Guidelines, 57 Fed. Reg. 41552, 41558, 41560 (Sept. 10, 1992) [hereinafter Merger Guidelines]; *see Baker,* 908 F.2d at 983.

25. *Baker,* 908 F.2d at 983.

26. Administrative Complaint, *supra* note 18, at 3.

27. *In re* Adventist Health Sys., 117 F.T.C. 224, 278 (1994) (observing that FTC complaint counsel proposed a product market of inpatient acute hospital care, which was the product market found by the ALJ, and that that product market conformed to the decisions in FTC v. Univ. Health Sys., 938 F.2d 1206, 1210-11 (11th Cir. 1991); United States v. Rockford Mem. Hosp. Corp., 898 F.2d 1278 (7th Cir. 1990); Hosp. Corp. of America, 106 F.T.C. 361, 464-66 (1985), *aff'd*, Hosp. Corp. of America v. FTC, 807 F.2d 1381 (7th Cir. 1986)); *see also* FTC v. Freeman Hosp., 69 F.3d 260, 268 (W.D. Mo. 1995), *and* California v. Sutter Health Sys., 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001).

28. Administrative Complaint, *supra* note 18, at 3-7.

mately did include tertiary services at trial and the validity of the product market definition used in the Complaint was not litigated.[29]

The geographic market consisted of an area fifteen miles long (running north-south along Lake Michigan) and ten miles wide. The Complaint alleged that the resulting relevant market was highly concentrated and that the post-merger firm produced an impermissible level of concentration as measured by the Herfindahl-Hirschman Index ("HHI").[30] HHI is a measure of market share concentration and is computed by adding up the square of each market participant's market share.[31] HHI below 1000 reflects a market characterized as unconcentrated, HHI between 1000 and 1800 reflects a market characterized as moderately concentrated, and HHI above 1800 reflects a market characterized as highly concentrated.[32] Under the Merger Guidelines, the agencies look at the increase in concentration caused by the merger.[33] If the delta, or increase, is less than 100 points in moderately concentrated markets, the merger is presumed to not have adverse competitive consequences.[34] Mergers that potentially raise competitive concerns and may be challenged include mergers in moderately concentrated markets that result in an increase of 100 points or more, and mergers in highly concentrated markets that result in an increase of fifty points, depending on certain other factors.[35] By comparison, the Complaint in the present case alleged an increase of 500 in the HHI to a level above 3000.[36] That being said, the standards described in the Merger Guidelines are not a very reliable gauge for when the agencies will challenge a merger or when a merger will be found illegal. More cases exist in which the agencies have deviated from the standards rather than followed them.[37]

Count Two focused on conduct: the increase in prices post-merger. This arguably showed actual anticompetitive effects. The FTC probably brought the case because ENH's administrators had riled MCOs; in fact, the FTC's investigation uncovered statements in internal reports that ENH's ability to increase prices to MCOs was made possible by the merger.[38] At trial,

29. *See* Initial Decision, *supra* note 5, at 135.

30. Merger Guidelines, *supra* note 24, at 41558; Administrative Complaint, *supra* note 18, at 4 (noting an increase of more than 500 to a level exceeding 3000 on the HHI index).

31. Merger Guidelines, *supra* note 24, at 41558.

32. *Id.*

33. *Id.*

34. *Id.*

35. *Id.*

36. Administrative Complaint, *supra* note 18, at 4.

37. *See* Merger Guidelines, *supra* note 24, at 41562.

38. Initial Decision, *supra* note 5, at 47-51.

Complaint Counsel showed that the leaders of the hospitals planning the merger saw it as an opportunity "to strengthen negotiation capability," "to join forces rather than compete with each other," and to build "negotiating strength with payers."[39]

The FTC was able to focus on post-merger price increases and assert the unconventional approach that evidence of actual anticompetitive effects existed because the case was a rare *retrospective* challenge to a merger.[40] Under the Hart-Scott-Rodino Act ("HSR Act"), parties to a merger of requisite size must file a pre-merger notification form and observe a "waiting period" after which they are free to consummate the merger if the agencies determine not to challenge.[41] The HSR Act has had the effect of making most merger challenges *prospective*.[42] In fact, one reason why the HSR Act passed was because the business community objected to the uncertainty of the pre-HSR Act days, when mergers were routinely challenged retrospectively.[43] Thus, the conventional proof to show illegality is the structural analysis of the market discussed above and typically there is no direct evidence of anticompetitive effects.

CHANGING THE ANALYTICAL TOOLS

The prosecution of the ENH merger was intended not only to break the agencies' track record of losing seven straight hospital merger challenges, but it was also aimed at validating changes the agencies have promoted regarding how mergers in the healthcare field should be analyzed in the future. For example, in 2004, following twenty-seven days of joint hearings, the DOJ and FTC issued a report entitled *Improving Health Care: A Dose of Competition*.[44] The Report did not produce case studies of past mergers.[45] Instead, it offered criticisms of the traditional analytical tools, suggested that some traditional tools should not be used, and set the stage for some of the approaches used in the retrospective challenge to the ENH–HPH merger. The Report signaled the attempt to use new theories to sup-

39. *Id.* at 44.

40. *Id.* at 138.

41. 15 U.S.C. § 18a (2000).

42. *See generally* 43 Fed. Reg. 33,450 (1978), 44 Fed. Reg. 66,781 (1979), *and* 45 Fed. Reg. 14,205 (1980).

43. STAFF OF THE BUREAU OF COMPETITION, F.T.C., A STUDY OF THE COMMISSION'S DIVESTITURE PROCESS 1-4 (1999).

44. FEDERAL TRADE COMMISSION AND DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July 2004), *available at* http://www.ftc.gov/reports/healthcare/040723healthcarept.pdf [hereinafter A DOSE OF COMPETITION].

45. *See id.*

port hospital merger prosecutions.[46] Both the Report and the filing of *FTC v. ENH* were initiatives taken by the FTC during Chairman Muris's tenure.[47]

In analyzing the hospital merger cases that the agencies had lost, the agencies generally did not encounter any difficulty having courts accept their proposed *product* market definitions.[48] However, their proposed *geographic* market definitions were more problematic. A number of challenges to hospital mergers were rejected based on the government's failure to identify a properly defined geographic market.[49]

The geographic market is one of the three elements that must be established to prove that a merger is anticompetitive.[50] The other two are the product market and the requisite anticompetitive effect.[51] These elements come straight out of the statute.[52] Section 7 of the Clayton Act makes an acquisition illegal where:

> In any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.[53]

The "section of the country" is the geographic market, the "line of commerce" is the product market, and the "effect" is the competitive effect of the transaction. However, the statute does not explain how geographic markets should be determined, and geographic market analysis has evolved slowly as better analytical tools have been developed.

The Supreme Court has held that a geographic market should describe "the area of effective competition . . . in which the seller operates, and to which the purchaser can practicably turn for supplies."[54] One method developed to identify that area was economic analysis using the "Elzinga-Hogarty" test.[55]

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46. *Id.* at 4-5.

47. *Id.*; *see* F.T.C., COMMISSIONERS AND CHAIRMEN OF THE FEDERAL TRADE COMMISSION (2006), http://www.ftc.gov/ftc/history/06commisionerchartlegal.pdf.

48. *But see* United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997) (rejecting the product market proposed by the Department of Justice).

49. Initial Decision, *supra* note 5, at 137.

50. *Id.* at 131.

51. *Id.*

52. 15 U.S.C. § 18 (2000).

53. *Id.*

54. United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 359 (1963) (quoting Tampa Elec. Co. v. Nashville Coal Co., 399 U.S. 320, 327 (1961)); *see generally* Merger Guidelines, *supra* note 24.

55. *See generally* Kenneth G. Elzinga & Thomas F. Hogarty, *The Problem of Geographic Market Delineation in Antimerger Suits,* 18 ANTITRUST BULL. 45 (1973) [hereinafter *Geographic Market Delineation*]; *see also* Kenneth G. Elzinga & Thomas F. Hogarty, *The*

THE LOGIC OF THE ELZINGA-HOGARTY TEST

The Elzinga-Hogarty test, when applied to hospital mergers, examines patient origin data to determine where the patients admitted to the merging hospitals came from and where people living in or near that same area went when they sought hospitalization at hospitals other than the merging hospitals. The test utilizes two numerical measures which the authors dubbed LOFI ("little out from inside") and LIFO ("little in from outside").[56]

The LOFI area can be determined by taking the two merging hospitals' patient origin data and ranking that data by zip code in descending order from most populous (in terms of patient volume to the hospitals) to least.[57] Those zip codes can then be assembled in a compact and contiguous array to account for various levels of the patient population. The LOFI step identifies what is often referred to as the hospitals' service area.

The second step, the LIFO measure, seeks to identify where residents living within the service area go when they seek hospitalization at hospitals other than the merging ones.[58] While the first step relies on data from the merging hospitals that obtain home addresses when patients are admitted, this second step requires data from hospitals other than the two merging. State hospital associations often compile these data. This second step identifies the competing hospitals that residents of the service area go to when they do not go to one of the merging hospitals. Those hospitals attracting significant numbers of patients from the service area should probably be included in the relevant market. Thus, the relevant geographic market will usually be an area larger than the merging hospitals' service area. It also can be described by referring to the hospitals identified in the second step rather than to the zip codes of their respective service areas.

The logic behind the LOFI determination is that a LOFI of 100% for an area would indicate that all the patients going to the two hospitals reside in the area identified. Symmetrically, a LIFO of 100% would mean that all of the residents of the proposed area seek hospitalization within the area described. The authors of the test originally recommended using a 75% cutoff for the LOFI and LIFO calculations to define the geographic market. In other words, in the hospital setting, the exercise of assembling zip codes reflecting patients admitted to a hospital in the LOFI step would be satisfied once 75% of the hospitals' admissions were accounted for, and the geographic market would include the competing hospitals that account for 75%

Problem of Geographic Market Delineation Revisited: The Case of Coal, 23 ANTITRUST BULL. 1 (1978).

56. *Geographic Market Delineation*, *supra* note 55, at 57-59.

57. *Id.* at 58-59.

58. *Id.*

of the people seeking hospitalization from the LOFI area. However, in their subsequent article the authors expressed a preference for a 90% cut-off. The results from using these two standards are sometimes referred to as producing a "weak market," *i.e.*, one employing the 75% standard, or a "strong market," one employing the 90% standard.

The FTC's Complaint Counsel relied on this test in the *Ukiah* case, which was a hospital merger case similar to the *ENH* case because it was also a retrospective challenge to a merger.[59] In *Ukiah*, while the Commission did not endorse the use of either the 75% or 90% threshold to define a market, the Commission held that Complaint Counsel failed to carry their burden of proof when they relied on a geographic market that was based on a LOFI statistic of only 74.57%.[60]

The difference between the 75-75 or 90-90 cut-off is critically important. The so-called "weaker" market would implicate a smaller geographic market, which, in turn, would increase the market shares of the merging hospitals and raise the HHIs. Thus, if 75-75 were the standard, then it would tend to make more mergers look illegal under the government's Merger Guidelines.

SHOOT THE MESSENGER

Unable to use the Elzinga-Hogarty test effectively to win hospital merger cases, the agencies set about to attack the test's validity. In the July 2004 "Dose of Competition" Report, the agencies observed that "hospital markets should be defined properly," explaining:

> To date, the Agencies' experience and research indicate that the Elzinga-Hogarty test is not valid or reliable in defining geographic markets in hospitals merger cases.[61]

The Report further summarized the testimony of the test's critics, who were invited to speak at the hearings sponsored by the agencies.[62] The critics suggested that

- the test produced "implausibly large geographic markets";

59. *In re* Adventist Health Sys./West, 117 F.T.C. 224, 224 (1994).

60. *Id.* at 294-97.

61. A DOSE OF COMPETITION, *supra* note 44, at 26.

62. The Dose Of Competition Report cited certain commentators and the presentations of individuals who were invited to be panelists in the hearings held by the DOJ and FTC. Those whose comments were reported as being critical of the Elzinga-Hogarty test were: Gregory Vistnes, H.E. Frech, III, Thomas L. Greaney, Jack Zwanziger, Cory S. Capps, David Dranove, Shane Greenstein, and Mark Satherwaite.

- because the test was designed to identify markets for homogenous goods, it should not be applied to "heterogeneous goods or differentiated products," such as the goods and services provided by hospitals; and

- the test draws a conclusion from the behavior of a small number of patients who travel, and therefore may not accurately reflect the behavior of the "silent majority."[63]

In the *FTC v. ENH* trial, Complaint Counsel sought to give the Elzinga-Hogarty test the *coup de grâce* by retaining none other than Ken Elzinga, an author of the test, to testify that, in his expert opinion, his test should not be applied to hospital mergers.[64] Elzinga testified that his test has a "fundamental flaw" because of the "silent majority fallacy."[65] He went on to explain that the silent majority fallacy is the assumption that, while some patients currently go to a distant hospital, if prices were to go up, then an even larger number of patients would travel to distant hospitals.[66] This freed Complaint Counsel to ignore the empirical data that reflected where patients go when they proposed a geographic market to meet their burden in Count One's structural challenge. For good measure, Elzinga also said that defining a geographic market was not necessary where there was persuasive post-merger evidence of the consequences of a merger and that the "payer problem" also made the Elzinga-Hogarty test "less useful."[67] This cleared the way for Complaint Counsel to sidestep defining the relevant market in meeting their burden of proof in Count Two.

THE DIVIDENDS

All of this investment in creating a more enforcement-friendly world paid off when the ALJ, in his Initial Decision, made the following findings:

> 216. Patient-flow data and the Elzinga-Hogarty test are inapplicable to geographic market definition for a differentiated product such as hospital services.

63. A DOSE OF COMPETITION, *supra* note 44, at ch. 4, 4-7.

64. FTC v. ENH, Tr. May 25, 2005 at 2342-418.

65. *Id.*

66. *Id.*

67. United States v. Oracle Corp., 331 F. Supp.2d 1098, 1161-65 (N.D. Cal. 2004) (rejecting testimony from Elzinga himself that the Elzinga-Hogarty test was inapplicable); *see also* California v. Sutter Health Sys. 84 F. Supp. 2d 1057, 1069 (N.D. Cal. 2000), *and* United States v. Mercy Health Servs., 902 F. Supp. 968, 980 (N.D. Iowa 1995) (establishing a basis for the Oracle court to reject Elzinga's testimony that the Elzinga-Hogarty test was inapplicable).

> 220. A "silent majority" of people will *not* travel in response to a change in hospital prices, and those people can be subject to an anticompetitive price increase.
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> 222. However, basing geographic market definition on patient migration and patient flow data *inherently* will overstate the size of the geographic market for hospital services.[68]

The ALJ based each of these findings on Elzinga's testimony. Unfortunately, the effort to gut the Elzinga-Hogarty test went unchallenged by counsel for ENH at trial. Elzinga was not deposed before trial and his cross-examination at trial was perfunctory. As the briefs filed on appeal to the Commission show, ENH is not contesting those findings on appeal and, as a result, the case unfortunately does not present a vehicle for testing the validity of the criticisms that the FTC has promoted.

EASING THE GOVERNMENT'S BURDEN

In 1966, in his famous dissent in *United States v. Von's Grocery*, Justice Potter Stewart remarked that "[t]he sole consistency that I can find in litigation under [Section] 7, [is that] the Government always wins."[69] This became the call to arms for commentators such as then-Professors Richard Posner and Robert Bork, who called for a more rigorous economic analysis to support antitrust decisions. The effort to discredit the Elzinga-Hogarty test undercuts the economic enlightenment movement. It is an undisguised effort to lighten the agencies' burden. This would not be the first time the agencies tried to rewrite the legal standards to ease their burden. For example, in *United States v. Baker Hughes Inc.*, the DOJ argued that its prima facie case challenging the merger of manufacturers of underground drilling equipment could be overcome "only by a clear showing that entry into the market by competitors would be quick and effective."[70] Then-Judge Clarence Thomas rejected this argument as an improper attempt to change the standard:

> We find no merit in the legal standard propounded by the government. It is devoid of support in the statute, in the case law, and in the government's own Merger Guidelines. Moreover, it is flawed on its merits in three fundamental respects. First, it assumes that ease of entry by competitors is the only consideration relevant to a section 7 defendant's rebuttal. Second, it requires that a defendant who seeks to show ease of en-

68. Initial Decision, *supra* note 5, at 30-31 (emphasis added).
69. 384 U.S. 270, 301 (1966).
70. United States v. Baker Hughes Inc., 908 F.2d 981, 983 (D.C. Cir. 1990).

> try bear the onerous burden of proving that entry will be"quick and effective." Finally, by stating that the defendant can rebut a prima facie case only by a *clear* showing, the standard in effect shifts the government's ultimate burden of persuasion to the defendant.[71]

Similarly, discarding the Elzinga-Hogarty test entirely would be a step backward. Admittedly, the test analyzes what patients have done in the recent past. Thus, any conclusion as to what they might do in the future is a prediction. Yet that shortcoming was not part of the FTC's basis for discarding the test. The test has the virtue of being an empirical analysis —it looks at real data that show what choices patients in the hospital setting have actually made. Complaint Counsel suggested that patient choices were not important because the focus should be on the competition for MCO contracts. However, MCOs assemble networks of hospitals and physicians to be attractive to patients, and MCOs' preferences are derived from the choices their members make. Therefore, even with an MCO-centered focus, it does not make sense to ignore where patients choose to go. Determining where the patients have actually gone in the past provides a valuable check on any geographic market devised by other means.

THE QUESTIONABLE VALIDITY OF THE "SILENT MAJORITY FALLACY"

In his testimony, Elzinga declined to take credit for bestowing the "silent majority fallacy" label on his test and cited Greg Werden as the originator of that term.[72] Of course, the term "silent majority" is borrowed from President Richard Nixon's famous "Silent Majority" speech delivered on November 3, 1969.[73] President Nixon suggested that the majority of the people supported his carrying on the Vietnam War and that the public should disregard the vocal minority.[74]

The assertion that there is a "silent majority" of hospital patients who do not travel is a generality that deserves a skeptical reception equal to its Nixonian forebear. It is undoubtedly true that patients "travel" — *i.e.*, go to more distant hospitals—for a variety of reasons. Some may have done so to be hospitalized closer to work, some to be nearer to family, some for perceived quality differences, some to obtain a service not available locally, and some because of price—either because of the price they pay (through a

71. *Id.*

72. FTC v. ENH, Tr. May 25, 2005 at 2342-418.

73. Richard Nixon, Address to the Nation (November 3, 1969), *available at* http://www.americanrhetoric.com/speeches/richardnixongreatsilentmajority.html.

74. *Id.*

co-pay or deductible), or because their chosen health plan steers them to the more distant facility. The data can neither tell us why those that traveled did so nor explain the motivations of those who did not. There is no empirical foundation to ascribe an aversion to travel to those who did not travel. While packaged and delivered as the expert opinion of Werden and Elzinga, this notion is nothing more than speculation and conjecture. Whether the trick is performed by Werden, Elzinga, Nixon or the Amazing Karnack, it has no scientific validity.

In its "Dose of Competition" Report, the DOJ and FTC asserted that there was an empirical basis for the silent majority fallacy criticism of the Elzinga-Hogarty test.[75] However, that article makes clear that its methodology rests on "suppositions." A more concrete and legally relevant view of the validity of the suggestion that patients will not travel can be found in the opinion of the trial court in the *Mercy Hospital* case, where the DOJ alleged a market that included "Dubuque County, Iowa and a half-circle with a 15 mile radius extending from Dubuque County's eastern edge into Illinois and Wisconsin."[76] The DOJ constructed this market based, in part, on the assumption that the majority of patients would not travel. The trial court found otherwise:

> The fact that the residents of southwest Wisconsin are willing to drive to Madison for their inpatient needs also shows that the government's assumption that persons within twenty-five miles of Dubuque will only go to Dubuque for their inpatient needs is an incorrect assumption. The government has also failed to account for the fact that there are several zip codes within 25 miles of Dubuque which currently send over one-third of their inpatients to other hospitals. Looking at the zip codes encompassing Cuba City, Wisconsin; Galena, Illinois; New Vienna, Iowa; Potosi, Wisconsin; and Hazel Green, Wisconsin, there were 930 discharges in a six month period from these zip codes and only 560 were discharged from Mercy or Finley (60.2%). 179 of these discharges were to hospitals other than Mercy, Finley, the seven rurals or the University of Iowa (19.2%). Obviously, these persons are already being attracted to hospitals outside the immediate area.[77]

75. DOSE OF COMPETITION, *supra* note 44, at ch. 4, 9 (citing CORY CAPPS ET AL., THE SILENT MAJORITY FALLACY OF THE ELZINGA-HOGARTY CRITERIA: A CRITIQUE AND NEW APPROACH TO ANALYZING HOSPITAL MERGERS 1 (Nat'l Bureau of Econ. Research, Working Paper No. w8216, 2001), *available at* http://www.nber.org/papers/w8216).

76. United States v. Mercy Health Servs., 902 F. Supp. 968, 976 (N.D. Iowa 1995) *vacated as moot,* 107 F.3d 632 (8th Cir. 1997).

77. *Id.* at 979 (The appeal was dismissed as moot after the parties abandoned the transaction.).

DEFINING THE GEOGRAPHIC MARKET WITHOUT DATA

Without data revealing where patients have actually gone in the past, the enforcement agencies are free to offer a geographic market definition based on less objective evidence. In light of the fact that the Merger Guidelines employ the "the hypothetical monopolist test" to define markets, one might expect the enforcement agencies to turn to this test, but they have seldom done so.[78]

According to the Guidelines, the hypothetical monopolist test entails starting with the merging firms and asking what would happen if a hypothetical monopolist imposed a small but significant and non-transitory increase on the price of relevant goods ("S.N.I.P."), assuming that the prices and terms remained constant at other locations.[79] If, due to the price increase and the concomitant tendency for consumers within the identified region to seek services outside the region, the reduction in sales due to the price increase was sufficiently large to render the price increase unprofitable, then the agency adds the next best substitute location to the proposed location, and the test is repeated.[80] This theoretical construct is not helpful, however, when it comes to presenting concrete empirical proof of the boundaries of a real market.

The DOJ's economist in the *Rockford Memorial* case tried to use the S.N.I.P. test by asking administrators of nearby hospitals whether they would get more business if the two hospitals in Rockford (Rockford Memorial and SwedishAmerican) were to merge and, in collusion with the third hospital in Rockford, raise prices "by a small but significant amount."[81] The trial court thought this approach did not produce probative evidence:

> The government ran into trouble, however, when it attempted to question the administrative heads of these hospitals on whether they "compete" with the three Rockford hospitals.... Dr. Allen, the government's economist, queried the administrators as to the effect of a hypothetical price increase (usually 10 to 20%) in services offer[ed] by the three Rockford hospitals. This approach was not without its difficulties. First, the pricing of the same services between the three Rockford hospitals often differed by more than ten percent, creating doubt as to what was meant by a 10% or 20% price increase in services offered by the Rock-

78. *See* Adventist Health System/West, 117 F.T.C. 224, 229 (1994) ("Instead of attempting to establish how Ukiah consumers of hospital services would respond to a small but non-transitory price increase, Complaint Counsel relied on expert testimony regarding the Elzinga-Hogarty test.").

79. Merger Guidelines, *supra* note 24, at 41556.

80. *Id.*

81. United States v. Rockford Mem'l Corp., 717 F. Supp. 1251, 1263-64 (N.D. Ill. 1989).

> ford hospitals. Secondly, Dr. Allen did not employ a set routine in asking the administrators the hypothetical "price question," also creating doubt as to the consistency of the questions and hence the answers.[82]

The problem that the trial court in *Rockford Memorial* identified, which is the inability to determine what is meant by a hospital's price because of the range of different services a hospital provides, persists in all hospital mergers. As ENH pointed out in its Appeal Brief to the Commission, a typical hospital chargemaster has 15,000 to 20,000 individual line items.[83]

Another method for defining geographic markets is the "critical loss" analysis. The DOJ and FTC also disapproved of this methodology in their "Dose of Competition" Report.[84] Ironically, the critical loss test is derived from the Merger Guidelines' hypothetical monopolist test.[85] The Merger Guidelines direct the FTC to start with the location of each merging firm and ask what would happen if a hypothetical monopolist imposed a small but significant and non-transitory price increase, assuming prices and services remained constant at other locations.[86] The critical loss analysis involves calculating the percentage loss in sales that would make a given price increase unprofitable for a hypothetical monopolist within a candidate market. The first step in this analysis is to calculate the percentage loss in sales that would make a hypothetical monopolist unprofitable within the candidate market.[87] This step depends on the contribution margin, which is a function of marginal cost. The next step in the critical loss analysis is to estimate the likely actual loss in sales that would result from such a price increase, asking what percentage of patients likely would stop patronizing the hospitals in the candidate market as a result of the price increase.[88] The estimated actual loss is then compared to the calculated critical loss, and if the estimated actual loss exceeds the critical loss, it is inferred that the price increase would be unprofitable and the candidate market is too small to be a market.[89]

The agencies disapproved of the critical loss analysis because it depends on several variables, such as the marginal cost of services, which can be difficult to identify with any certainty.[90] According to the agencies, the calcu-

82. *Id.*

83. Evanston Northwestern Healthcare Corp., F.T.C. No. 9315 (Dec. 20, 2005) (respondent's appellate brief), http://www.ftc.gov/os/adjpro/d9315/051220enhappealbrief.pdf.

84. *See* A DOSE OF COMPETITION, *supra* note 44, at ch. 4, 10-14.

85. *Id.*

86. *Id.*

87. *Id.*

88. *Id.*

89. *Id.*

90. *See* A DOSE OF COMPETITION, *supra* note 44, at ch. 4, 10-14.

lation depends on the price posited and the contribution margin, which in turn requires knowing the marginal cost.[91] As a result, the value of the critical loss analysis is questionable because it depends on variables that are difficult to accurately measure.

THE TRIANGLE

Instead of employing one of the analytical methodologies that focused on patient travel, prices, or margins, Complaint Counsel argued that a geographic market could be determined using MCO preferences, basing this case on the anecdotal testimony of MCO representatives who claimed that they could not assemble a hospital network that excluded the three ENH hospitals (Evanston, Glenbrook, and Highland Park).[92] Complaint Counsel argued that the hospitals faced "two-stage" competition.[93] First they competed to get an MCO to include them in the MCO's network, and, if successful, they also competed to get the MCO's members to come to their hospital instead of another hospital in the MCO's network. Complaint Counsel thus argued that the proper geographic market is the geographic triangle formed by the three ENH hospitals.[94]

The ALJ did not agree.[95] He found that the geographic market consisted of seven hospitals: the three ENH hospitals plus Lake Forest, Advocate Lutheran General, Rush North Shore, and St. Francis.[96] He also found that this market was highly concentrated with an HHI of 2739, supporting a presumption that the merger created or enhanced market power.[97]

The ALJ agreed with Complaint Counsel that the Elzinga-Hogarty test should not be used, reasoning that it would "overstate" the geographic market.[98] He adopted the "silent majority" rationale for disregarding the test and also the "payor problem," which he described as follows:

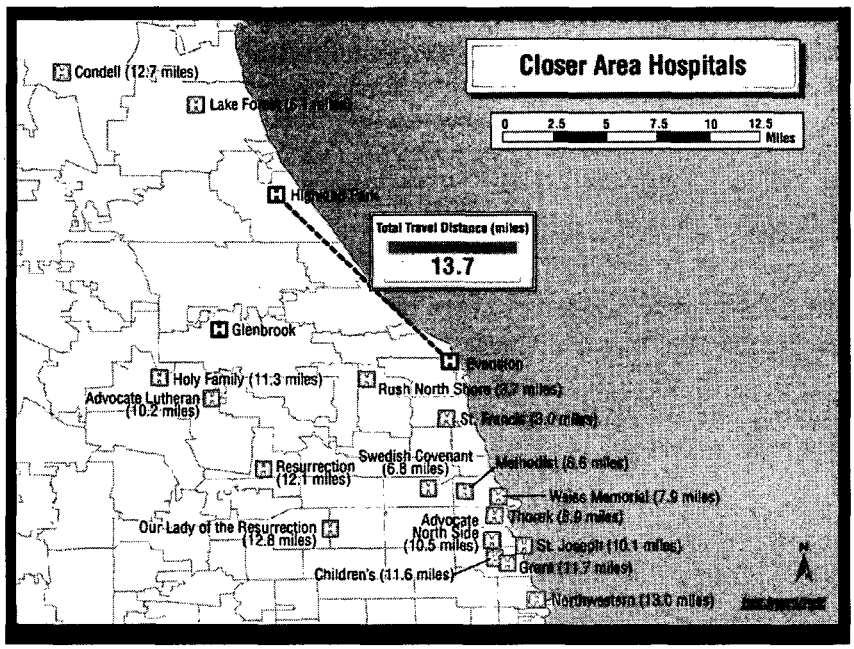
> 217. The first problem with use of patient flow data and the Elzinga-Hogarty test is the "payor problem," which recognizes that in the hospital industry, managed care organizations pay for hospital services but patients are the ones who use the services.

91. *Id.*
92. *See* Initial Decision, *supra* note 5, at 31-33.
93. *Id.* at 16-18.
94. *Id.* at 137.
95. *Id.* at 143-44.
96. *Id.*
97. *Id.* at 200.
98. *See* Initial Decision, *supra* note 5, at 30-31.

218. Because patients do not set the price of hospital services, their willingness to travel tells us nothing about their sensitivity to price changes by the merging hospitals.[99]

This rejection of data on actual patient choice patterns left the ALJ with the testimony of the MCO representatives. From their testimony he distilled the following principles: networks must include local hospitals; affluent consumers prize convenience and are less willing to travel; and ENH and HPH are each other's main competitors.[100] With regard to convenience, the ALJ cited a survey that indicated consumers are willing to travel, on average, up to sixteen minutes for emergency care, twenty-eight minutes to a primary care physician for routine care, and thirty-five minutes to a hospital for an overnight stay.[101]

On appeal to the Commission, Complaint Counsel argued that the ALJ's geographic market was wrong and reasserted their triangle market.[102] ENH's counsel pointed out the illogic of both markets, which disregarded eighteen hospitals that are closer to Evanston or HPH than those two are to each other.



99. *Id.* at 30.

100. *Id.* at 31.

101. *Id.* at 35.

102. Evanston Northwestern Healthcare Corp., F.T.C. No. 9315 (Dec. 20, 2005) (complaint counsel's answering and cross-appeal brief), http://www.ftc.gov/os/adjpro/d9315/060210ccattachmntpursuantrule.pdf.

To ground a determination of the geographic market principally on the testimony of the MCO representatives is to rely on evidence of questionable weight. The *ex post* testimony by MCO representatives that they "had" to have the ENH hospitals in their networks was a subjective opinion given by witnesses with interests adverse to the hospitals' and difficult to corroborate based on any pre-merger objective evidence. The one exception would appear to be the testimony of One Health, which dropped ENH from its network, lost members, and later determined that it had to include ENH in its network.[103] Cross-examination should have exposed the weakness of this testimony.[104]

The MCO witnesses, with one important exception, had a tale of woe as to how they had been forced to accede to contracts with higher prices post-merger.[105] This post-merger evidence was used by the ALJ to confirm his finding of the exercise of market power.[106]

The ALJ concluded that the evidence demonstrated the following: that the relevant product market was acute care inpatient services sold to MCOs; that the relevant geographic market was the seven hospitals he identified; and that, based on his calculation of a resulting HHI of 2739 and an increase of 384, the resulting market was highly concentrated.[107] This analysis supported an inference that the merged hospital had achieved market power, which was confirmed by the post-merger pricing conduct. The ALJ rejected ENH's explanations attempting to rebut these findings.[108]

THE DIRECT EFFECTS CASE

To meet its burden on Count Two, the FTC argued that the market definition step could be skipped entirely because in this case there was direct evidence of anticompetitive effects. Count Two was an alternative theory of liability that did not rely on predictions based on market concentration

103. *Id.* at 56.

104. FTC v. Tenet Health Care Corp., 186 F.3d 1045, 1054 (8th Cir. 1999) (reversing the grant of an injunction to stop the hospital merger in Poplar Bluff, Missouri, the court was much more skeptical about the weight to be afforded the testimony of MCO representatives, stating, "[w]e question the district court's reliance on the testimony of managed care payers, in the face of contrary evidence, that these for-profit entities would unhesitatingly accept a price increase rather than steer their subscribers to hospitals in Sikeston or Cape Girardeau. Without necessarily being disingenuous or self-serving or both, the testimony is at least contrary to the payers' economic interests and thus is suspect. In spite of their testimony to the contrary, the evidence shows that large, sophisticated third-party buyers can and do resist price increases, especially where consolidation results in cost savings to the merging entities.").

105. Initial Decision, *supra* note 5, at 52-58.

106. *Id.* at 47.

107. *Id.* at 1.

108. *Id.* at 200.

data.[109] In Count Two, Complaint Counsel argued that post acquisition evidence established that ENH exercised its enhanced post merger market power by obtaining price increases significantly above its pre-merger prices and in increments substantially above a comparison group of hospitals.[110]

The ALJ dismissed Count Two as moot after finding for Complaint Counsel on Count One.[111] Ironically, he reasoned that Complaint Counsel's proof for Count Two was deficient because it did not allege and prove a relevant market.[112] He pointed out that the paragraphs in the FTC's Complaint describing the market that the FTC alleged were not incorporated by reference in Count Two.[113] Nevertheless, it is important to understand the proof offered and the extent to which it is at variance with other merger cases. On appeal, the Commission could only find for Complaint Counsel on Count Two if it reversed the ALJ on the need to identify a market.

Complaint Counsel relied on four types of evidence to show that the price increases were the result of an exercise of market power.[114] First, contemporaneous business records showed the hospitals' administrators and their consultant were motivated to obtain "leverage" over MCOs to get better pricing.[115] Second, the MCO representatives claimed they had little or no power to resist demands for price increases.[116] Third, a study was presented of the price increases, arguably showing that the magnitude of the increases compared to price increases at other comparison hospitals reflected the exercise of market power.[117] Fourth, testimony from ENH employees tended to mirror themes from the business records and planning documents that the merger was a path to increased market power.[118]

The first two types of proof are conventional. There is no question that the administrators and their consultant, Bain & Co., described the merger as an opportunity to gain "additional negotiating power and leverage with the payors."[119] ENH's attempts at trial to explain these statements away were not very persuasive. ENH claimed that, when it retained Bain in 1999 to look at ENH's and HPH's MCO contracts as part of due diligence, it learned that ENH's contracts were woefully below market and that it should

109. Administrative Complaint, *supra* note 18, at 5-7.

110. *Id.*

111. *Id.*

112. *Id.* at 201.

113. *Id.* at 200-01.

114. Evanston Northwestern Healthcare Corp., F.T.C. No. 9315 at 3-6 (May 27, 2005) (complaint counsel's post-trial brief), http://www.ftc.gov/os/adjpro/d9315/050527 ccposttrialbrief.pdf [hereinafter Complaint Counsel's Post-Trial Brief].

115. *Id.* at 5-7.

116. *Id.* at 3-5.

117. *Id.* at 3.

118. *Id.* at 7.

119. Initial Decision, *supra* note 5, at 158.

change its contracting methodology to get market prices and switch from seeking to be in all networks to a more price conscious strategy.[120] Unfortunately, ENH was saddled with an overabundance of swaggering statements that made the justifications offered at trial sound hollow.

As discussed above, the MCO representatives complained of being victimized by the powerful merged hospital.[121] However, ENH did not succeed in raising prices with Blue Cross, the largest MCO with which it contracted, thus raising doubt about the ENH's alleged exercise of market power.[122] After all, if ENH had market power, why was it unable to compel Blue Cross to agree to higher reimbursement rates? This incongruity represented a gap in logic that Complaint Counsel had trouble explaining.

The centerpiece of the FTC's direct effects case was the study by Dr. Deborah Haas-Wilson, Professor of Economics at Smith College, who did an empirical analysis of payment data.[123] Dr. Haas-Wilson used four data sources: payment data from the MCOs, the Universal dataset from the Illinois Department of Public Health, data from NERA (a consulting firm working for ENH), and data from ENH in response to a Civil Investigative Demand.[124] This study, like much of the record in the case, is heavily redacted because of a protective order that was designed to avoid disclosure of specific MCO and hospital pricing, contractual terms, and payment methodologies.[125] This makes it difficult to evaluate the methodology she employed in her study and her conclusions about the level of prices. Nevertheless, her analysis focused on whether ENH's price increases from its premerger prices were greater than the price increases of other hospitals.[126] She concluded that price increases at ENH were larger than price increases at comparison hospitals.[127] She then looked to see whether
this difference could be explained by benign factors and determined that it could not be, leading to her ultimate conclusion that the large price increases were the result of an exercise of market power.[128]

120. *Id.* at 170.

121. *Id.* at 52-59.

122. Administrative Complaint, *supra* note 18, at 7.

123. Initial Decision, *supra* note 5, at 61.

124. *Id.* at 61-62.

125. *See id.* at 65-74; *see also* Complaint Counsel's Post-Trial Brief, *supra* note 114.

126. Initial Decision, *supra* note 5, at 62.

127. *Id.* at 62, 65 (noting that comparing price increases is not the same as a comparison of actual prices). *See also* FTC v. Staples, Inc., 970 F. Supp. 1066, 1076 (D. D.C. 1997) (granting a preliminary injunction to the FTC barring the merger of two office supply superstores, Staples, Inc. and Office Depot, Inc., based on evidence that prices were higher in markets where Staples was the only office supply superstore compared to markets where there were three such stores by 5% or more).

128. Initial Decision, *supra* note 5, at 88-96.

Complaint Counsel once again ventured off the beaten path. The study did not seek to determine whether ENH was charging prices above competitive levels. In fact, as the ALJ found, Complaint Counsel conceded that the question of whether ENH charged prices higher than competitive levels was not the inquiry.[129] The failure to identify a competitive level of prices undermines the conclusion that the pricing study is supposed to support. If ENH's prices before the merger were below the competitive level and if, after the increases, they were at or below the competitive level, how can the magnitude of the increase show an exercise of market power? The Guidelines define market power as the power of a seller to profitably "maintain prices above *competitive* levels for a significant period of time."[130]

THE ZINGER

When the ALJ identified the other four hospitals in the geographic market, he made this observation:

> It is highly probable that the four non-ENH hospitals in the geographic market would have the ability to constrain prices at ENH, either now or in the future, and could be utilized by managed care organizations to create alternative hospital networks.[131]

This statement is a zinger. It completely contradicts the finding of market power and exposes the conundrum presented by the ALJ's opinion. As mentioned earlier, the injury to competition threatened by an illegal merger can take one of two forms. The lessening of competition can facilitate collusion among the remaining firms or give a single firm the power to act unilaterally to raise price or exclude competitors. Here, the finding that the four non-ENH hospitals can constrain ENH's future price increases would appear to negate any possibility of *unilateral effects*. Yet Complaint Counsel's theory was that the merger was illegal because of the unilateral effects, as demonstrated by the price increases that ENH implemented. Nor can Complaint Counsel fall back on *coordinated effects*. The proof presented in Count Two was that ENH had raised prices, not that the other hospitals in the market the ALJ identified did so in conjunction with ENH. In other words, the direct effects evidence could only support a unilateral effects theory, and could not support a coordinated effects theory.

PROGNOSIS

There are other issues presented in the ENH merger case that are not central to the inquiry of this article, but are substantial enough to merit some

129. *Id.* at 155.
130. Merger Guidelines, *supra* note 24, at 41553.
131. Initial Decision, *supra* note 5, at 144.

attention. One issue of considerable importance to ENH is whether divestiture is proper even if a violation is found. ENH has argued on appeal that it is not and that a less restrictive remedy would suffice. Another issue is whether the ALJ gave sufficient weight to ENH's defense of improved quality of care. The ALJ found that ENH invested $120 million into HPH but did not find that those improvements were merger-specific or justified the price increases of ENH.

In trying to prognosticate how this case might be decided, the discussion above shows that the structural case is weak and the record does not appear to support a finding of a conventional market in which the merged hospitals have a high market share. On the other hand, the price increases and leverage statements provide some evidence of power over price. However, the zinger finding makes it difficult to hold the merger illegal under a unilateral effects rationale. Furthermore, Blue Cross played the role of the "dog that did not bark," further undercutting the market power argument.[132] Overall, the Commission would like to claim a victory to redeem its prosecution record. It also would like to validate its new analytical tools. Thus, it is conceivable that the finding of illegality will be confirmed based on the direct evidence of price increases but that the decision will not order divestiture. In other words, the Commission may craft a compromised decision that accomplishes the FTC's two goals without inviting a further appeal (which an order of divestiture might do). The Commission would probably prefer to avoid a further appeal. In addition, a Court of Appeals might be less accepting of the new analytical tools the FTC has promoted.

WHAT'S NEXT?

The ENH prosecution reveals some of the new weapons that the agencies can be expected to use in future merger cases. Most future cases will not be retrospective challenges[133] and thus there will not be many instances whereevidence of direct anticompetitive effects is an issue. The ENH case reveals some theories that hospital defendants should be prepared to address in future mergers. These include:

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132. *See* SIR ARTHUR CONAN DOYLE, *Silver Blaze, in* THE MEMOIRS OF SHERLOCK HOLMES 22 (Harper & Brothers Publishers 1903) (1893). In this story about the murder of a race horse's trainer, Holmes solves the case in part by deducing that The Scotland Yard detective's theory of the case did not fit:

Gregory (Scotland Yard detective): "Is there any other point to which you would wish to draw my attention?"

Holmes: "To the curious incident of the dog in the night-time."

Gregory: "The dog did nothing in the night-time."

Holmes: "That was the curious incident."

133. *See* Antitrust Modernization Commission, Tentative Recommendations 5 (Jan. 11, 2007) (indicating that the recommendations are tentative), http://www.amc.gov/pdf/meetings/list_of_recommendations_jan_11v3.pdf.

1. Identify the pro-competitive rationale. Because the parties to a merger are required to file their "4c" documents when they file their Hart-Scott-Rodino pre-merger notification form, particular attention should be paid to documents describing the purpose and intent of the transaction. The process must be managed to make sure statements about the purpose of the merger stay on message. The definition of 4c documents is:

> All studies, surveys, analyses and reports which were prepared by or for any officer(s) or director(s) for the purpose of evaluating or analyzing the proposed affiliation with respect to market shares, competition, competitors, markets, potential for sales growth or expansion into product or geographic markets.

At the earliest planning stages, it is important for the hospitals to identify the reasons they are pursuing the transaction, to make sure that the pro-competitive rationale is documented, and to make sure that statements implying anticompetitive motives are avoided. The FTC might never have targeted ENH but for the statements of its administrators and consultants implying that the purpose of the transaction was to gain leverage over MCOs and to increase prices in managed care contracts. While a legal argument can always be made that statements of intent are irrelevant to the structural analysis, a merger is easier to defend without that additional hurdle.

2. Proselytize. Identify in the planning stages what constituencies might object and design a strategy to enlist their support. ENH needlessly confronted, and indeed virtually taunted, the MCOs. Had there been a credible pro-competitive rationale—quality improvements, efficiencies, and so on—MCOs might have been persuaded that they were going to reap the benefits of these gains. Even if ENH was correct to believe its existing MCO contracts were "below market," the timing and size of its increases could have been moderated. The concerns of other constituencies, such as physicians, suppliers, and consumer advocates, should similarly be addressed.

3. Avoid inadvertent descriptions of the market or competitors that overstate the hospital's market share or power in regularly generated reports. "Market" has a particular meaning in antitrust analysis, yet participants in the hospital industry sometimes use that word carelessly. Strategic plans, board reports, Certificate of Need ("CON") applications, objections to a competitor's CON application, and other internally generated documents often describe the supposed geographic market in which the hospital competes, estimate its share of that market, identify its principal competitors, and estimate the market shares of those competitors. These descriptions may be appropriate for the analytical purpose of the given report.

However, they can take on a life of their own when used for a different purpose and can cause mischief.

4. Document competitive initiatives. In the ENH case, the ALJ's Initial Decision seemed to describe a healthcare market that was lopsided, where the hospitals had the whip hand. Only ENH appeared to be making contract demands and initiating changes in reimbursement methodology. MCOs are not powerless. The hospitals should document HMO mergers, contract term changes, carve-outs, dropping hospitals or physicians from the network, employing stricter credentialing processes, etc.

Of course, the hospitals have to be aware of their own competitive initiatives. ENH participated in two prior attempts to consolidate with competing hospitals, and gaining leverage over MCOs was a stated reason in each case. Bargaining positions and statements in MCO negotiations may be seized upon as evidence confirming an expected misuse of market power.

The product market defined by the ALJ in this case assumes that MCOs all want to contract for the full array of inpatient acute care offered by the hospitals and that the MCOs were powerless to resist price increases because they had determined they had to have ENH in their networks. This fails to recognize the power MCOs have to steer patients even within their own networks. To what extent did any MCO steer patients for open heart surgery away from a Chicago area network hospital and send them to the Mayo Clinic, or other out of area providers, by designing financial incentives that promoted the use of a competing cardiac surgery program instead of the local program? To what extent did any MCO threaten to send lab work to a third party, carving it out of the hospital's contract? MCOs have leverage from their ability to steer in this way that arguably neutralizes any leverage of the merging hospitals. These episodes must be identified and documented.

With the demise of CON laws and the expected growth of specialty hospitals, MCOs can be expected to "break the package" and not contract for all the services a hospital offers. This strategy is aimed at obtaining better pricing by carving out some services they would normally turn to full service hospitals to supply. The MCO may get better pricing on the carved out service and it may get better contractual terms on the remaining services through its negotiations with the hospital.

5. Monitor communications with competitors. The coordinated effects type of competitive injury posits collusive activity in the wake of a merger that increases the market share of the merging parties. To what extent have there been communications with competitors in the past and what has been the tenor of those communications? Are there cooperative ventures? With the advent of email, there may be communications on a wide array of subjects that might support an inference that coordination in the future is likely.

6. Rein in the consultants. The 4c documents and any second request will harvest not only the documents of the merging parties, but also those of their consultants and advisers. Mergers are often proposed by advisers who use terms like "leverage" and "dominate" and express the objective of obtaining a "dominant market share" or "control over pricing." Statements like these are magnets for further investigation by the enforcement agencies.

7. Prepare the pro-competitive case and be prepared to disprove the unorthodox elements that the agencies are likely to employ in future challenges. Both the market definitions and the price analysis types of proof should be anticipated, and a solid defense should be constructed showing the weaknesses of both the economic theories and their application. If the parties to a merger want to be sure that they can go forward with their transaction, they should be prepared to take on the agencies in court (or before an ALJ), and they should prepare to litigate as soon as the possibility of a challenge arises.

BLIND MEN AND THE ELEPHANT

The decision by the ALJ in the challenge to the ENH merger accomplished the two main goals of the FTC as set forth by former FTC Chairman Muris. The FTC's Complaint Counsel has a scalp (for the moment), thus stopping a losing streak and gaining the new analytical tools that have been sanctioned by an ALJ. Nevertheless, the result is unsatisfactory. The markets that the FTC alleged, a product market of only the acute inpatient care that is sold to MCOs and a three-hospital triangle geographic market, do not describe an area of effective competition that most people in the hospital industry would recognize. The analytical tools utilized to prove the case are unorthodox and stray from those used in prior cases. The result does not fit comfortably with the reality of this industry.

The product market, limited to services sold to MCOs, is a sliver of the business that hospitals rely on for revenue. Hospitals also provide inpatient care that is reimbursed by Medicare and Medicaid and they provide inpatient charity care. They also provide an extensive amount of outpatient care. Simply put, no hospital provides inpatient acute care only to MCOs. What does that say about the validity of the product market used to justify a challenge leading to divestiture?[134]

The same can be said of the geographic market. The map of competing hospitals makes it clear that there are many alternatives. Neither ENH nor HPH, before the merger, would have described the market in which they

134. *See* United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 137-39 (E.D.N.Y. 1997) (rejecting a product market defined as the bundle of inpatient services provided by anchor hospitals to managed care plans).

competed as the triangle market of Complaint Counsel or the seven-hospital market of the ALJ. Nor would the MCOs. At the end of the day, the prices the FTC has complained about have not been shown to be above competitive levels. To rely on Complaint Counsel's study showing that ENH's price increases were greater than other hospitals' increases in order to show market power and its misuse is akin to a three cushion billiard shot.[135]

Hospitals today face competition from a growing list of competitors. Physicians can and do perform tests in their offices. There are freestanding labs. There are independent imaging centers. The number of specialty hospitals is growing. In an age when people routinely have one-hour commutes from home to work, constructing a geographic market based on sixteen-minute driving times from home seems contrary to reality.

Chairman Muris started off in the right direction when he proposed a study of past hospital transactions that would demonstrate whether transactions challenged in the past resulted in anticompetitive effects.[136] No such study has ever been released. This leaves observers wondering whether there is a valid basis for the merger tools now being advocated as appropriate to measure hospital mergers. The ENH case may not resolve the issues.

Can the analytical tools that the FTC employs give it a clear picture of hospital competition? Or, has the FTC, through its ENH decision, compelled future courts and ALJs to operate like the Blind Men who "prate about an Elephant not one of them has seen."[137]

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135. Three cushion billiard is one of the most difficult variants of billiards requiring the cue ball to carom off the first object ball and then strike three cushions before striking the second object ball.

136. *See* Muris, *supra* note 2.

137. John Godfrey Saxe's poem "The Blind Men and the Elephant," is based on an old Indian fable:

> It was six men of Indostan
> To learning much inclined
> Who went to see the Elephant
> (Though all of them were blind),
> That each by observation
> Might satisfy his mind
> The First approached the Elephant,
> And happening to fall
> Against his broad and sturdy side,
> At once began to bawl:
> "God bless me! But the Elephant
> Is very like a wall!"
> The Second, feeling of the tusk,
> Cried, "Ho! What have we here
> So very round and smooth and sharp?
> To me 'tis mighty clear
> This wonder of an Elephant

Is very like a spear!"
The Third approached the animal,
And happening to take
The squirming trunk within his hands,
Thus boldly up and spake:
"I see," quoth he, "the Elephant
Is very like a snake!"
The Fourth reached out an eager hand,
And felt about the knee.
"What most this wondrous beast is like
Is mighty plain," quoth he;
"'Tis clear enough the Elephant
Is very like a tree!"
The Fifth, who chanced to touch the ear,
Said: "E'en the blindest man
Can tell what this resembles most;
Deny the fact who can
This marvel of an Elephant
Is very like a fan!"
The Sixth no sooner had begun
About the beast to grope,
Than, seizing on the swinging tail
That fell within his scope,
"I see," quoth he, "the Elephant
Is very like a rope!"
And so these men of Indostan
Disputed loud and long,
Each in his own opinion
Exceeding stiff and strong,
Though each was partly in the right,
And all were in the wrong!
Moral:
So oft in theologic wars,
The disputants, I ween,
Rail on in utter ignorance
Of what each other mean,
And prate about an Elephant
Not one of them has seen!