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COMPETITION COMMITTEE**

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Working Party No. 2 on Competition and Regulation

**ROUNDTABLE ON COMPETITION TO PROMOTE EFFICIENCY IN THE PROVISION OF
HOSPITAL SERVICES.**

---United States---

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The attached document is submitted by the delegation of The United States to the Working Party No. 2 of the Competition Committee FOR DISCUSSION under Item III of the agenda at its forthcoming meeting on 17 October 2005.

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1. The competition enforcement agencies of the United States – the Antitrust Division of the Department of Justice and the Federal Trade Commission (“the Agencies”) – have been active in applying competition laws to the health care marketplace, including the hospital industry, for more than two decades.

2. The invitation for written submissions to this roundtable identified a number of issues of interest including: structural conditions in the hospital industry, contracting and competitive mechanisms, and the application of competition law. In this submission, we have focused on these three areas, which are particularly germane to the experience of the United States hospital industry. We describe the market environment in which hospitals in the United States operate, including the competitive and other pressures that hospitals face; the restructuring of the hospital industry that has occurred in recent years, through consolidations, the growth of hospital networks and other developments; and the effect of private payor and government purchasing of hospital services on the hospital marketplace. Finally, we consider the application of competition laws to hospital competition, focusing primarily on merger cases, and discuss a number of issues important to merger law analysis, including market definition, entry, efficiencies, and the non-profit status of hospitals.*

I. INTRODUCTION TO STRUCTURAL CONDITIONS IN THE HOSPITAL INDUSTRY

3. In cities and towns throughout the United States, hospitals are a key part of the health care delivery system. Currently, payments to hospitals for inpatient care account for approximately 31 percent of total health care expenditures in the United States. Expenditures on hospital services have grown over the past two decades, but the rate of spending growth has varied. The federal government’s introduction of a prospective payment system in the early 1980’s (see discussion Section II) slowed the rate of hospital expenditure growth. The rise of private-sector managed care plans slowed the rate of expenditure growth further; from 1993 through 1998, hospital expenditures increased at an average annual rate of 3.7 percent, and, in some areas of the country, the *per diem* price of a hospital stay actually decreased. In the past five years, however, rising hospital prices have driven spending on hospitals higher, even though hospital utilisation is declining.¹ As discussed below, analysts attribute rising hospital prices to a variety of factors, including hospitals’ increasing ability to negotiate higher prices from private payers.²

4. By way of background, hospitals in the United States vary by the types of services they offer, ranging from specialty hospitals that treat only a single type of patient (paediatric and women’s hospitals) or condition (cardiac, orthopaedic, psychiatric and rehabilitation hospitals) to “general acute care hospitals”, which treat a variety of acute medical conditions, excluding treatments such as long term rehabilitation, psychiatric care, or substance abuse care. Hospitals also vary in the sophistication of the services they offer, ranging from the most basic hospital services, to the most sophisticated, cutting edge procedures.

5. Hospitals in the United States are also differentiated by their ownership structure into one of three categories: (1) non-profit (71 percent of hospital beds); (2) for-profit (13 percent of hospital beds); and (3) governmentally owned (or “public”) (16 percent of hospital beds). Although these classifications might appear mutually exclusive and immutable - they are not. Many non-profit hospitals own for-profit institutions or have for-profit subsidiaries. Similarly, for-profit systems often manage non-profit and publicly owned hospitals. Hospitals also may change their institutional status. Even without changing

* Much of the material in this paper is drawn from *Improving Health Care: A Dose of Competition-A Report by the Federal Trade Commission and the Department of Justice* (2004) available at http://www.usdoj.gov/atr/public/health_care/204694.htm.

their status, hospitals that previously have not competed in the marketplace can choose to do so. For example, some states have granted local government's broad authority to determine how public hospitals under their control will be operated. Relying on that authority, public hospitals are increasingly entering into competition with private hospitals.³

II. CONTRACTING AND COMPETITION MECHANISMS

A. *Public Payors*

6. Federal and state governments are responsible for almost 60 percent of payments to hospitals for inpatient care.⁴ A substantial share of hospital spending is provided by the Federal Centres for Medicare & Medicaid Services (CMS), chiefly for care of the elderly. Each state also has a Medicaid program, which pays for care provided to the poor and disabled. Within broad guidelines established by Federal law, each state sets its own payment rates for Medicaid services and administers its own programme.

7. Prior to 1983, CMS and most other insurers paid hospitals on a cost-based reimbursement system. Under the cost-based reimbursement system, hospitals informed payors of the cost of the care that was provided, and payors reimbursed hospitals for those amounts. Although there were some constraints on what a hospital could claim as its costs, the overall result was to increase the volume of procedures performed and discourage efficiency. Additionally, comprehensive health insurance (both private and public) imposed minimal out-of-pocket costs on patients. Thus, insured patients had little incentive to select lower cost procedures or more efficient providers.

8. The cost-based payment system led to substantial increases in health care spending over time. An important initial effort to curb these increases in spending was launched in 1983, when CMS implemented a prospective payment system for inpatient care.

1. *Prospective Payment Systems (Benchmark Competition)*

9. Under the prospective payment system CMS uses for inpatient care (IPPS), the payment that a hospital receives for treating a patient is based on the diagnosis-related group (DRG) that justified the episode of hospitalization. Each DRG has a payment weight assigned to it, based on the average cost of treating patients in that DRG. The average reimbursement for each DRG is derived from an analysis of the costs of treating both the very ill patients who require more intensive care for a particular DRG, and the "healthier" ill, who do not cost as much to treat. All DRGs are adjusted to reflect the wage index of the geographic location of the hospital; in addition, DRG payments are increased for teaching hospitals and for any hospital's treatment of exceptionally ill, "outlier" patients. By receiving a predetermined amount regardless of the actual cost of care of a particular patient, hospitals have an incentive not to use more resources than are necessary to treat any given patient. The IPPS was intended to moderate rising federal expenditures, create a more "competitive, market-like environment, and curb inefficiencies in hospital operations engendered by reimbursement of incurred cost."⁵

10. As with inpatient care, CMS also formerly paid hospitals for outpatient care on a cost-based system. Under the prospective payment system that CMS adopted in 2000 for outpatient care (OPPS), however, hospitals receive a predetermined median cost amount for each outpatient service or procedure, based on which one of the approximately 750 ambulatory payment classifications justified the episode of care. The inpatient IPPS system was designed to control rising inpatient hospital costs and shift more care to the outpatient setting. The OPPS was designed to control rising outpatient costs, and both systems help to constrain costs more effectively than the cost-based systems they replaced.⁶

2. *The Impact of Government Purchasing*

11. CMS has tremendous bargaining power in the market for medical services, and providers are extremely responsive to the signals sent by CMS. Prior to the adoption of the IPPS, average hospital length-of-stay had been stable for seven years. Once IPPS went into effect, the length-of-stay began an immediate decline.

12. There are limitations, however, to CMS's ability to create incentives that encourage price and non-price competition among providers. CMS does not have the freedom to respond to changes in the marketplace as do many private purchasers. For example, CMS has only limited authority to contract selectively with providers or to use competitive bidding to meet its needs. With a few exceptions, CMS cannot require providers to compete for CMS's business or encourage suppliers to reduce their costs and enhance their quality by rewarding them with substantially increased volume or substantially higher payments if they do.

13. One Medicare programme that has generated competitive incentives for providers is a managed care option, the Medicare Advantage (MA) programme. MA programmes provide Medicare beneficiaries with a range of managed care options, including health maintenance organisations and preferred provider organisations. Medicare beneficiaries who have joined MA plans have often received greater benefits (e.g., prescription drug coverage) in exchange for accepting limits on their choice of providers. Nevertheless, these plans are new and have limited acceptance among Medicare participants. In 2002, MA plans (then-called the Medicare + Choice (M+C) plan) provided health care to 5 million Medicare beneficiaries, down from 6.35 million enrollees in December 1999.

14. Generally, however, CMS's payment systems do not reward higher quality care, or punish lower quality care. Indeed the Medicare payment system is said to be largely neutral or negative towards quality. All providers meeting basic requirements are paid the same regardless of the quality of service provided. To be sure, these problems are not unique to Medicare but confront private payors as well. Indeed, the Institute of Medicine noted that "current [compensation] methods provide little financial reward for improvements in the quality of health care delivery, and may even inadvertently pose barriers to innovation."⁷

B. *Private Third Party Payors*

15. The second largest source of payment for hospital services is payments from private health insurance plans. Private health insurance is primarily obtained through benefits offered by employers, but is also available through other types of groups and through individual purchases from insurance companies. These payors are collectively referred to as third-party payors. Included in this category are employers who self insure their employees medical costs, but hire an insurance company to administer the health insurance benefits, including negotiating prices with hospitals for services covered by the employer's plan.

16. Third-party payors typically contract directly with hospitals to provide services to the patients covered under the payors' plan(s), and the prices are negotiated directly between the payor and the hospital.⁸ The most common payment schemes are *per diem* rates, per case rates, or discounts off charges rates. Under a *per diem* rate, the third party payor pays the hospital a fixed price for each day of hospital care without regard to the actual diagnosis of the patient or the resources the hospital uses in the treatment. Under a per case rate, the third party payor pays the hospital a fixed price for the hospital stay for a particular type of case, regardless of the number of days the patient stays or the resources the hospital uses in the treatment. Under a discount off charges rate, also called a percentage-of-charges rate, the third party

payor pays a percentage of the hospital's "charges" for the hospital stay, where the "charges" are the prices the hospital charges for each resource used in treating the patient.

17. In some instances, private payors have copied Medicare's reimbursement strategies or used Medicare DRGs as a reference price for reimbursement negotiations with hospitals. Thus, some payors negotiate either a specified discount or a specified payment relative to the amount CMS would pay for a specified treatment episode. Outpatient payment provisions, where the hospital does not provide an overnight stay for the patient, are typically structured on a percentage-of-billed charges or a fee-schedule basis.

18. Generally speaking, payors seek to contract with hospitals that contribute to the marketability of their insurance products.⁹ Factors that affect marketability include: the price of coverage; the number of hospitals at which care can be provided; the perceived quality, desirability, and accessibility of those institutions; and the alternative insurance products that are available in the market. Payors seek to balance the price of the hospital services they must purchase to offer insurance coverage against the desirability of the resulting network to the purchasers of their insurance products. If patients view several hospitals as adequate substitutes for one another, it will be easier for the payor to threaten credibly to exclude one or more of these hospitals. Conversely, if enrollees will drop an insurance plan if their preferred hospital is no longer in its network, the hospital will find it easier to insist on higher reimbursement.

1. Consumer Price Sensitivity and Information

19. The lack of consumer information about the costs of hospital services and lack of incentives for the consumer to choose the most cost effective hospital makes it more difficult for payors to exclude high-priced, but otherwise desirable hospitals from the payors health plans. Insured consumers often have only a vague idea of the price of the medical services they receive, because insurance largely insulates them from the financial implications of their medical treatment.¹⁰ Consumers who pay the same co-payment, regardless of the price of the treatment they receive, have no reason to inquire into the price of the treatment, or to factor that price into their decisions. Consumers who have co-payments that vary depending on where they receive care will focus on the differing amounts of the co-payment, but not on the total price of the services they receive. Even if consumers become motivated to know the total price of the care they receive, they will find it extremely difficult to obtain that information.¹¹ Proposals to increase consumer price sensitivity must confront this reality, and develop strategies to increase the transparency of hospital pricing.¹²

2. Hospital Tiering – A Competitive Response to Market Conditions

20. Consumer pressure for broader or open networks has made it more difficult for payors to exclude an entire hospital system from their plans outright; this affects the bargaining dynamics. In a few markets, payors have responded by seeking to "tier" hospitals. Tiering is a payor reimbursement method whereby consumers incur different co-payments (*i.e.*, high or low cost sharing) depending on the hospital at which the consumer chooses to have care provided. Tiering generally does not apply to emergency admissions and may depend upon where routine and specialty services are offered.

21. For payors, tiering offers a potential response to multi-hospital system pressure for inclusion of all system hospitals within a payor network. Tiering allows the payor to maintain a broad network, and include a "must-have" hospital in its plans, but simultaneously creates an incentive for consumers to use lower-cost providers. Some hospitals resist tiering, and with sufficient bargaining power, they can credibly threaten to withdraw from a payor network if they are placed in an unfavourable tier. In some markets, hospital systems have taken pre-emptive steps to negotiate contract language with payors that prohibit

tiering. Because tiering is a relatively new development, there are, as yet, no systematic studies available on the prevalence or consequences of this strategy.

3. *“Any Willing Provider” Laws*

22. An important parameter in hospital/payor contracting practices in many states has been the presence in those states of so-called “any willing provider” or “freedom of choice” laws. Any willing provider (AWP) laws require managed care companies to include in their networks any provider that is willing to participate in the plan in accordance with the plan’s terms.¹³ Freedom of choice (FOC) laws are similar to AWP laws, but are directed at consumers instead of providers. FOC laws prohibit payors from denying coverage to an insured for using any licensed provider that the patient chooses. Many states have adopted some form of AWP and/or FOC laws.¹⁴

23. The staff of the FTC has repeatedly expressed concerns about AWP and FOC laws, noting that they could have anticompetitive effects and harm consumers.¹⁵ These laws can make it more difficult for health insurers to negotiate discounts from providers in exchange for the higher patient volume that otherwise likely would result from restricted provider networks. They can also limit competition, by restricting the ability of insurance companies to structure different plans with varying levels of choice in response to consumer demand. These restrictions on competition may result in insurance companies paying higher fees to providers, which in turn generally results in higher premiums, and may increase the number of uninsured Americans.

24. As Commission staff explained in one of its advocacy letters on this issue,

Empirical evaluations of any willing provider and “freedom of choice” provisions indicate that these policies result in higher health care expenditures. One study found that states with highly restrictive any willing provider/freedom of choice laws spent approximately 2% more on healthcare than did states without such policies. This finding likely reflects the fact that these laws reduce the ability of insurers to offer less expensive plans with limited provider panels.¹⁶

III. RESTRUCTURING OF THE HOSPITAL INDUSTRY

A. Background on the Consolidation Trend

25. Over the past 25 years, hospitals have been consolidating into multi-hospital systems.¹⁷ While in 1979, only about 31 percent of hospitals were part of a multi-hospital system, by 2001 almost 54 percent of hospitals operated as part of a system, with an additional 12.7 percent in looser health networks. Initially, consolidations involved national systems acquiring hospitals throughout the United States, but recent acquisitions have been more localised.¹⁸ Consolidation can occur over a broad spectrum of possibilities. At one end of the spectrum, consolidating hospitals may have a shared license and common ownership; reports unified financial records, and eliminate duplicative facilities. At the other end, a common governing body may own the consolidating hospitals, but the hospitals maintain separate hospital facilities, retain individual business licenses, and keep separate financial records.

26. Some observers of the hospital industry assert that hospital consolidations have provided opportunities for hospitals to compete more efficiently, improve the quality of care, and limit duplication of services or administrative expenses. Others, including many payors, believe that important motivations for the creation of multi-hospital systems have been hospitals’ desire to gain market power, secure higher reimbursement from payors, and impose other onerous requirements on payors, e.g., “all-or-nothing” contracting. The development of hospital networks, through common ownership of, or other affiliations

among, hospitals may play a significant role in the evolution of hospital markets. If the hospital networks formed do not include significant integration among the member hospitals, for example, if they are simply “virtual networks,” with no integration or real common ownership, and formed merely to set prices collectively, they run the risk of being challenged as illegal combinations under the antitrust laws. Most studies of the relationship between competition and hospital prices generally find that increased hospital concentration is associated with increased prices.¹⁹

B. Certificate of Need (CON) Programs – Entry Limitations

27. A factor influencing the restructuring of the hospital industry has been the presence or absence of certification of need (CON) laws or regulations in particular states. CON programmes, which initially were adopted at a time that cost-plus reimbursement was the norm, were intended to control costs by restricting provider capital expenditures. State CON programs generally prevent firms from entering certain areas of the health care market unless they can demonstrate to state authorities that there is an unmet need for their services. Upon making such a showing, prospective entrants receive from the state a CON allowing them to proceed.²⁰

1. Competitive Concerns Raised by CON Programs

28. CON regimes prevent new health care entrants from competing without a state-issued certificate of need, which is often difficult to obtain. Their effect is to shield incumbent health care providers from new entrants. As a result, CON programs may actually increase health care costs, as supply is depressed below competitive levels. Moreover, CON programs can retard entry of firms that could provide higher quality services than the incumbents. By protecting incumbents, CON programs likewise can delay the introduction and acceptance of less costly, innovative treatment methods. Similarly, CON programmes curtailing of services or facilities may force some consumers to resort to more expensive or less-desirable substitutes, thus increasing costs for patients or third-party payers. Empirical studies confirm that CON programmes generally fail to control costs and can actually lead to increased prices.²¹

2. CON and Cost Control

29. Commentators note that the reason that CON restrictions have been ineffective in controlling costs is that they do not put a stop to supposedly unnecessary expenditures but merely redirect any such expenditure into other areas. Thus, a CON rule that restricts capital investment in new beds does nothing to prevent hospitals from adding other kinds of high-tech equipment and using them to compete for consumers.

30. Furthermore, CON programmes can provide hospitals with a forum in which to engage in anticompetitive conduct. For example, the Justice Department recently charged two competing West Virginia hospitals with using the CON programme of their state as a mechanism for developing an illegal service allocation agreement, in which one hospital agreed not to offer cardiac surgery in return for the other hospital not offering cancer services.²²

31. For all these reasons, the Agencies believe that CON programmes are generally not successful in containing health care costs and can pose anticompetitive risks. Therefore, the Agencies have urged states with CON programmes to reconsider whether the continuation of such programs best serves their citizens’ health care needs.

C. Development of Specialty Hospitals and Ambulatory Surgery Centres

1. Specialty Hospitals

32. Specialty hospitals are not new to the hospital industry; paediatric, rehabilitation, and psychiatric hospitals have existed for decades. More recently, specialty cardiac and orthopaedic surgery hospitals have opened. These newer, single-specialty hospitals (SSHs) differ from their predecessors in that many of the physicians who refer patients to them have an ownership interest in the facility. SSHs may compete with both inpatient and outpatient general hospital surgery departments as well as with ambulatory surgery centres.

33. There still are relatively few SSHs. In 2003, the General Accounting Office (GAO) identified 100 existing SSHs with an additional 26 under development. SSHs are located in 28 states, but two-thirds are located in only seven states.²³ The GAO concluded that “the location of specialty hospitals is strongly correlated to whether [the CON programmes of] states allow hospitals to add beds or build new facilities without first obtaining state approval for such health care capacity increases.”²⁴ Observers have identified a number of market developments that have encouraged the emergence of SSHs, including: less tightly managed care, the willingness of providers to invest in an SSH, physicians’ desire to “provide better, more timely patient care,” physicians looking for ways to supplement declining professional fees, and the growth of health care provider entrepreneurs.

34. Among the asserted benefits of SSHs are achieving better outcomes and important disease management and clinical standards, as a result of focusing on a single area of medical specialty and performing increased volumes of procedures. Critics of SSHs, however, note that some SSHs do not provide emergency departments and thus avoid the higher costs of trauma treatment and indigent care. Such critics believe this gives SSHs an unfair competitive advantage over 24-hour hospitals with emergency departments. A 2003 GAO study analysed whether SSHs provided care to Medicare and Medicaid patients. The study found that there were modest differences between the percentage of Medicare and Medicaid patients who received treatment at general hospitals and SSHs.²⁵

35. Other critics of SSHs are concerned that SSHs would siphon off the most profitable procedures and patients, leaving general hospitals with less money to cross-subsidise other socially valuable, but less profitable, care. Still others suggest that physicians with an ownership interest in an SSH have an incentive to over-refer patients to that facility to maximise their income. In 2004 a moratorium was imposed on Medicare payments to SSHs, and Congress mandated that the cost structure of specialty hospitals and their effect on community hospitals be studied. Under the moratorium, physicians were not allowed to refer Medicare patients to a specialty hospital in which they had an ownership interest, and Medicare may not pay specialty hospitals for any services rendered as a result of a prohibited referral.

36. In early 2005, the MedPAC and CMS published the reports that Congress had instructed them to prepare, regarding physician-owned specialty hospitals.²⁶ Following these reports, CMS continued the Medicare reimbursement moratorium on new specialty hospitals until 2006, so that it would have an opportunity to determine whether Medicare reimbursement rates for certain procedures may have unwarrantedly encouraged the development of physician-owned specialty hospitals.²⁷

37. In addition, the MedPAC Report found that although the industry is in its early stage, physician-owned specialty hospitals thus far do not appear to have lowered the costs for treating Medicare patients. It also concluded that, although specialty hospitals generally treat patients having less severe illnesses than patients treated in community hospitals, they have had limited impact on community hospitals.²⁸ The CMS Report found that specialty hospitals provide a high level of quality of care; the total proportion of net revenue that specialty hospitals devoted to uncompensated care and taxes combined exceeded the

proportion of net revenues that tax-exempt community hospitals devoted to uncompensated care; and “the notion that specialty cardiac hospitals are transferring more severely ill patients to general hospitals is not supported.”²⁹

38. General hospitals have reportedly reacted to the emergence of SSHs in a number of ways. Some general hospitals have established their own specialised single-specialty wings or partnered with physicians on their medical staff to open SSHs. Other general hospitals have reacted with actions targeted at the SSH’s physicians, such as removing those physicians from on-call rotation; making it more difficult for them to schedule surgeries; and limiting their access to operating rooms and ability to take on “extra assignments” to augment their professional fees. General hospitals also have used CON laws to encumber specialty hospital entry.

2. *Ambulatory Surgery Centres*

39. Ambulatory surgery centres (ASCs) perform surgical procedures on patients who do not require an overnight stay in the hospital. Approximately half of ASCs are single-specialty. Single-specialty ASCs generally specialise in gastroenterology, orthopaedics, or ophthalmology. Most ASCs are small (two to four operating rooms). ASCs’ ownership structures vary: some are completely physician owned; some are owned by joint ventures between physicians and companies; some are owned by physician/hospital joint ventures; and some are owned by hospitals and hospital networks. Innovations in technology have made it possible to offer a broad range of services in ASCs.

40. ASCs require less capital than SSHs, and are generally less difficult to develop because they do not require the facilities or support services needed to offer care twenty-four hours a day, seven days a week. ASCs generally do not have emergency departments, and CON regulations, if they apply at all, often are not as rigorous for ASCs. ASCs were originally intended to compete with hospital inpatient units, but they now compete more against hospital outpatient surgery units. The number of ASCs has doubled in the past decade, and they currently total more than 3,000. ASC development was encouraged by many of the same factors that spurred the growth of specialty hospitals.

41. Many of the concerns expressed about SSHs have also been expressed about ASCs. In general, critics assert that ASCs are eroding the outpatient market share of hospitals; they do not care for Medicaid beneficiaries; they “cherry-pick” the patient base, focusing on the more profitable procedures and the better-insured patients; and they only enter areas where business is profitable. It also appears that many of the actions taken to curb the entry of specialty hospitals are also being employed against ASCs. For example, hospitals have engaged in legislative efforts to encumber ASCs with unnecessary regulations and mandatory services. Consistent with the First Amendment, antitrust law does not typically prevent hospitals from lobbying state governments, either unilaterally or collectively, in connection with CON proceedings. In addition, the antitrust laws would not, in most instances, prevent individual hospitals from unilaterally responding to SSH or ASC competition by, for example, terminating physician admitting privileges. If there is specific evidence of anticompetitive conduct by an individual hospital or of hospitals acting together against SSHs or ASCs, then the Agencies will aggressively pursue those activities.

IV. HOSPITAL MERGER ANALYSIS

A. *Overview*

42. While the Agencies have wide jurisdiction over anticompetitive conduct in the hospital industry,³⁰ Most of the cases brought by the Agencies have involved mergers. For this reason, this section will focus on hospital mergers. Because preservation of hospital competition is vital to health care cost

containment, both Agencies maintain vigorous enforcement programs to scrutinise hospital mergers for their potential effects on competition. The Agencies have a long history of such scrutiny, which has on occasion led to the challenge of particular hospital mergers. Most hospital mergers and acquisitions, however, do not present competitive concerns.

43. The Agencies analyse hospital mergers using the same analytical framework they use for other mergers, following the *1992 Horizontal Merger Guidelines* (“*Merger Guidelines*”). The *Merger Guidelines* specify that “mergers should not be permitted to create or enhance market power or to facilitate its exercise.”³¹ In applying the *Merger Guidelines* to hospital mergers particular issues have arisen with respect to the definition of the product and geographical market. In addition, some questions have been raised about whether the non-profit ownership structure of many hospitals should alter the *Merger Guidelines* analysis.

B. Product Market Definition

44. The *Merger Guidelines* provide the framework for defining the relevant product market for hospital services. The product market has typically been defined as a broad group of medical and surgical diagnostic and treatment services for acute medical conditions where the patient must remain in a health care facility for at least 24 hours for recovery or observation.³² This broad grouping makes sense because, from the perspectives of payors and patients, inpatient services are complementary and bundled. Even if inpatient hospital prices are increased, patients and payors cannot separate and outsource nursing care, diagnostic tests, and room and board from the other treatments provided as part of a hospital stay.

45. Over the past twenty years, many hospital merger cases have considered and rejected outpatient services as part of the relevant product market for hospitals.³³ Commentators agree that providers of outpatient services, such as physicians’ offices, urgent care centres, and ambulatory surgery centres, should generally not be included in the product market definition for hospital services.

46. In the future, it is likely that the Agencies will have to determine whether certain specialty hospitals should be included in an inpatient product market for particular proposed hospital mergers. Historically, the narrow scope of services provided by various specialty hospitals (children’s, psychiatric, Veterans Administration, military, and rehabilitation) justified their exclusion from the product market in analysing mergers of general acute care hospitals.³⁴ In recent years, specialty hospitals focusing on cardiac or orthopaedic care have emerged in numerous locations. General acute care hospitals view these specialty hospitals as competitors in the provision of such services.

47. Some also have suggested approaches for defining an inpatient hospital product market more narrowly. Instead of treating acute inpatient treatment as an aggregated group, some suggest the possibility of grouping diagnosis related groups (DRGs) together, based upon the types of diseases and medical conditions treated. Or if more specialised medical procedures raise greater competitive concerns than do primary care services, the product market may include only a specific service or limited number of services. Similarly, it is possible that some mergers may involve hospitals with distinct attributes, such as strong expertise in one or more specific specialities, so that health plans would need to include one of them to make their networks acceptable to consumers. In such cases, a separate product market analysis, focusing on such “must have” or anchor hospitals, may be justified.³⁵

C. Geographical Market Definition

48. The Agencies define hospital geographical markets using the framework set forth in the *Merger Guidelines*. Although there is widespread agreement on the basic theory, there is much controversy on the

specifics of how to define relevant geographical markets for hospitals. Some advocate using the *Elzinga-Hogarty* test and critical loss analysis while others offer alternative analytical techniques and evidentiary sources.³⁶ In addition, direct evidence of anticompetitive effects may make it unnecessary to define a relevant geographical market. For example, consummated merger cases may present opportunities to assess competitive effects without using detailed market definitions.³⁷

49. Since 1995, the Agencies have lost several hospital merger cases because the courts accepted the merging parties' reliance on patient flow data to define the geographic market much more broadly than the plaintiff Agency alleged.³⁸ Patient flow data is data maintained by each hospital showing the zip (postal) code of origin of each patient admitted to the hospital for inpatient care. Analysis of patient origin data for all of the hospitals in a geographical area can reveal the area from which the hospitals draw various percentages of their patients, as well as calculate the percentage of patients living in the geographical area who are admitted to hospitals outside the area. Many believe that judicial acceptance of implausibly large geographical markets relying too heavily on patient flow data, has led to judicial approval of mergers that would not be permitted in other industries, and thus to the lessening of competition in hospital services markets.

50. Most commentators agree that it is not appropriate to use patient flow data uncritically as the sole basis for defining the geographical market. They agree that no one piece of information is sufficient to define a hospital's geographical market. In essence, these commentators hold that the courts should apply the *Merger Guidelines*' hypothetical monopolist test in hospital merger cases, just as they do in merger cases involving other industries and products. The question is *how* to implement the hypothetical monopolist test, and what analytical frameworks and evidence should be used to do so.

51. One important analytical framework for defining hospital geographical markets that has been offered is built on the observation that hospital competition is a two-stage process. In the first stage, hospitals compete to be included in the networks of health plans. At this point, health plans are the buyers, and prices may be constrained if a health plan can credibly threaten to, or actually, exclude the merging hospitals from its provider network and divert patients to alternative hospitals. In defining the geographical market for this first stage of competition the focus is on hospital locations, not patient locations. Once a hospital is in the plan's network or in some cases even if it is not, the hospitals then compete at the second stage - for individual patients. Other proposed alternative approaches to geographic market definition in this sector include a formal demand analysis model that would require data on patient and hospital characteristics in addition to the patient origin and destination data traditionally used.

52. There are numerous additional sources of evidence that could be used to help to establish the geographical market for hospital services. These sources include types of evidence typically assessed in non-hospital merger cases: strategic planning documents and testimony from the merging parties and their competitors, and documents and testimony from major purchasers of services from the merging parties - here, third-party payors.

D. *The Impact of Non-profit Status*

53. The significance of a hospital's institutional form (non-profit versus for-profit) to competition analysis has been a long-disputed issue in hospital merger cases, and the subject of a number of empirical studies. In antitrust merger analysis the relevant question is not whether non-profit hospitals behave in a manner indistinguishable from for-profit institutions, but whether they would use merger-created market power in ways harmful to consumers. Some courts and analysts have taken the position that even if non-profit hospitals achieve market power through merger, their long-term public interest missions will prevent

them from raising prices above competitive levels. The best current empirical evidence, however, indicates that nonprofits will exercise market power when given the opportunity to do so.³⁹

E. Efficiencies Claims for Consolidations

54. Merging hospitals often claim that their merger will produce significant efficiencies. Claimed efficiencies often include avoidance of capital expenditures, consolidation of management and operational support jobs, consolidation of specific services to one location (e.g., all cardiac care at Hospital A and all cancer treatment at Hospital B), and reduction of operational costs, such as purchasing and accounting costs.

55. Scholars have conducted numerous studies on the effect of hospital mergers on hospital costs.⁴⁰ The results are mixed: Some studies have found that merged hospitals enjoy lower costs (or lower rates of cost increase) than non-merging hospitals; others have found no differences in cost experience between merging hospitals and otherwise similar non-merging facilities. Even if a hospital merger is likely to create efficiencies, however, to pass antitrust muster those efficiencies must be sufficient to reverse a hospital merger's potential to lead to price increases.

56. In several merger cases, hospitals have signed "community commitments" or agreements with state attorneys general, promising not to raise prices for a specified period of time or promising to pass on to consumers a specified amount of money from claimed efficiencies.⁴¹ Some state attorneys general have signed these agreements in an attempt to translate claimed merger-induced cost savings into actual price reductions to consumers. Community commitments are temporary and do not solve the underlying competitive problem when a hospital merger has increased the likelihood that market power will be exercised.⁴² Community commitments represent a regulatory approach to what is, at bottom, a structural market problem -- and that problem will remain after the commitment has expired. Therefore, the Agencies do not endorse community commitments as an effective resolution to likely anticompetitive effects from a hospital (or any other) merger.

F. A Summary of the Agencies' Hospital Merger Challenges

57. The Agencies prevailed in some early challenges to hospital mergers,⁴³ and also obtained a number of consent decrees, allowing multiple hospital mergers to proceed, subject to requirements that certain hospitals be divested.⁴⁴ However, more recently courts have rejected the Agencies' (and state attorneys' general) attempts to prevent mergers between hospitals that the Agencies claimed would reduce competition.⁴⁵

58. Focusing solely on litigated cases, however, obscures the larger picture of the Agencies' overall enforcement agenda. The Agencies are sometimes able to obtain relief without trials, as when the hospitals agree to a settlement or abandon the transaction.⁴⁶ For example, the Antitrust Division's investigation of the merger of two hospitals in Cape Girardeau, Missouri, led, in part, to the hospitals deciding not to merge.⁴⁷ The Cape Girardeau matter also reflects the continuing efforts of the Agencies to prevent anticompetitive hospital mergers, an effort currently reflected in the FTC's challenge to the Evanston hospital merger.

59. In 2004, the Federal Trade Commission issued a complaint against Evanston Northwestern Healthcare Corporation (ENH), an organisation that owns three hospitals in the Chicago, Illinois suburbs.⁴⁸ The Complaint alleges that, in January 2000, ENH, which was then a two-hospital system, merged with a third hospital, Highland Park Hospital. According to the complaint, following the merger, ENH negotiated

uniform prices for the three hospitals, and raised prices. The Complaint further alleges that ENH raised prices far above the price increases at comparable area hospitals.

60. The three hospitals that formed ENH after the merger form a geographical triangle in the northern suburbs of Chicago, a relatively affluent area. There are no other hospitals within the triangle formed by the three ENH hospitals, but there are hospitals outside of the triangle, including hospitals relatively close to each of the three ENH hospitals. The geographical triangle defined by the locations of the three ENH hospitals did not satisfy the kinds of tests that courts had previously used to define geographical markets in hospital merger cases.

61. This Complaint is a marked departure from the previous Agency actions regarding hospital mergers. In the other cases, the Agencies attempted to prevent the consummation of mergers that they alleged would lead to a diminution of competition. In this case, suit was filed over four years after the merger, and the Complaint seeks to undo a merger that had long been consummated.

62. The Complaint against ENH was tried before an Administrative Law Judge (ALJ) in the winter and spring of 2005. The current scheduling order calls for the ALJ to issue his decision by mid October, 2005, although if the ALJ needs more time, he may grant himself an extension.

V. CONCLUSION

63. The appropriate competition policy with respect to hospitals, and particularly hospital mergers, has not been settled by the courts. While the *Evanston* case may bring some answers it is unlikely to be the final answer. At the same time the hospital industry in the United States continues to evolve, as does public policy toward paying the hospital costs of an aging population. The move to prospective payments systems is unlikely to be the final change in government payment programmes to hospitals. Government programmes and institutional relationships are likely to continue to change as new programmes are developed and tested. The goal is the availability of efficiently provided high quality hospital care. The industry and its customers continue to look for ways to achieve this goal.

ENDNOTES

- ^{1/} See Bradley C. Strunk & Paul B. Ginsburg, *Tracking Health Care Costs: Trends Turn Downward in 2003*, 2004 Health Affairs (Web Exclusive) W354, 356-57 (spending on hospital inpatient care per privately insured person rose 6.5 percent; spending on hospital outpatient care per privately insured person rose 11 percent), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.354v1>.
- ^{2/} See Katharine Levit *et al.*, *Health Spending Rebound Continues in 2002*, 23 Health Affairs 147, (Jan. /Feb. 2004) at 154-55. See also Strunk & Gisburg, *supra* note 1, at W357 (“This trend is consistent with qualitative research, which has showed that many hospitals solidified their negotiating leverage over plans during 2002 and 2003 and continued to use their formidable power to demand large payment rate increases.”)
- ^{3/} Authorising healthcare statutes in several states, including Michigan, Kentucky and Ohio, have granted local governments the broad power to operate hospitals. M.C.L.A. sections 331.1301(g) *et seq.*; (KRS section 216.335(6)); and Ohio (R.C. section 339.06)(boards of municipal hospital corporations in Ohio “shall have the entire management and control of the hospital, and shall establish such rules for its government and the admissions of persons as are expedient”). The purpose behind many of these broad grants of authority has been to remove the legal constraints upon the operation of public hospitals that inhibit their ability to compete with private hospitals. See, e.g., *Surgical Care Ctr. of Hammond v. Hospital Serv. Dist. No. 1 of Tangipahoa Parish*, 171 F.3d 231, 235 (5th Cir. 1999) (en banc) (Louisiana statutes granted additional powers to hospital service districts so they could compete with other entities on a level playing field); *Jackson, Tenn. Hosp. Co. v. West Tenn. Healthcare, Inc.*, 414 F.3d 608, 610 (6th Cir. 2005) (Tennessee statutes intended to remedy a competitive disadvantage of some public hospitals by removing certain legal constraints upon their operations and giving them the same operating and organizational powers enjoyed by private hospital authorities).
- ^{4/} See Levit, *supra* note 2, at 154. Because private insurance tends to cover a younger and typically healthier population, it accounts for a smaller share of overall health care spending.
- ^{5/} Gregory C. Pope, *Hospital Nonprice Competition and Medicare Reimbursement Policy*, 8 J. HEALTH ECON. 147 (1989) DAF/COMP/WP2/WD(2005)71).
- ^{6/} See Centers for Medicare & Medicaid Services, *Program Information on Medicare, Medicaid, SCHIP, and Other Programs*, § 1, at 18 (June 2002), at <http://www.cms.hhs.gov/charts/series/sec1.pdf>.
- ^{7/} Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* 193 (2001).
- ^{8/} Contracting between hospitals and private payors has sometimes been contentious. Some hospital industry observers claim that hospital systems routinely “terminate then negotiate” for large increases in reimbursement, and use the media to scare the public. They also state that hospital systems insist that all hospitals in the system be included in a payor network (“all or nothing contracts”), irrespective of whether the payor actually wants to include the entire hospital system. Hospital representatives claim that they are protecting their institutions’ interests and that their services had been artificially and unsustainably underpriced in the past. These dynamics have played out in several markets in the past few years. Although commentators have noted that particular hospitals and hospital systems seem to have the upper hand in some markets, whether hospitals or health plans have bargaining advantages varies substantially within and among different markets.
- ^{9/} See generally Gregory Vistnes, *Hospital, Mergers and Two Stage Competition*, 67 ANTITRUST L. J. 671, 674 (2000). A marketable network is one that is not too expensive and includes hospitals that enrollees and plan physicians want. Complex rules can make a plan less marketable.
- ^{10/} Herbert Simon, *A Behavioral Model of Rational Choice*, in MODELS OF MAN (1957).

- ^{11/} See Uwe E. Reinhardt, *Can Efficiency in Health Care Be Left to the Market?*, 26 J. HEALTH Pol., Pol'y & L. 967, 986 (2001) (“[O]ne need only imagine a patient beset by chest or stomach pain in Anytown, USA, as he or she attempt to ‘shop around’ for a cost-effective resolution to those problems. Only rarely, in a few locations, do American patients have access to even a rudimentary version of the information infrastructure on which the theory of competitive market and the theory of managed care rest. The prices of health services are jealously guarded proprietary information.”).
- ^{12/} Medical savings accounts represent a recent attempt to require consumers to bear some of the increased expenses associated with receiving care at a more expensive hospital. A medical savings account provides the consumer with a fixed sum of money to pay for the consumer’s portion of their healthcare costs. If, in any given year, the consumer does not use all of the money, the consumer retains the money for future use. Medical savings accounts attempt to raise consumer sensitivity to the costs associated with their health care decisions. For this strategy to work effectively, however, consumers need access to good information about the price and quality of the services they must choose between. Without good information about the actual prices charged by different hospitals, a consumer facing a 25 percent co-payment at one hospital and a 15 percent co-payment at another cannot accurately assess the financial consequences of choosing one hospital over the other.
- ^{13/} Michael Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of ‘Any Willing Provider’ Regulations*, 20 J. HEALTH Econ. 955, 956 (2001).
- ^{14/} See, e.g., *id.* (“By one count, 34 states had enacted some form of FOC or AWP law by 1996”).
- ^{15/} See FTC staff comments on proposed legislation that incorporated any willing provider or “freedom of choice” provisions in the following states: Rhode Island (Letter from Office of Policy Planning et al., to Patrick C. Lynch, Attorney General (Apr. 8, 2004)), at <http://www.ftc.gov/os/2004/04/ribills.pdg>; Massachusetts (Letter from Bureau of Competition, to John C. Bartley, Representative (May 30, 1989)); New Hampshire (Letter from Office of Consumer & Competition Advocacy, to Paul J. Alfano (Mar. 17, 1992)); California (Letter from Office of Consumer & Competition Advocacy, to Patrick Johnston, Senator (June 26, 1992)), at <http://www.ftc.gov/opa/predawn/F93/calpharm.htm>; Montana (Letter from Office of Consumer and Competition Advocacy, to Joseph P. Mazurek, Attorney General (Feb. 4, 1993)); New Jersey (Letter from Office of Consumer and Competition Advocacy, to E. Scott Garrett, Assemblyman (Mar. 29, 1993)); Pennsylvania (Letter from Office of Consumer and Competition Advocacy, to Roger Madigan, Senator (Apr. 19, 1993)); South Carolina (Letter from Office of Consumer and Competition Advocacy, to Thomas C. Alexander, Representative (May 10, 1993)); and Nevada (Letter from Bureau of Competition, to David A. Gates, Commissioner of Insurance (Nov. 5, 1986)).
- ^{16/} See, e.g., FTC Staff letter to Rhode Island, *supra* note 15 at 6. See also Michael A. Morrissey & Robert L. Ohsteldt, *Do State ‘Any Willing Provider’ and ‘Freedom of Choice’ Laws Affect HMO Market Share?*, 40 INQUIRY 362 (2003/2004).
- ^{17/} Deborah Haas-Wilson, *Managed Care and Monopoly Power: The Antitrust Challenge* 28 (2003). See also Deborah Haas-Wilson & Martin Gaynor, *Increasing Consolidation in Healthcare Markets: What Are the Antitrust Policy Implications?*, 33 Health Services Res. 1403 (1998) (“Healthcare providers and insurers have been aligning in a plethora of coalitions as mergers, networks, joint ventures, and contracts have developed and dissolved with great rapidity. The implications of this reorganization for healthcare competition, and thus for costs, quality, and innovation, are profound. The key questions are to what extent these changes enhance efficiency and quality, and to what extent they facilitate collusion and market power.”); Martin Gaynor & Deborah Haas-Wilson, *Change, Consolidation and Competition in Health Care Market* 19 (Nat’l Bureau of Econ. Research, Working Paper No. 6701, 1998) (“The most extensive research evidence on competitive conduct by firms in health care markets is on hospitals; Dranove and White (1994) offer an extensive survey. These studies use differing product and geographic market definitions and research methods, yet the consistency of the results is striking. Increased concentration is associated with increased prices in markets for hospital services.”), available at <http://papers.nber.org/papers/w6701.pdg>.

- ^{18/} David Dranove & Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22 J. Health Econ. 983, 984 (2003); Alison Evans Cuellar & Paul J. Gertler, *Trends in Hospital Consolidation: The Formation of Local Systems*, 22 Health Affairs 77, 80 (Nov./Dec. 2003).
- ^{19/} David Dranove et al., *Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition*, 36 J.L. & Econ. 179, 201 (1993) (finding that market concentration in California led to rate increases); Glenn A. Melnick et al., *The Effect of Market Structure and Bargaining Position on Hospital Prices*, 11 J. Health Econ. 217 (1992) (finding market concentration appears to increase hospitals' bargaining power with insurers and self-insurers); Ranjan Krishnan, *Market Restructuring and Pricing in the Hospital Industry*, 20 J. Health Econ. 213, 215 (2001) (mergers that increase hospital market share in specific hospital services, as measured 33 DRGs, show a corresponding increase in prices of those services).
- ^{20/} See John Miles, 2 Health Care & Antitrust Laws: Principles and Practice § 16:1, at 16-2, 16-5 to 16-6 (2003); James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 Utah L. Rev. 3; Randall Boybjerg, *The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 Utah L. Rev. 83; Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 Va. L. Rev. 1143 (1973).
- ^{21/} See Daniel Sherman, Federal Trade Comm'n, *The Effect of State Certificate-of-Need Laws On Hospital Costs: An Economic Policy Analysis* (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data, that strong CON programs do not lead to lower costs but may actually increase costs); Monica Noether, Federal Trade Comm'n, *Competition Among Hospitals 82* (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); Keith B. Anderson & David I. Kass, Federal Trade Comm'n, *Certificate of Need Regulation of Entry into Home Health Care: A Multi-Product Cost Function Analysis* (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale).
- ^{22/} Press Release, U.S. Department of Justice, "Justice Department Requires Two West Virginia Hospitals To End Illegal Market-Allocation Agreements" March 21, 2005, available at http://www.usdoj.gov/atr/publis/press_releases/2005/208209.htm.
- ^{23/} U.S. General Accounting Office, GAO-04-167, *Specialty Hospitals: Geographic Locations, Services Provided and Financial Performance 3-4* (2003) (Report to Congressional Requesters) [hereinafter GAO, *Specialty Hospitals*], at <http://www.gao.gov/new.items/d04167.pdg>. The seven states are Arizona, California, Texas, Oklahoma, South Dakota, Louisiana, and Kansas. Of those seven states, only three (Texas, Oklahoma and Arizona) require all hospitals to have an emergency room. *Id.*
- ^{24/} *Id.* at 15.
- ^{25/} *Id.* at 18. There were larger differences in the frequency of emergency departments (ED) at SSHs and general hospitals. In particular, 92 percent of general hospitals had an ED, but by contrast 72 percent of cardiac hospitals, 50 percent of women's hospitals, 39 percent of surgical hospitals, and 33 percent of orthopedic hospitals had an ED. *Id.*
- ^{26/} Report to The Congress, *Physician-Owned Specialty Hospitals* (March 2005) ("MedPAC Report"), available at www.medpac.gov/publications/congressional_reports/Mar05_SpecHospitals.pdf; CMS, *Study of Physician-Owned Specialty Hospitals Required In Section 507©)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003* ("CMS Study"), available at <http://www.cms.hhs.gov/media/press/files/052005/RTC-StudyofPhysOwnedSpecHosp.pdf>.
- ^{27/} Fact Sheet, *CMS Outlines Next Steps As Moratorium On New Specialty Hospitals Expires* (June 9, 2005), available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1478>.
- ^{28/} MedPAC Report at vii.

^{29/} CMS Study at 62-63.

^{30/} With some minor exceptions, the Federal Trade Commission does not have jurisdiction over the conduct of non-profit hospitals outside of merger review. The Antitrust Division is not so limited in its jurisdiction.

^{31/} U.S. Dep't of Justice & Federal Trade Comm'n, Horizontal Merger Guidelines § 0.1 (1992 rev. 1997, efficiencies section only) [hereinafter *Merger Guidelines*], available at <http://www.ftc.gov/bc/docs/horizmer.htm>.

^{32/} In *American Medical International, Inc. and Hospital Corp. of America*, the FTC defined the relevant product market as a group of general acute care hospital services. *American Med. Int'l*, 104 F.T.C. 1, 107 (1984); *In re Hospital Corp. of Am.*, 106 F.T.C. 361 (1985), *aff'd*, 807 F.2d 1381 (7th Cir. 1986).

^{33/} See, e.g., *FTC v. University Health, Inc.*, 938 F. 2d 1206, 1210-11 (11th Cir. 1991); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir. 1990) (Posner, J.); *Hospital Corp. of Am. v. FTC*, 807 F.2d at 1388.

^{34/} Psychiatric and rehabilitation hospitals provide a limited scope of care and do not offer general acute care services. Children's and Veterans Administration hospitals provide inpatient care similar to general acute care hospitals, but are dedicated to a specific group. Although a children's hospital might compete with a general hospital for a subset of the general hospital's patients, non-veterans cannot substitute the VA for a general hospital.

^{35/} See *Healthcare and Competition Law and Policy Hearings*, [hereinafter "*Healthcare Hearings*"] March 28, 2003 at 76:12-76:25, 77:10-78:11 (discussing the Antitrust Division's proposed product market in 1997 hospital challenge). But see *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 138-40 (E.D.N.Y. 1997) (rejecting DOJ's argument that the relevant product market was "the bundle of acute care inpatient services provided by anchor hospitals to managed care plans").

^{36/} The *Elzinga-Hogarty* test is named for the two economists who first proposed this particular analysis. See Kenneth Elzinga & Thomas Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 Antitrust Bull. 45 (1973) Kenneth Elzinga & Thomas Hogarty, *The Problem of Geographic Market Delineation Revisited: The Case of Coal*, 23 Antitrust Bull. 1 (1978). The *Elzinga-Hogarty* test has been used extensively in hospital merger cases despite the fact that, as many commentators note, it is not readily applicable to heterogenous goods or differentiated products--and hospitals generally provide heterogenous or differentiated goods and services.

The term "critical loss analysis" was first used in an article: Barry Harris & Joseph Simons, *Focusing Market Definition: How Much Substitution Is Necessary?* 12 Res. IN L. & Econ. 207 (1989). Critical loss analysis has the potential to provide a useful way to implement the *Merger Guidelines*' hypothetical monopolist test, but problems with its application have led some commentators to question its value to antitrust analysis. Conventional critical loss analysis posits a particular price increase and asks what proportion of the hypothetical monopolists' sales would have to be lost to yield a net decrease in the hypothetical monopolist's profits. 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.

There are a number of pitfalls that analysts face in applying critical loss analysis. Most notably, typical applications posit only a small (five percent) price increase. Yet, the *Merger Guidelines*' methodology for delineation of relevant markets recognizes that a profit-maximizing price increase could be larger than five percent. In other words, even though a monopolist might find a five percent price increase unprofitable, a larger price increase might be profitable. Other possible calculation errors, stemming to incorrect estimates of hospitals' marginal costs and profit margins, may skew the critical loss analysis. Likewise, critical loss analysis can go awry in the second step of the process-- estimation of the actual loss--through the inappropriate use of consumer surveys or patient flow data to estimate the actual losses in sales that would result from a price increase.

- ^{37/} See e.g., Michael Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. Indus. Econ. 63 (2001) (using a control group methodology to assess competitive effects). Here, the competitive effect of the transaction is identified by comparing the change in price at the merging hospitals to the change in price (measured over the same time period) at a set of “control” hospitals. The control hospitals are hospitals in other geographic areas that are otherwise similar to the merging hospitals. Note, however, that a price increase by itself may not be sufficient to prove anticompetitive effects.
- ^{38/} See *FTC v. Tenet Healthcare Corp.*, 186 F.3d 1045 (8th Cir. 1999). In this case, the Eighth Circuit relied on both an Elzinga-Hogarty test and a critical loss analysis to conclude that a broad geographic market was appropriate. Similarly, in *United States v. Mercy Health Services*, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 1045 (8th Cir. 1997) the District Court relied on patient migration patterns, regional hospitals’ outreach clinics, and the lack of evidence that patients’ loyalty to their physicians would prevent them from defeating a price increase to find a broad geographic market. See also J. Jacobs 3/28 at 72-74 (noting DOJ lost the *Mercy Health Services* case on the geographic market definition for all these reasons, but suggesting that the government could address successfully some of these issues today); *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057 (N.D. Cal. 2000) (finding insufficient evidence of a relevant geographic market); *FTC v. Freeman Hosp.*, 911 F. Supp. 1213 (W.D. Mo.), *aff’d*, 69 F.3d 260 (8th Cir. 1995) (holding the Commission had failed to identify a relevant geographic market).
- ^{39/} Robert Connor et al., *The Effects of Market Concentration From Horizontal Mergers on Hospital Costs and Prices*, 5 Int’l J. Econ. Bus. 159 (1998). Michael Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. Indus. Econ. 63, 76-77 Tbls. III & IV, 80-82 (2001). An earlier study by different authors found that hospital mergers resulted, on average, in a 5 percent cost savings. Connor et al., *supra*, at 159. Emmett B. Keeler et al., *The Changing Effects of Competition on Nonprofits and For-Profit Hospital Pricing Behavior*, 18 J. Health Econ. 69 (1999). *But See* 23 Health Affairs 147, 154 (Jan./Feb. 2004).
- ^{40/} Jeffrey A. Alexander et al., *The Short-Term Effects of Merger on Hospital Operations*, 30 Health Services res. 827 (1996); Robert A. Connor et al., *Which Types of hospital Mergers Save Consumers Money?* 16 Health Affairs 62 (Nov./Dec. 1997); Robert A. Connor et al., *The Effects of Market Concentration and Horizontal Mergers on Hospital Costs and Prices*, 5 Int’l J. Econ. Bus. 159 (1998); David Dranove & Mark Shanley, *Cost Reductions Versus Reputation Enhancements as Motives for Mergers: The Logic of Multihospital Systems*, 16 Strategic Mgmt. J. 55 (1995); David Dranove et al., *Are Multihospital Systems More Efficient?* 15 Health Affairs 100 (Spring 1996); Heather Radach Spang et al., *Hospital Mergers and Savings for Consumers: Exploring New Evidence*, 20 Health Affairs 150 (July/Aug. 2001).
- ^{41/} See *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 149; *Butterworth Health Corp.*, 946 F. Supp. at 1302. Other states also have entered into decrees with merging hospitals that provided for some type of community commitment. See, e.g., *Wisconsin v. Kenosha Hosp. & Med. Ctr.*, 1997-1 Trade Cas. (CCH) ¶ 71,669 (E.D. Wis. 1996) (consent decree); *Pennsylvania v. Capital Health Sys.*, 1995-2 Trade Cas. (CCH) ¶ 71,205 (M.D. Pa. 1995) (consent decree) (court ordered merged hospitals to pass at least 80 percent of the net cost savings to consumers); *Pennsylvania v. Providence Health Sys.*, 1994-1 Trade Cas. (CCH) ¶ 70,603 (M.D. Pa. 1994) (consent decree).
- ^{42/} See *Healthcare Hearings*, *supra* note 35 at 78:16-80:10 (discussing what happened after one community commitment expired).
- ^{43/} See, e.g., *In re Hospital Corp. of Am.*, 106 F.T.C. 361 (1985), *aff’d*, 807 F.2d 1381 (7th Cir. 1986); *American Med. Int’l, Inc.*, 104 F.T.C. 1 (1984), *as modified by*, 104 F.T.C. 617 (1984) and 107 F.T.C. 310 (1986).
- ^{44/} *Columbia/HCA Healthcare Corp./Healthtrust, Inc. - The Hosp. Co.*, 120 F.T.C. 743 (1995) (consent order); *Healthtrust, Inc. - The Hosp. Co./Holy Cross Health Servs. of Utah*, 118 F.T.C. 959 (1994) (consent order); *Columbia Healthcare Corp./HCA-Hosp. Corp. of Am.*, 118 F.T.C. 8 (1994) (consent order).

^{45/} *Tenet Healthcare Corp.*, 186 F.3d 1045; *Freeman Hosp.*, 69 F.3d 260; *Sutter Health Sys.*, 130 F.Supp.2d 1109; *Long Island Jewish Med. Ctr.*, 983 F. Supp. 121; *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, *aff'd*, 1997-2 Trade Cas. (CCH) ¶ 71,863 (6th. Cir. 1997); *Mercy Health Servs.*, 902 F.Supp. 968.

^{46/} *Healthcare Hearings*, *supra* note 35 at 69:19-70:07 (discussing one matter in which the Division obtained relief through a settlement and one matter in which the Division obtained relief because the transaction was abandoned)

^{47/} *Id.* at 70:01-70:07

^{48/} The Complaint can be found at <http://www.ftc.gov/os/caselist/0110234/04021emhcomplaint.pdf>. All the public pleadings in the case can be found at <http://www/ftc/gov/os/adjpro/d9315/index.htm>. The complaint also included allegations concerning physician price fixing not germane to this discussion.