

FEDERAL TRADE COMMISSION

HEALTH CARE AND COMPETITION LAW AND POLICY

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I N D E X

Issues in Litigating Hospital Mergers -- Page 3

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2
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6
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8
9
10
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14
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P R O C E E D I N G S

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3 MR. HYMAN: Thank you all for coming today. I
4 apologize for starting a little late, but there have been
5 some delays in Washington.

6 This morning we're going to consider issues in
7 litigating hospital mergers. We've got until 12:30, and a
8 quite distinguished panel, so rather than take up any more of
9 your time, I'll just make one announcement, which is that
10 after we finish our session today, we'll reconvene on April
11 9th through the 11th to consider another series of issues
12 involving hospitals and competition policy.

13 So, now, let me turn it over to Leslie Melman, who
14 is co-moderating today, and will introduce the rest of the
15 panel.

16 MS. MELMAN: Good morning. I'd like to introduce
17 our panel of experts. You have their full biographies in
18 your handout, so I'm just going to do a short introduction
19 before we get into the program.

20 On my far right I'd like to welcome Bob
21 Leibenluft, he's a partner with Hogan & Hartson, where his
22 practice is devoted entirely to health law and health care
23 antitrust matters. The Commission was privileged to have Bob
24 two times, once early in his career in policy planning, and
25 again in the late '90s as head of the Commission's Health

1 Care Division.

2 Next we have my colleague, Mel Orlans. He's
3 Special Litigation Counsel in the Commission's Office of
4 General Counsel. Mel has been involved in litigating many of
5 the Commission's most significant cases, both on the
6 competition and the consumer protection sides. In the area
7 of health care antitrust, Mel's been involved in a number of
8 matters, including as lead trial counsel in FTC v.
9 Butterworth Health, and he also defended the Commission's
10 final decision in Hospital Corporation of America before the
11 Seventh Circuit.

12 On my right, I'd like to welcome Toby Singer,
13 she's a partner in the D.C. Office of Jones Day, where her
14 practice is devoted to antitrust counsel and litigation,
15 principally on behalf of health care providers and payors.
16 The litigated hospital mergers in which she has been involved
17 include Lee Memorial and Sutter/Summit. Before leaving the
18 FTC's Division of Competition to join Jones Day, Toby
19 participated in a broad range of health care antitrust
20 matters, including the Chattanooga/HCA merger.

21 Toward my left, I'd like to introduce and welcome
22 Dave Argue. He's Vice President of Economists, Incorporated.
23 He's worked as an economic consultant in a number of
24 litigated hospital mergers, including Sutter/Summit, Poplar
25 Bluff, Long Island Jewish and Mercy Health.

1 I'd also like to welcome David Eisenstadt, a
2 principal in the antitrust consulting firm, Microeconomic
3 Consulting and Research Associates, which he co-founded.
4 David has been retained as an economic expert in numerous
5 health care antitrust matters and he has also testified in a
6 number of litigated matters, including Butterworth and
7 Carillon.

8 And, then, to my far left, I'd like to introduce
9 Jon Jacobs, he's an attorney in the Antitrust Division, the
10 Litigation 1 shop. Jon's been a member of the trial team in
11 a number of antitrust matters, both in health care and other
12 industries. He's been involved in many hospital merger
13 investigations and he was on the trial team in Mercy Health.

14 Bob, I wonder if we could start with your
15 presentation?

16 MR. LEIBENLUFT: Thank you, Leslie. I really
17 appreciate the opportunity to participate in this important
18 set of hearings. Let me tell you what I'd like to cover
19 today. First, I want to give you a little bit about my
20 background biases and caveats before I go on to the
21 presentation, and then I'd like to give at least my spin on
22 what explains the Government losing streak, and finally offer
23 some fairly modest suggestions on what the enforcers can do.

24 With respect to my background, Leslie mentioned I
25 had two stints at the FTC, the last one as head of the Health

1 Care Shop is really framed by working in two hospital
2 mergers, and they really caused me to give a lot of
3 consideration to the Government position on hospital mergers.

4 The first was the Butterworth merger in Grand
5 Rapids, and that was a case in which the FTC prevailed in
6 establishing its prima facie case, the Judge agreed that the
7 FTC had shown its geographic market, its product market, that
8 there were barriers to entry, and that, in fact, the
9 hospitals could exercise market power. But, notwithstanding
10 that, the Court ruled that the hospitals would not exercise
11 that market power to the detriment of consumers because of
12 their nonprofit boards and their community commitment.

13 And that was at the start of my stint at the FTC
14 and really caused me, and a lot of other people around the
15 FTC, to think about what we should do, what should the next
16 case look like, if we were to bring a next case? And we
17 spent a lot of time thinking about those issues.

18 Which brings me to the last case, which sort of
19 framed my stay there, which was the Poplar Bluff, Missouri,
20 case involving Tenet. That was a case involving, essentially
21 what the FTC framed as a two-to-one merger, with two for-
22 profit hospitals in an isolated community where virtually all
23 the employers and health plans opposed the merger, and we
24 were in Court alongside the state attorney general, and we
25 actually won, in District Court, before Judge Perry. That

1 ruling was reversed by the Eighth Circuit, which basically
2 rejected the lower court's findings concerning geographic
3 market, and in doing so, with respect to the FTC standard of
4 what the FTC burden is in these kinds of PI matters,
5 concluded that the case didn't raise questions going to the
6 merit, so serious, substantial, difficult and doubtful, as to
7 make them fair ground for thorough investigation, study,
8 deliberation and determination.

9 Basically, the Eighth Circuit rejected the lower
10 court's findings and said that they didn't even rise to the
11 level of requiring further consideration by an FTC ALJ. And
12 that was the last case that either the FTC or DOJ has brought
13 challenging a hospital merger. So, I thoroughly understand
14 the frustration the Government has in losing those cases.

15 My practice today, in private practice, is divided
16 evenly amongst payors and health care providers. I want to
17 provide a caveat that my remarks are totally my own. They
18 don't reflect, necessarily, the views of Hogan & Hartson or
19 of any of my clients.

20 With that said, let's go to why does the
21 Government lose so many cases? Basically, there are two
22 broad reasons, I think. One is these cases are very
23 difficult in terms of traditional antitrust issues. And I'm
24 going to go into some of those issues. And, second, those
25 difficult questions are overlaid by what we used to call

1 litigation risk, and these relate to the nonprofit status,
2 often, when we're dealing with nonprofit hospitals, of an
3 underlying skepticism about antitrust in health care and of a
4 home court disadvantage.

5 Let me go through all of those. What are these
6 difficult issues? First, on geographic market, it's sort of
7 a Catch 22. The courts require -- and, I think, rightfully
8 so -- that the analysis be dynamic. What will happen if the
9 hospitals merge? As a result of that, the plaintiff is faced
10 with a difficult task. What they have is traditional hard
11 evidence which relates to, for example, patient flow data,
12 which reflects historical patient patterns, and is historical
13 conduct.

14 But that doesn't reflect what might happen in the
15 future. But when the Government tries to find what may or
16 look to what may suggest what will happen dynamically, then
17 that evidence could be attacked as being speculative or
18 anecdotal. And, so, it's a hard line to cross.

19 Second, as we've heard in some of the preceding
20 talks, some of the Courts have applied the Elzinga-Hogarty
21 test and, at times, have applied it in a very rigid fashion.
22 For example, 88 percent is not good; 90 percent has to be
23 reached, in a way that I think is a little bit more rigid
24 than is appropriate.

25 And, third, a critical loss analysis suggests that

1 they are very broad, geographic markets, and that has been a
2 hard issue for the Government to overcome.

3 On the product market -- this has not been a big
4 issue in terms of actual litigation, in terms of the actual
5 issue at hand, although I think it might be in the future.
6 In a way, I think the Government has had something of a pass
7 in some of these issues -- because in many hospitals there is
8 competition at the low end from freestanding centers and
9 doctors' offices -- and maybe even more so as time goes on,
10 as more of the care moves to the outpatient setting.

11 Competition from the high end, from regional
12 referral centers or even national centers, there's
13 competition now increasingly from single-specialty hospitals.
14 So, all those factors mean that what is really at stake in a
15 merger, in terms of where there's not other competition
16 coming in from outside the hospital setting, might be quite
17 small.

18 We also have the issue of anchor hospitals in an
19 urban setting, which, so far, the courts have not found to be
20 a viable concept, but without that, it's difficult, I think,
21 for the Government to challenge mergers in urban settings.
22 Then we have the issue of, really, what's going on in
23 competition, which -- I was here at the session yesterday and
24 it was raised by a number of the speakers -- there's a lot
25 that's happening in hospital competition.

1 First of all, the effects that we're seeing in
2 terms of price competition really occur only with respect to
3 commercial payors. And that's just a minority of what the
4 hospitals are serving. So, at the outset, the Courts may
5 ask, gee, this is really not affecting a whole lot of what's
6 going on there.

7 The roles of health plans, employers and consumers
8 in the different levels of competition on the health plan
9 level and competition for consumers within a health plan
10 offering, complicates the competitive story.

11 The analysis tends to focus almost entirely on
12 hospital competition for price and ignores, I think, a lot of
13 the other competition, which also takes place, which exists
14 for competition to obtain doctors to refer patients and
15 nonprice competition with respect to services and technology.
16 And, finally, hospitals often pledge to limit price
17 increases, and that can dull the apparent need for
18 enforcement action.

19 Lastly, efficiencies. Efficiencies come up in
20 almost all merger investigations and challenges. But with
21 respect to hospitals, there's a widespread, long-standing
22 view that consolidation can address over-bedding issues and
23 can address what's been called the medical arms race, and
24 there's a thought that the medical arms race ended in the
25 '70s and '80s with changes in particularly Government

1 reimbursement policies. But, many people still believe that
2 there is an arms race, and many employers will be concerned
3 locally that hospitals are needlessly buying more equipment
4 than they really need to buy and that they're having to pay
5 for that.

6 So, those are all the tricky issues that one needs
7 to deal with in terms of the standard antitrust analysis.
8 And, then, I think, what happens is they're hard enough to
9 begin with, but when you get a Judge who may be more willing
10 to accept the defendant's view -- for a number of reasons --
11 it makes the Government's position that much harder.

12 There's perception that nonprofits act differently
13 and they certainly are, typically, very highly regarded
14 locally. And I can tell you from working with nonprofits, if
15 you walk into a nonprofit board meeting, it is conducted
16 differently than a board meeting for a typical for-profit
17 entity. There's a lot of controversy about what that really
18 means and how that affects behavior, but there is certainly
19 that perception out there, and I think there's some reality
20 to that perception, as well.

21 And there's some empirical research, although it's
22 really divided, about whether nonprofits behave differently
23 than for-profits or the extent to which they behave
24 differently.

25 I want to emphasize that not all nonprofits are

1 alike and, certainly, in the spectrum there are some
2 nonprofits that behave as aggressively or more aggressively
3 than the typical for-profit, and there are some who behave, I
4 think, quite differently.

5 I think there's also a widespread skepticism about
6 -- just in general -- about the application of antitrust to
7 health care, and this pervades, in many respects, a lot of
8 the decisions, even though it's not really emphasized and
9 there's an acknowledgement that antitrust clearly applies to
10 health care. But, I think underlying this, on the part of
11 the judiciary, there is just a degree of discomfort, and,
12 also, a degree of discomfort on the part of many people out
13 there, who are not judges, just in general.

14 This, I think, is particularly the case when, at
15 issue, are conduct of nonprofits that are locally controlled,
16 that tend to be highly regarded in the community that people
17 know about, that people have dealt with.

18 There's skepticism that competition in health care
19 will necessarily result in the best quality and price trade-
20 off for consumers, and there are many reasons for that and we
21 could spend a lot of time talking about that, but there is
22 skepticism that this really works.

23 And, then, finally, in many of these cases, the
24 complainants typically are health plans and there's a managed
25 care backlash and, so, there is -- and you can see this again

1 in some of the opinions -- some skepticism about the
2 complaints from health plans.

3 And, finally, we have the home court disadvantage.
4 Unlike with most Government merger challenges, here we have
5 in a typical hospital injunction case, it's tried in the
6 backyard of the merging parties and the Judge is likely to
7 have first-hand experience with, if not the hospitals, at
8 least with hospital care. Judges know what hospitals are
9 like, maybe they don't know what smokeless tobacco is, for
10 example, as a recent case the FTC brought -- they may not,
11 anyhow -- but, they certainly know what hospitals are about
12 and they have experience with local community hospitals and
13 they may not have a whole lot of experience with merger law
14 or sophisticated antitrust or economic analysis. So, what
15 should the Government do? I have 11 modest suggestions --
16 actually, I had a 12th -- the 12th was to avoid the Eighth
17 Circuit.

18 (Laughter).

19 MR. LEIBENLUFT: First, I would suggest, don't
20 abandon the field. I think there's a real role for Federal
21 antitrust enforcement. In the absence of state regulation --
22 and there's essentially no real state regulation of hospital
23 prices. I think the State enforcers can play a valuable
24 role, but they don't have the resources or the expertise,
25 generally, that the Government does, and neither, do I think,

1 private litigants. We don't see too many of them out there
2 and they don't have the kind of expertise as the Government
3 does. And I think vigilant enforcement -- even if there are
4 relatively few cases -- can provide an important sentinel
5 effect. So, don't abandon the field.

6 Second, don't underestimate the complexities to be
7 analyzed. I just talked about a lot of the traditional
8 antitrust issues. It's extremely challenging to identify the
9 potential problems and to identify cases, in particular, that
10 the enforcers can win. We thought we were going to win
11 Poplar Bluff and we looked hard before we brought that case,
12 I can tell you. We thought we had everything going with us
13 and we didn't.

14 The staff and management, at the agencies, must
15 keep current on developments. We've heard a lot of changes
16 in the field -- how competition is changing, how hospitals
17 are changing -- they must push hard on the theories and the
18 evidence, not go in with preconceived notions and not try to
19 fight the last war.

20 Related to that, it's important to build on and
21 retain relevant agency expertise among lawyers, economists,
22 outside consultants. When I was at the Commission, I really
23 felt the need to have good support, particularly with respect
24 to the economists -- people who knew hospital competition
25 issues and were going to stay at the Commission long enough

1 that we could use them consistently over a period of time.

2 I think it's important to maintain that and it's
3 important to understand these markets, it's important if
4 you're going to bring a ripe case.

5 Increase communications with a number of entities
6 out there. The first is health plans and employers. These
7 are the people who are experiencing market conditions from
8 the receiving end. They're going to be able to identify
9 problems, they're going to be your witnesses and will be able
10 to develop crucial evidence.

11 It's just as important to maintain communications
12 with the hospital community. They need to understand what
13 you're doing; you need to understand what they're doing; you
14 need to understand what they're facing. You don't want to
15 have to learn about their issues in litigation, you want to
16 hear about them before.

17 Increased communication with other Government
18 entities. Now, this includes payors -- Government payors pay
19 for the majority of health care in hospitals -- as those
20 reimbursement systems change, it's important to understand
21 that impact, you can, perhaps, influence a little bit the
22 margins at least about how they're approaching some of their
23 reimbursement policies.

24 Contacts with the Agency for Health, Research and
25 Quality, which has a lot of health services research

1 capability, and a different kind of research capability than
2 the economics, the antitrust economists tend to focus on.
3 And I obviously think it's important for FTC and DOJ to work
4 with each other, to communicate with each other, particularly
5 in matters where they have complementary expertise or
6 jurisdiction.

7 Continue the research agenda, it's vital to
8 understand and explain what the missions are about and to
9 generally gain acceptability for what the agencies are doing;
10 collaborate with health service researchers. Issues include
11 some of the things I mentioned before -- market definition,
12 nonprofits, nature of hospital competition and efficiencies.
13 I think these hearings are an excellent start.

14 Take into account nonprice issues -- quality
15 competition, competition for doctors, competition for new
16 technology and expanded services, work with the state
17 enforcers. They have their ear to the ground. I think it's
18 basically impossible to win a hospital merger case if you're
19 the Federal Government if the state is opposing you. I think
20 the LIJ case is maybe one example of that.

21 It's not to say you're going to win if the state's
22 by your side -- Poplar Bluff is an example of that -- but I
23 think it's really important to have them at least on your
24 side, if you're the Government, or neutral.

25 I think the hospital merger retrospective is a

1 good idea. It could be very informative if it's done in a
2 methodologically sound way and results are publicly
3 available. It could lead to more informed Government actions
4 and help provide guidance to both the industry and
5 practitioners.

6 And my last point is to choose your battles very
7 carefully.

8 Thanks very much.

9 MS. MELMAN: Thank you, Bob.

10 (Applause).

11 MS. MELMAN: Mel will be our next presenter.

12 MR. ORLEANS: I'm glad to see that even though
13 he's gone over to the dark side that Bob still has some
14 sympathy for the Government position in hospital merger
15 cases, although, maybe, he just wants the business in the
16 event the Government continues in the area.

17 Let me offer the usual caveat that the views that
18 I'm going to express are my own and not those of the FTC or
19 of any Commissioners at the FTC. My experience in the
20 hospital field, in particular, comes from being lead trial
21 counsel in the Butterworth-Blodgett case. I also have been a
22 consultant and active in a number of other hospital mergers
23 the FTC has brought, including Freeman Hospital.

24 And based on that, I have fairly strong views
25 about the explanations or possible explanations for the

1 Government's history -- recent history -- in hospital mergers
2 and the Government's lack of success. Clearly, that recent
3 history teaches us that hospital mergers have been
4 increasingly difficult for the Government. The Government
5 has a string of losses over the past nine years that, I
6 think, everyone here is well aware of.

7 In my view, the bulk of those cases brought during
8 that time were well-founded cases. Now, the Government
9 shouldn't have won them all, but on the other hand, the
10 Government shouldn't have lost them all, either. In fact, I
11 will tell you that from a personal perspective, that
12 Butterworth-Blodgett still wrangles me to this very day.
13 David Eisenstadt, who is also on this panel, was the opposing
14 expert, and he may have different views, but to this day I
15 feel that's a case that we should have won.

16 In contrast, and interestingly, during this same
17 period, the Government's success rate in nonhospital mergers
18 has been quite high. So, again, what's the explanation or
19 what are the explanations? And I'm going to offer you my own
20 perspective as a trial lawyer, who's been on the front lines
21 and dealt with judges in these cases.

22 Let me emphasize at the outset that the same law
23 applies to hospital mergers as to other mergers. That being
24 the case, a changing legal environment certainly does not
25 provide an explanation for the string of losses. And, yet,

1 there's no doubt, at least in my mind, that hospital mergers
2 are treated differently by the courts than other kinds of
3 mergers.

4 The main factors that I would identify as having
5 an impact on the outcome are as follows -- and there are four
6 of them in my view. The first is that hospital mergers are
7 inherently local in nature; the second is that hospital
8 mergers, typically, although not always, involve nonprofit
9 hospitals; the third is the lack of sophisticated customers
10 who are willing to challenge hospital mergers; and the fourth
11 is that geographical markets are increasingly difficult to
12 prove. And let me take those one at a time.

13 First of all, hospital mergers are inherently
14 local, and I don't mean that from the standpoint of defining
15 a geographic market, but more from the perspective that
16 hospital mergers involve local community health care. And
17 that being the case, I think that this is a key factor
18 because it injects a number of systematic biases into the
19 judicial system.

20 For one thing, I believe that District Courts --
21 and even Courts of Appeals -- are quite resistant to
22 perceived interference from outside the local community into
23 the issue of local health care.

24 And there are a number of examples that I would
25 base that on. For instance, in the Freeman Hospital case,

1 Judge Whipple actually told us at one point, off the record,
2 that the FTC -- that Washington -- really had no business
3 being involved in telling the local community what to do.

4 Obviously, that statement was made off the record,
5 not on the record, although he made some ill-tempered remarks
6 that actually were on the record that got him criticized by
7 the Court of Appeals, but not overturned.

8 Even in University Health -- and University Health
9 was a case that many of you know the Government actually won,
10 albeit on appeal on the Eleventh Circuit. That case was
11 remanded from the Eleventh Circuit to the District Court for
12 the entry of an order prohibiting the merger, and in entering
13 that order, the Judge reluctantly recognized he had to follow
14 the dictates of the Eleventh Circuit, but he stated in his
15 order, and I quote, "I am mindful of the mischief that such
16 an order will work in this community."

17 So, at that point, the Judge, even though he had
18 entered the order, came out of the closet and basically said
19 that Washington had no business doing mischief in his
20 community, that this was a local matter.

21 So, again, I think the sense we get from these
22 cases -- and I certainly had it in Butterworth-Blodgett
23 -- although the Judge there avoided ill-tempered remarks --
24 at least on the record -- is that the judicial perception is
25 that health care policy should be decided by the community.

1 Another aspect of the local nature of hospital
2 cases is that the trial court often knows, either directly or
3 indirectly, the members of the hospital board who often
4 testify in such cases. And, of course, this enhances both
5 the credibility of those witnesses and their impact before
6 the court.

7 Another factor that is a part of this inherently
8 local nature of hospital mergers is that there's typically
9 not major resistance from local employers or from the
10 business community. Generally because we're looking at
11 nonprofit hospitals, the local employers are often on the
12 boards of these hospitals. But, at a minimum, even when
13 local employers, other local businessmen are not heavily
14 involved in the merger, their inclination is not to step
15 forward and actively oppose the merger.

16 And, finally, this community focus is exacerbated
17 by the fact that for market definition purposes most of the
18 hospital markets that have been challenged have been smaller
19 communities, which, again, emphasizes and exaggerates the
20 local effects of these cases.

21 Secondly, there's the nonprofit status of the
22 hospitals. My sense is the courts are inclined, either
23 explicitly or implicitly, to offer nonprofit hospitals the
24 benefit of the doubt. In Butterworth, as Bob mentioned, the
25 District Court found that, even though the hospitals would

1 have market power -- which is usually the be all and end all
2 of a merger case -- it nonetheless went on and concluded that
3 the hospitals wouldn't abuse that power.

4 I always felt that was particularly interesting
5 because there was evidence in Butterworth-Blodgett that if
6 the merger had not gone through that the Blodgett board was
7 inclined and committed to building a new facility and it was
8 generally recognized in the community that that new facility
9 would be very expensive and would raise community health care
10 costs.

11 Interesting in the sense that one of the Judge's
12 justifications for giving extra credence to the position of
13 the hospitals in a nonprofit status was that the boards,
14 because they consisted of members of the local community,
15 that those boards would, in fact, act for the benefit of the
16 community, and, yet, here we had a very specific instance
17 where, at least in my view, it would be demonstrated that
18 those boards would not, necessarily, act for the benefit of
19 the community.

20 And I think the explanation for that, and the one
21 that we offered to the court at the time, is that although
22 one could not question the good intentions of the board
23 members, we believe that, for the most part, those board
24 members would act in the benefits and best interests of the
25 hospitals and not of the communities, because they, after

1 all, were functioning as board members of the hospital. And
2 the goal, therefore, was to enhance the hospital's future,
3 not necessarily to keep health care costs to the community at
4 the lowest possible levels.

5 I would note, as important as the nonprofit status
6 of hospitals is, that the Government has lost cases involving
7 for-profit hospitals, and Bob gave Tenet as an example of
8 that. So, even when challenging a for-profit hospital, the
9 Government has had difficulties.

10 Third, I would emphasize the lack of sophisticated
11 customers. The testimony of major customers is usually quite
12 probative in merger cases. And, yet, such testimony is often
13 unavailable in hospital mergers. Employers are generally
14 unwilling to challenge the mergers. The local employers
15 often are on the hospital boards. Even when they're not on
16 the boards, as I said before, the inclination of the local
17 employer is not to challenge his fellow businesspeople who
18 have made the decision that the merger should go forward.

19 Naturally employers typically feel that they have
20 the leverage to avoid the impact of any price increase and
21 are disinclined to step forward and involve themselves in
22 local affairs. So, we've had difficulty getting strong
23 employer testimony. It has happened, and Tenet is an example
24 of that, but nonetheless it has been a problem for us.

25 As a result of that, the Commission has often

1 looked at testimony from third-party payors and treated them
2 as customers, and I think with some justification. But even
3 third-party payors can be reluctant to step forward for fear
4 of retaliation should the merger go through.

5 In those instances where we've have strong
6 testimony from third-party payors, the courts have typically
7 discounted it for a couple of reasons. For one thing, as in
8 Butterworth-Blodgett, many courts seemed to feel that the
9 third-party payor has money at heart as its main interest and
10 not the best interest of the community and of the consumers.
11 And, in addition to that, the courts typically view the
12 third-party payors as not representative of the consuming
13 public because many people are not within the ambit of those
14 plans.

15 Finally, there's the difficulty of proving the
16 geographic market. Courts, of course -- particularly the
17 Eighth Circuit -- have been quite critical of the
18 Government's efforts at market definition. In a sense,
19 whenever I deal with market definition, I'm reminded of Judge
20 Posner's comments in the Rockford case, where he said, "It's
21 always easy to nitpick a market definition." It strikes me
22 that a lot of what's going on really could be characterized
23 in that fashion.

24 Courts have rejected, in market definition
25 situations, the use of internal documents. And, yet, these

1 are often the kinds of documents that Courts in nonhospital
2 cases often find to be the most probative.

3 Courts have also rejected other qualitative
4 evidence on market definition, such as, for example, the
5 testimony of third-party payors.

6 So, what the courts seem to be insisting on is
7 quantitative evidence. And, yet, in nonhospital cases,
8 qualitative evidence, whether it be testimony or ordinary
9 course of business documents, is often the sort of evidence
10 that's seen as most probative.

11 Ordinary course of business documents, in my
12 experience, are documents that are often credited by the
13 Court; certainly in comparison to data which is often
14 imperfect to begin with and can be easily manipulated. Most
15 of the data analyses is specifically prepared for litigation.
16 And, in my view, as a result of that, should be viewed with
17 some inherent skepticism.

18 But, nonetheless, it's clear that, at a minimum,
19 the courts do expect a heavy use of empirical analysis and an
20 emphasis on quantitative versus qualitative material.

21 As a result of this problem, an acceptable,
22 practical methodology for defining a market is uncertain at
23 this point. It's clearly in a state of flux, we all, I
24 think, recognize that the merger guidelines are the
25 appropriate general analytical tool, but trying to come up

1 with a practical approach to geographic market definition has
2 been quite problematic.

3 But, again, it's important to note that either
4 when the Government has prevailed on geographic market
5 issues, as it did in Butterworth-Blodgett, we still lost
6 those cases.

7 So, finally, I come to possible solutions for the
8 future and strategies that the Government, perhaps, could
9 implement in order to avoid this string of losses. Half
10 jokingly, I would agree with Bob that we probably should stay
11 out of the Eighth Circuit. But, putting that aside, I think
12 the Government needs to target the strongest cases going
13 forward. And that's by paying particular attention to
14 geographic market and also to efficiencies, and that's
15 because those two issues, in particular -- maybe product
16 market in the future -- become more complicated -- those are
17 the issues where factual findings by the District Court will
18 be particularly difficult to overcome on appeal.

19 In trying to bring our strongest cases, we also
20 need to make better use of data, and, in particular, to rely
21 more on natural experiments to the extent that we can look to
22 natural experiments -- situations in the past -- it gives us
23 a way of using empirical analysis that does not involve
24 prepared-for-litigation-type analysis.

25 Obviously, there is some concern about the use of

1 patient flow data, which does present a static rather than a
2 dynamic analysis and patient flow data, obviously, has to be
3 used as a starting point and not an ending point.

4 Secondly, if possible, Government should try to
5 obtain strong community support prior to a Court challenge.
6 And I thoroughly agree with Bob that, if at all possible, the
7 Government should try to get support from the State and,
8 hopefully, from the local community, as well. And the local
9 community may even be more important than the State. It's
10 historically been quite hard for the Government to win cases
11 where the State has come out on the other side.

12 Third, I think that the Commission, at least,
13 could consider bringing administrative cases rather than
14 going to District Court. Of course, this is an option only
15 for the Federal Trade Commission and not for the Department
16 of Justice.

17 It also means permitting consummation of the
18 merger and then seeking divestiture down the road. And this,
19 of course, presents certain problems because the Government
20 will be forced, in seeking divestiture, to unscramble the
21 eggs. Nonetheless, hospital mergers, typically, have taken
22 awhile to consolidate. And, so, it may be that by giving up
23 the option of stopping the merger at the outset, the
24 Government isn't risking as much as it might in other kinds
25 of markets with other kinds of products.

1 Finally, I think, that both DOJ and the FTC should
2 spend more energy looking at consummated mergers. In a
3 consummated merger, the harm is easier to demonstrate. In
4 part, because some of it has already occurred, and this will
5 also help the Government get over the hurdle of defining the
6 product market and the geographic market -- the assumption
7 being that if a harm has occurred to be demonstrated that
8 there is clearly a geographic and a product market that's at
9 issue.

10 And, finally, of course, by looking at consummated
11 mergers, assuming we can look a few years down the road, we
12 should present a much clearer picture of the efficiencies --
13 those efficiencies will either have been realized or not
14 realized, and, therefore, will not be viewed as something
15 that has to be projected into the future with all the
16 uncertainties that that entails.

17 I think that concludes my remarks. Thank you.

18 MS. MELMAN: Thank you very much, Mel.

19 (Applause).

20 MS. MELMAN: Toby?

21 MS. SINGER: Thank you. I'd like to start by
22 thanking the FTC for inviting me to speak here and echo the
23 points made by a number of the speakers that these health
24 care hearings are very valuable contributions to the learning
25 in very difficult health care issues.

1 As some of you know, my background involves a very
2 long string of litigating hospital mergers. I started at the
3 FTC -- maybe I won't say when -- but I litigated some of the
4 very first hospital mergers, including the HCA-Chattanooga
5 merger, which was an FTC administrative proceeding involving
6 a seven-week trial, appealed to the Seventh Circuit, and a
7 very thorough and well-developed record.

8 Since leaving the FTC, I've been involved in a
9 number of litigated cases as well; the most recent being the
10 Sutter case, which was brought by the State of California,
11 which the FTC, in its wisdom, chose not to challenge.

12 It's often argued and we've heard some of this
13 today, that the Federal courts don't like hospital mergers --
14 hospital merger cases -- hospital merger enforcement. And
15 under that theory, the string of losses that's been suffered
16 by the Federal Government since about the mid-90s is
17 attributable to the courts' finding excuses to dismiss the
18 cases, because either, (1) they don't believe that not-for-
19 profit hospitals are likely to engage in anti-competitive
20 activities; or (2) they're reacting to the Federal Government
21 coming to town to tell the leading citizens of the community
22 -- the hospital board members -- what is best for the
23 citizens of that community.

24 A close look, however, at the hospital merger
25 decision doesn't really support those as unifying theories

1 for those cases. You really cannot generalize, you cannot
2 say that there's the same set of reasons for all of these
3 losses or even almost all of these losses.

4 In only one of these cases did the court find that
5 the Government had proven its prima facie case, yet ruled
6 against the Government, and that was the Butterworth case.
7 And I think in Butterworth the court was very up front about
8 saying I don't believe not-for-profit hospitals are going to
9 do bad things and this merger is important for the community.
10 Perhaps there was some of that going on in the Freeman case,
11 as well, although that case was decided, ultimately, on the
12 antitrust merits.

13 But if you look at the other cases, you'll find a
14 string of cases that contradict those two theories. The
15 Government has prevailed in cases where the merging hospitals
16 were not-for-profit entities; the Rockford case, brought by
17 the Justice Department; and the Augusta, Georgia case,
18 University Health, brought by the FTC, are examples of those.

19 In fact, Rockford and Augusta squarely rejected
20 the not-for-profit defense in ruling for the Government.
21 Even in the case, Rockford, where the court stated that the
22 court was not unsympathetic to the motivations of the
23 defendants.

24 And even in Dubuque, in the Iowa case that I think
25 surprised everybody when the Government lost, the court

1 rejected the nonprofit argument. There's a fairly
2 interesting discussion of that in the opinion in seeing the
3 correct analysis of the not-for-profit defense. The Court
4 stated that in spite of the fact there wasn't any evidence
5 that these board members, these hospitals, had really anti-
6 competitive intent, that wasn't the point. The fact is that
7 the board members' testimony was very credible, they were
8 intending to do the right thing, but the Court said there's
9 nothing inherent in the nonprofit status of the hospitals
10 which would stop any anti-competitive behavior. And the
11 Court, of course, said you could always have new board
12 members coming along that would behave anti-competitively.

13 And even beyond that, in arguments that we at the
14 FTC made in some of the early not-for-profit investigations,
15 the fact that an entity is not-for-profit may mean that it
16 has good intentions, but that does mean that the way it's
17 going to operate in the marketplace is the same way that it
18 would operate if a market is competitive when a market is not
19 a competitive market. So, I don't think that that
20 argument can explain a lot of these cases.

21 On the "we don't want the Federal Government
22 coming to town to tell us what to do" point, the Government
23 has prevailed when cases were tried in the town that the
24 hospitals were located; for example, the Rockford case,
25 again, was tried in Rockford. And the Government, of course,

1 has lost where courts were located elsewhere.

2 In the Sutter case, the case was tried in San
3 Francisco; the hospitals were over in East Bay, and if anyone
4 is familiar with that area, you know those are two different
5 worlds, not just two different towns. The Long Island Jewish
6 case was not tried right in the backyard of the hospitals.
7 Even the Tenet case, where the Government won in the District
8 Court, that was in St. Louis and the Court of Appeals, which
9 reserved the Government win, was also not in the hometown.

10 Perhaps my favorite example of the Government,
11 using that to mean complaint counsel in this case, has lost
12 is the Ukiah case, which was brought by the FTC a number of
13 years ago, where the FTC, itself, through the ALJ, lost on
14 lack of proof of a relevant geographic market, hardly a home
15 court advantage for the hospitals in that case.

16 So, if these reasons don't stand up to scrutiny,
17 what are the reasons for these losses? It's clear that the
18 Government has just not been able to prove or to persuade the
19 courts on the merits that competition will be lessened by
20 many of these mergers. And you have to look at the specific
21 facts of all of these mergers to figure out why, in each
22 case, the Government did not prevail.

23 We antitrust lawyers are very fond of saying that
24 antitrust is very fact-specific, very fact-intensive and
25 that's just as true for hospital cases as it is for every

1 case. A hospital merger in one market may or may not be
2 similar to a hospital merger in another market.

3 And I think we can't underestimate the value of
4 precedent. Once the Government had lost a couple of these
5 cases, as Bob said, don't go to the Eighth Circuit, it's
6 going to be very hard for a court in the Eighth Circuit to
7 find a narrow geographic market, and that's not just true of
8 hospital cases, the Eighth Circuit case law, in general,
9 finds very broad geographic markets.

10 And, of course, other courts have relied on the
11 cases in the Eighth Circuit and elsewhere. So, it's going to
12 be an uphill battle just based on precedent alone.

13 Second, I think the courts just haven't been
14 willing to believe the testimony of health plans and others
15 when it's contradicted by other evidence, in particular, the
16 statistical evidence and market definition. And I'll talk
17 about that again in a minute.

18 The best examples of those, of course, are the
19 Sutter case, where the health plan said one thing and it was
20 contradicted by other evidence; Tenet, same thing, the courts
21 just did not believe the anecdotal evidence when it was,
22 again, contradicted by the statistics; and Long Island
23 Jewish, where in that case there was actually conflicting
24 testimonial evidence. So, it was probably a little easier to
25 reject it.

1 Why however, has the Government been able to carry
2 its burden in some of the cases? In the older cases, the
3 Government did prevail. My theory about that is that the
4 Government has departed from two of the key aspects of the
5 early enforcement efforts.

6 The first, and I think this is the most important,
7 is before asserting that competition has been lessened, the
8 Government spent a lot of time in those older cases
9 establishing the ways in which hospitals compete. In the
10 earlier cases, everybody understood the Courts are not
11 familiar with or comfortable with the notion of hospitals as
12 competitive entities in a competitive marketplace. So, we
13 all went out of our way to explain to the Courts this is, in
14 fact, how hospitals compete.

15 The early cases focused on the nature of
16 competition and built on that discussion in order to project
17 the kinds of anti-competitive effects that could occur if a
18 merger were allowed to proceed. The HCA/Chattanooga case and
19 the Rockford case are both examples of that.

20 A couple of quotes from HCA from the Commission
21 opinion: "Before considering the merits of this case, it's
22 important to have a fundamental understanding of the role of
23 physicians and third-party payors in the health care
24 transaction." In fact, the Commission devoted 10 pages of
25 its opinion just to describing the nature of competition

1 before going on to explore the competitive effects.

2 Then, once it did that, once it established the
3 market and the market shares, it didn't stop with the market
4 shares. It said, "Because HCA denies that anti-competitive
5 behavior is likely," -- and, by the way, HCA premised some of
6 that on the notion that the not-for-profits in the market
7 would not collude -- "it is useful to consider the likely
8 forms that anti-competitive behavior would take." And the
9 Commission went back to the examples of competition in the
10 market and how competition had been lessened before the
11 merger and built on that to show that these are the things
12 that could happen now that the market is more highly
13 concentrated.

14 The Seventh Circuit, when it came time to examine
15 the case -- and Mel probably remembers that we were all a
16 little surprised it had gone to the Seventh Circuit and we
17 decided it was probably trying to get a judge like Posner,
18 who perhaps would be skeptical of the Government's case --
19 but what Judge Posner said is that the Commission had engaged
20 in a very detailed analysis and an inquiry into the
21 probability of harm to consumers, summarized that analysis in
22 several pages of its opinion and actually noted that the
23 Commission may have even gone further than it needed to in
24 exploring these issues.

25 Similarly, in Rockford, the Justice Department put

1 in quite a bit of evidence on the nature of competition,
2 explaining this to the Court and the District Court in
3 Rockford devoted several pages of its opinion, which was much
4 shorter than the HCA opinion, to the nature of competition
5 before it went on to the anti-competitive effects.

6 The second thing that I think used to be done more
7 and perhaps could be brought back, and it's sort of a subset
8 of this, and that this is the question of nonprice or quality
9 related competition. And this is something that Bob
10 mentioned as well and I agree.

11 If the Government were to establish the benefits
12 of nonprice competition in explaining the way hospitals
13 compete, it provides another dimension in which competition
14 can be lessened. So, even if you don't believe that
15 hospitals are going to be able to raise prices, maybe there
16 is another dimension in which they could lessen competition
17 by providing lower quality services. And not so much that
18 the care will be worse for the patients, but perhaps the
19 number and amount of services provided will be less.

20 One of the things the Courts have seized upon,
21 have thought about, is it a good thing to have a medical arms
22 race? Is it a good thing to have two MRIs next to each
23 other?

24 Well, I think that anyone who believes in the
25 competitive market will say, yes, it is a good thing. And,

1 so, again, if the enforcers spend some time developing the
2 way competition works and why that's good, maybe it will be
3 easier for the courts to understand why a merger that might
4 lead to one MRI instead of two and, therefore, less access
5 for consumers, might be a bad thing.

6 In fact, the Eighth Circuit in Tenet recognized
7 the quality component of hospital competition, criticized the
8 lower court and the Government for an inordinate emphasis on
9 price competition without considering the impact of reduction
10 in quality, and mentioned that the higher quality is maybe a
11 reason for patients to go outside of the FTC's market.

12 I'd also like to spend a minute on what's
13 developed into the great debate in the hospital merger cases;
14 and that is the relevance of statistical versus anecdotal
15 information. In my view, the enforcement agencies have been
16 too willing to rely on what they were told by the health
17 plans and others, like IPAs, some employers, but haven't gone
18 beyond the stories to actually test what the health plans are
19 saying.

20 For example, health plans often will testify or
21 will tell the Government and sign affidavits that say: "There
22 is no way that we can get our patients to go to hospital X,
23 they're only going to stay in this area where the merging
24 hospitals are."

25 But when you take their deposition, you discover

1 that they haven't even gone back and looked at their own
2 information about where their subscribers go and that their
3 subscribers are maybe already using those hospitals. You can
4 get, for example, the information, the claims data, from the
5 health plans and look at the zip codes of their subscribers
6 and what their historical patterns have been.

7 The ability to go behind what the payors are
8 saying would allow the Government, perhaps, to shore up that
9 testimony with other kinds of harder evidence that's maybe
10 consistent with what they're saying.

11 The nonhospital cases that rely on qualitative
12 evidence, like testimony, like documents, tend to be cases in
13 which that's not inconsistent with the statistical evidence;
14 that cases in other arenas where the Government has been able
15 to prove its case, the defendants have not been able to point
16 to the statistical evidence as inconsistent.

17 So, for example, in the Staples case, where the
18 market was defined based on a lot of emphasis on internal
19 documents of the merging parties, it was also supported by
20 the scanner data that showed, in fact, the hard numbers
21 supported what the internal documents said.

22 But, in some of these hospital cases, the
23 statistical evidence is just not consistent with what
24 people's perceptions are, and I think courts are going to be
25 more willing to rely on numbers than on perceptions.

1 The other criticism on the reliance on statistical
2 patient origin data is that it's a static kind of analysis
3 and you can't assume just because there are certain people
4 going to certain places that more people would go to those
5 places. I think that that may or may not be true, but you
6 have to show why that's the case.

7 In most of the cases where statistical information
8 was used to show a broader market than what the Government
9 was alleging, the defendants were able to show that the
10 statistical data proved that patients were already leaving
11 the market at issue or patients were coming into the market
12 from areas where there were legitimate hospital substitutes.
13 So, it was used as evidence of what would happen if the
14 merging hospitals raised prices. So, although it is a static
15 snapshot, the point that was made was a dynamic point.

16 And the critical loss analysis, which has been
17 much criticized, is, in fact, an attempt to use statistical
18 data to show that things would change.

19 Finally, I'd like to make a couple of points on
20 the hospital merger retrospectives. It really is useful, I
21 think, to go back and look at what has happened after
22 hospital mergers have been consummated. But I have a couple
23 of cautions.

24 The first is, it's going to be very, very
25 difficult to measure what the effects of the merger have been

1 in the particular market. In particular, in the hospital
2 industry it is very, very difficult to measure price. What
3 is a price increase? How do you compare the different types
4 of contracts with health plans? How do you account for the
5 fact that there has to be cost shifting due to indigent care
6 due to underpayment by Government entities? How do you
7 compare a capitated contract to a per diem? It's just going
8 to be very, very hard.

9 And, then, even assuming that that kind of
10 measurement can be done, how do you determine whether a price
11 increase is due to a merger or is due to other factors in
12 that particular market? I think that the Government needs
13 to be very careful in drawing conclusions there.

14 And, second, I think it would be easy to fall into
15 some of the same traps in these retrospectives by relying on
16 the anecdotal evidence from the health plans. This is
17 perhaps a case where we have the luxury of a little bit more
18 time, the health plans can be put to the same test as the
19 hospitals to provide the specific information about pricing,
20 revenues, what they do with their premiums, to really analyze
21 whether, in fact, the merger has had a negative impact on
22 competition.

23 Thank you.

24 (Applause).

25 MS. MELMAN: Thank you, Toby. Next we'll hear

1 from Dave Argue.

2 MR. ARGUE: Thanks, Leslie. I'd like to start off
3 by thanking the FTC and DOJ for inviting me to address you
4 guys. I think this set of hearings is likely to produce some
5 interesting and thoughtful perspectives that will help guide
6 us in the future.

7 In November, 2002, Chairman Muris of the FTC
8 remarked in reference to the Merger Litigation Task Force,
9 that the agencies needed to develop what he called "New
10 strategies for trying hospital mergers." This is clearly
11 reflecting the frustration that the agencies have been
12 feeling over the last several years with their inability to
13 prevail in the courts.

14 In that same address, he also referred to some
15 previous comments by Chairman Pitofsky, these comments dating
16 back a number a years, in which the former Chairman Pitofsky
17 talked about "a recurring need to return to first
18 principles." I believe, and I'll go through this in a little
19 bit more detail, that the best new strategy for litigating
20 hospital cases is to, in fact, return to first principles.

21 The right question is whether the existing tools,
22 which are good ones -- the Merger Guidelines -- are being
23 used properly. The Merger Guidelines' framework for
24 analyzing hospital mergers is fundamentally correct. It's
25 got the right concepts, it's got the right approaches. There

1 are disagreements that as to the emphasis that ought to be
2 put on one part of it compared to another part, but the
3 paradigm is right and the way to go through it is right. And
4 the courts have consistently endorsed the Merger Guidelines
5 as a framework for litigating hospital mergers.

6 I'd like to address some of the primary issues
7 that I see in the use of the merger guidelines, in what I'm
8 calling a "back to basics" approach to litigating hospital
9 mergers. If the Guidelines have the right framework, how
10 might they be better applied?

11 The Guidelines' framework focuses on the basic
12 question of whether enough customers -- in this case a
13 patient or payor - would switch suppliers -- in this case
14 hospitals -- in order to defeat an attempted price increase
15 or quality decrease. To implement this framework, there are
16 some fundamental, basic analytical principles that need to be
17 adhered to.

18 I'm just going to talk about two of these that I
19 think are especially important. I'm sure there are others
20 that fit into this category as well. The two that I'm going
21 to talk about are the need for internally consistent theories
22 and the need to have dynamic analyses.

23 Internally consistent theories, what I'm referring
24 to is the theory that links the competitive harm to the event
25 that has occurred. Presumably, the event is the merger and

1 the competitive harm is the ability or some supposed ability
2 of the hospitals to raise price or decrease their quality.

3 An internally consistent theory is not just a
4 formality. It's not something that you say nicely. It's an
5 important aspect of clear thinking and sensible evidence-
6 gathering. I don't think that you'd want to start one of
7 these processes without having gone through your theories
8 very carefully.

9 The theory has got to start with, as I said, a
10 link, causing a link between the merger and the supposed
11 harm. It also needs to be consistent with the bedrock
12 assumptions of the Merger Guidelines -- profit maximization,
13 if a firm possesses market power that they will actually
14 exercise that market power, and so forth.

15 The theory also needs to be consistent with the
16 source of the market power. For example, a lot of cases
17 begin with the theory of unilateral effects. If a hospital
18 in a multi-hospital market is reconfiguring its services so
19 that it's not offering the same services in both of the two
20 facilities, or if the two facilities are located very close
21 to each other, which is often the case in these, then the
22 unilateral effects theory is not likely to work.

23 So, if you're in a multi-hospital market but you
24 don't have unilateral effects theory, then you're heading
25 toward a coordinated effects theory. That gets back to the

1 beginning of the coordination is not consistent with a
2 unilateral effects theory in the first place.

3 There tends to be a lot of confusion about this as
4 these cases are brought forward, and it's true in private
5 litigation, as well, and that makes the whole analysis much
6 more difficult by failing to have a consistent theory.

7 The theory also needs to be consistent in the way
8 in which market power would be exercised. For example, a
9 theory that does not describe price discrimination should not
10 predict that market power will be exercised against some of
11 the customers.

12 The second main topic that I had wanted to talk
13 about was the need for dynamic analysis. The hypothetical
14 monopolist framework is fundamentally forward-looking. It's
15 hypothetical, after all, and it's a question of what would
16 happen if the merged parties got together.

17 A static analysis, as Toby had made reference
18 before, a static analysis is not adequate. Often in
19 analyzing data, parties -- or the Government -- will apply an
20 Elzinga-Hogarty test as a means of looking at the patient
21 flow data. That's fundamentally a static analysis and it
22 does not address the dynamic market definition question.

23 And the Courts have recognized the need for this
24 dynamic analysis. They talked about it in Sutter, it was
25 addressed in Tenet, it was brought up in Long Island Jewish

1 and Freeman as well.

2 Having considered some of the fundamental
3 principles, and as I've said, I'm sure there are more that
4 fairly fit into that category, let's just turn to some of the
5 key concepts. There are others, I'm sure, that, again, are
6 relevant, but I'm not going to address every one of them.

7 But, clearly, market definition, shares in
8 concentration and entry are issues that come out point by
9 point in the Merger Guidelines. Efficiencies, obviously, is
10 another one that fits into that category, but I'm not going
11 to work on that today.

12 For market definition, and markets do
13 fundamentally need to be defined properly, the analysis from
14 the Merger Guidelines comes back to that same question of
15 would enough customers switch suppliers, or switch hospitals
16 in this case, to defeat a price increase. Another way to say
17 that is what is the smallest group of hospitals that
18 collectively could profitably increase price or decrease
19 quality?

20 The framework in the Guidelines, as it relates to
21 market definition, addresses this question of how much is
22 enough? How much of customer switching is enough?

23 The answer that has evolved over the last 10 or 15
24 years focuses largely around the critical loss, or variations
25 on that concept. In determining the critical loss, the loss

1 is really just a threshold. It's a threshold above which any
2 additional loss would be unprofitable. There's nothing
3 magical or nothing especially difficult about the critical
4 loss calculation. I know there's a certain amount of
5 controversy surrounding the calculation, but the concept is
6 that that's difficult and it generally yields an intuitive
7 result. Hospitals have high fixed costs, so their
8 contribution margin is going to be high and the critical loss
9 tends to be low.

10 Some courts have explicitly noted the role of the
11 critical loss in the analysis; that was true in Tenet, it was
12 true in Sutter, it was true in LIJ and in Mercy Health
13 Services, as well. And interestingly some of the more recent
14 decisions, the courts have explicitly stated that that
15 critical loss concept comes right out of the Merger
16 Guidelines.

17 The Appeals Court said that in Tenet and the
18 District Court said it in Sutter as well. So calculating the
19 critical loss is one issue. The harder question is, and the
20 more controversial question certainly is, will the critical
21 loss be exceeded if the merger is allowed to occur and the
22 merged parties attempt some anti-competitive action?

23 What are some of the means by which we can assess
24 the answer to this question? And I'm going to talk about
25 three of them. The patient origin data; payors mechanisms

1 for shifting or for influencing patient choice; and for the
2 opinions of market participants.

3 The patient flow data, I believe, is still one of
4 the most important sources of information for analyzing a
5 hospital merger. It allows people to examine what has
6 actually gone on in the market and then make some inferences
7 about future behavior. There's some indications that the
8 agencies want to rely even less on patient flow data than
9 they have in the past. But the patient flow data are actual
10 in nature, they reflect actual transactions between the payor
11 and the patient, on the one hand, and the hospital on the
12 other.

13 The patient flow data are highly specific to the
14 transaction and reconsideration; they can be disaggregated to
15 a great level of detail, breaking it down to residential zip
16 code, to the specific service being offered, to the payors
17 under consideration and certainly to the right time frame.
18 In other words, it's possible with the patient flow data to
19 create a set of similarly situated patients which allows one
20 to make reasonable inferences about what patients are going
21 to do in the event of a price increase.

22 Now the inferences are certainly based on
23 assumption. There are some assumptions embedded in that type
24 of analysis, which is why you'd want to go back and test
25 those assumptions for their sensitivity -- or test the

1 results for the sensitivity to variations in the assumptions.

2 The patient origin data, as Toby had mentioned,
3 had been accepted by the Courts and relied on by the Courts
4 in making their decisions. In Butterworth, the patient flow
5 analysis was considered sufficiently strong, along with other
6 information, to define a market. And that was even with the
7 static analysis of the patient flow data.

8 In Mercy Health Services, the patient origin data
9 presented by the Department of Justice, in the Elzinga-
10 Hogarty test, was viewed by the Court as being too static a
11 view -- too static an interpretation of that data was put on
12 it by the Department, but that a more dynamic analysis could
13 be derived from it.

14 In LIJ, patient flows into and out of the area
15 were relevant considerations for the market definition. And
16 in Sutter, again, service area overlaps and patient flows
17 into and out of the area were cited by the Courts as part of
18 their reasoning for deciding on a geographic market.

19 The second mechanism or the second step or second
20 factor that we can look at in determining or assessing
21 whether the critical loss will be exceeded, is whether payors
22 have the right mechanisms to actually make or influence the
23 choice of hospitals being made by patients.

24 The question of consumers switching suppliers in
25 the hospital industry is a lot tougher than it is in other

1 industries because of the role of the third-party payor.
2 There needs to be some specific mechanism or some way in
3 which the payor can influence the choices being made by the
4 consumers. It's inappropriate, I believe, to argue that the
5 failure to see those mechanisms in place today or premerger,
6 let's say, is an indication that those mechanisms won't
7 appear in the future. They may not be necessary in a
8 premerger in a competitive market. The question, then,
9 becomes would they be available and could they be implemented
10 post-merger?

11 As I mentioned, the critical loss in a hospital
12 analysis typically results in the need to move a fairly small
13 number of patients. A small shift in the revenue is enough
14 to defeat a price increase. So, the focus needs to be on:
15 "Are there small numbers of patients that could be influenced
16 by the managed care plans?"

17 And the managed care plans have a number of tools.
18 Some of them are their traditional tools, the exclusion of
19 the merged parties from a network. That was a big deal in
20 the mid-to-late '90s or certainly the mid-90s, as managed
21 care came into its own. It's become less relevant these days
22 as more consumers are demanding open access to other
23 networks. Nevertheless, there are still some products, EPOs
24 and POS products, that have elements of that in it, in terms
25 of differences in the network.

1 One of the other older, more traditional tools or
2 mechanisms that the managed care plans have is the use of
3 capitated products or physician risk-sharing. These, again,
4 while they are not rolling as rapidly as they had been
5 previously, they are still there and they can still be used.

6 But there also are some innovative mechanisms and,
7 as Bob Leibenluft had said, keeping current in the field is
8 part of the process of litigating these cases. And there are
9 a number of new mechanisms that are showing up in the
10 literature, you see it in the managed care plans in
11 California, most places manage to get these things
12 implemented. But they're around. Not every one of them is
13 going to work in every circumstances, including there's a lot
14 of flux in testing going on. But let me just address a
15 couple of them.

16 One of them has been used extensively in the
17 pharmaceutical end of the business for a number of years. It
18 has become increasing common in provider networks as well, so
19 that the more expensive hospitals are in some different tiers
20 than the less expensive hospitals.

21 There also are variable premiums, and that's my
22 term for it, but the concept is that when managed care plans
23 and employers put a surcharge -- for lack of a better word --
24 onto the employee or the subscriber when they're using a
25 higher-priced provider.

1 Consumer-directed plans -- and sometimes these are
2 a variation and this is defined contribution plans -- also
3 are a means by which the managed care plans are getting the
4 money into the hands of the patients and the subscribers and
5 letting that influence their decision more directly.

6 The managed care plans can also, in some
7 circumstances, directly influence the hospitals with
8 retaliation in other markets, especially for large hospital
9 systems, and sometimes in other -- not in other geographic
10 markets, but other product markets, as they look toward
11 outpatient services.

12 The third element on here is the opinion of market
13 participants. The courts agree with the merger guidelines
14 that the opinions of the market participants is relevant.
15 But the courts have also stated that these opinions need to
16 be tested against the facts. In Freeman, the Court had said
17 that the opinions of these market participants needed to be
18 corroborated by the data. In Tenet, the Court doubted the
19 accuracy of the statements of some of these participants. In
20 quoting the Tenet Appeals Court, "Market participants are not
21 always in the best position to assess markets long term."

22 That, obviously, was very significant in that
23 case, because the FTC had relied so heavily on the opinions
24 of the employers and the managed care plans.

25 And in Sutter the Court noted, quoting again, "The

1 perception of market participants should be given
2 considerably less weight than quantitative analyses." So,
3 those things are the points on market definition.

4 Now, moving on to shares and concentration, to the
5 extent that shares have any value at all, it has to be in the
6 properly defined market. If the market is not defined
7 properly, then the shares are void of any particular meaning.
8 Moreover, the relevance of shares is not consistent with all
9 models of behavior. That ties us back to the need to have
10 internally consistent theories in the first place.

11 Certainly shares to the extent that they are
12 considered are one of many variables that should be assessed.
13 If it turns out that shares are something useful to look at
14 in a particular market, the next question is, well, how do
15 you measure the darn things? It turns out that it's a lot
16 more difficult than it may seem in a hospital market to
17 measure shares. You base it on beds. You base it on
18 admissions. Is it the hospitals located in the service area?
19 Is it all the hospitals serving the same set of patients as
20 the merging parties? Shares and concentration have been
21 cited in some of the cases and in some of the cases they have
22 not been cited. They've been cited only tangentially.

23 The next issue is entry. Historically, entry has
24 not been all that important. There's been fairly limited
25 consideration of entry, despite some of the Court opinions

1 indicating that it has some importance. It was cited --
2 entry was an issue in LIJ. There was an issue of
3 repositioning of some hospitals. In FTC vs. Tenet Health
4 Care, entry was discussed in the context of outreach clinics
5 as a means of entering another hospital service area.

6 More recently, entry has become a more important
7 issue, I think, because of the rapid growth of some areas in
8 population to fuel the ability to fill additional beds; aging
9 populations have led to increased demand; the shift in
10 managed care's ability to dampen patient days, leads to the
11 possibility of entry. And entry doesn't necessary have to
12 come in a gigantic hospital with a lot of bricks and mortar.
13 There are specialty hospitals that come in, short-stay
14 hospitals, but there are also general, full-care hospitals
15 that are built in some markets and can provide adequate
16 entry.

17 I'd like to finish up by just going back to
18 Chairman Muris' remarks. He entitled that address
19 "Everything old is new again -- health care and competition
20 in the 21st century." It's sort of a catchy title. I think
21 the lesson that should be taken to heart is that, indeed, to
22 make everything old new again, the agencies need to return to
23 basics in merger enforcement.

24 Thank you.

25 (Applause.)

1 MS. MELMAN: Thank you, David. David Eisenstadt?

2 MR. EISENSTADT: Good morning. I'm not as
3 mechanized as everyone else, so this is Dr. Serdar Kalkir who
4 will be operating the overhead, and he will also be speaking
5 in a couple of minutes.

6 I understand that the title of today's session is
7 "Looking at past litigated hospital mergers and considering
8 the mistakes that the Federal agencies have made." I'm going
9 to go against the grain this morning and I'm not going to
10 talk about past litigated mergers. I'm going to talk about a
11 class of hospital mergers that has not been litigated and, in
12 fact, these mergers have received almost no attention at all,
13 and virtually all of the time have received a clear pass.

14 And I'm going to talk about one private action
15 that was brought because both Federal agencies, I believe,
16 largely passed on this particular matter and, therefore,
17 private intervention and private enforcement was necessary.
18 And I'm also going to talk not only about that case, but I'm
19 going to talk about the economic modeling that was done in
20 order to demonstrate that consumer welfare would decline as a
21 result of this particular merger.

22 The title of today's session is "How mergers among
23 complements lower consumer welfare."

24 Antitrust and industrial organization 101 is that
25 only mergers among substitutes can lower consumer welfare and

1 mergers among complements will typically improve consumer
2 welfare. In fact, I believe if you polled 100 of our 100
3 economists, they would conclude that a merger between a
4 peanut butter monopolist and a jelly monopolist will
5 necessarily improve consumer welfare. This is one of the
6 first things you learn in industrial organization or
7 microeconomics in graduate school. And I believe that is
8 shifted through into antitrust enforcement and investigation
9 that mergers among complements, when they are proposed,
10 typically receive a clear pass.

11 Now, I'm going to stylize this question, though,
12 and ask: "What happens when the two manufacturers of the
13 premium components, i.e., the manufacturer of the premier
14 peanut butter brand and the manufacturer of the premier jelly
15 brand merge?" And, then, I'm going to talk about the
16 hospital merger that's actually a setting for this particular
17 type of merger that occurred in the analysis that was done.

18 I will say even though in this stylized example
19 the conventional argument would be that type of merger will
20 improve consumer welfare because when the premier component
21 manufacturers merge double marginalization is eliminated or
22 pricing externalities because of complementary are eliminated
23 and, therefore, consumers will be benefitted by lower prices.

24 I will mention, as an aside, that these types of
25 mergers are not unique to the hospital industry. They occur

1 across lines of commerce; examples are aircraft landing
2 systems, computer software, beverages -- where some of these
3 matters, I believe, either or both agencies have looked at --
4 beverages, for example, when the premier cola brand merges
5 with the premier lemon-lime brand, and even when there is no
6 customer overlap between cola consumers and lemon-lime
7 consumers, and there has been some attention paid to whether
8 these types of mergers could be problematic, but I believe
9 virtually all of the time, ultimately, the conclusion is --
10 and often with not a lot of investigation -- these mergers
11 must be good for consumers and they receive a pass.

12 What you need here, in order to analyze these
13 mergers, is components which are packed into systems by
14 middlemen. These systems are then sold for sale to consumers
15 or retailers. In the merger I'm going to talk about, the
16 middlemen are health insurers, and they package hospitals
17 into networks, which are sold to employers.

18 What you find is a merger among the premium brand
19 manufacturers largely permit a bypass of the middleman. On
20 the example I'm going to talk about, it's the health insurers
21 who perform an arbitrage function in disciplining the prices
22 of the premium brand components, premerger.

23 The interesting thing is that the health care
24 industry has structural characteristics that make these kinds
25 of mergers not all that atypical. For instance, you have

1 spatially complementary hospitals who combine. That is, the
2 best hospital on the east side of town proposes a merger with
3 the best hospital on the west side of town, and let's assume
4 for the moment that there's no customer overlap between
5 residents who live on the two sides of the town. So,
6 this is a merger between two complements.

7 Or you can have different service-type hospitals
8 who combine. For instance, the best obstetrics hospital in a
9 community merges with the best heart hospital in the
10 community. Again, let's assume for the moment that there is
11 no common customer overlap for other services, and we'll just
12 focus on the complementary.

13 It's not just hospitals that are combining. You
14 can have this type of event occurring with hospital physician
15 mergers. The best hospital in town merges with the best
16 physician group in town. Or you can have physician/physician
17 mergers where this is an issue -- the best physician group in
18 town merges with -- in one specialty -- merges with the best
19 physician group in another subspecialty.

20 In addition, what you find in hospital markets is
21 the existence of middlemen; specifically, health plans who
22 assemble these hospitals or providers into a package or a
23 system for purchase by employers.

24 Let me talk about the transaction at issue here.
25 Some of you may be familiar with this. In 2001, the

1 University of Pittsburgh Medical College Health System or
2 what I'll call UPMC, proposed an acquisition of Children's
3 Hospital of Pittsburgh, which I will call CHOP.

4 UPMC owned 11 general acute care facilities in the
5 Pittsburgh area; CHOP was the only specialty children's
6 hospital and it was the premier pediatrics facility in the
7 greater Pittsburgh area. UPMC was also the premier adult
8 hospital system. Its Allegheny County share was between 40
9 to 50 percent; its metropolitan Pittsburgh area share was
10 between 30 and 35 percent; its nearest adult competitor,
11 which is the West Penn Allegheny Health System, had a share
12 approximately one-half of UPMC's share.

13 As I mentioned, Children's Hospital was the
14 premier pediatric facility. Its Allegheny County share of
15 pediatric patients was about 70 percent; its metropolitan
16 area share was 60 percent; its nearest pediatric competitor
17 in Allegheny County had a share quite a bit smaller, about 10
18 percent, and UPMC's pediatric share was about 5 percent.

19 I was retained in the spring of 2001 to begin
20 looking at this transaction. And I did some field work,
21 initially, and I will represent to you that the two most
22 significant commercial payors, Highmark, which is Blue
23 Cross/Blue Shield of Western Pennsylvania, and Health
24 America, as well as major employers and West Penn Allegheny
25 Health System, opposed this transaction.

1 I will also tell you that the horizontal overlap
2 in pediatrics was of minor concern to both Highmark and
3 Health America. While it was noted that there would be some
4 modest to slight or slight to modest increase in
5 concentration in pediatrics, that was not the principal
6 concern; rather, the primary concern related to the proposed
7 combination of the preferred adult system and the premium
8 pediatric hospital. In other words, the two premier brand
9 manufacturers were merging.

10 There was concern expressed about post-merger
11 bundling, denial of access to Children's or unilateral price
12 increases at Children's Hospital, Pittsburgh, or, also, UPMC
13 facilities.

14 UPMC's basic position was the lack of horizontal
15 effect made the competitive analysis of the transaction an
16 absolute no-brainer. This was a merger between the
17 proverbial peanut butter monopolist and jelly monopolist; a
18 merger that must, necessarily, improve consumer welfare. And
19 UPMC could not understand why payors were opposed; why
20 employers were opposed; and felt that the opposition by West
21 Penn Allegheny Health System was, basically, sour grapes.

22 This matter was brought to the attention -- I
23 don't recall which agency, whether it was the FTC or DOJ - I
24 don't think either agency or the one that was approached
25 showed much interest. And I will also mention that several

1 years before that, when UPMC was proposing to acquire McGhee
2 Women and Children's Hospital, and there what you'd have is
3 the premier general, acute care, adult system, UPMC,
4 proposing to merge with the premier women's and children's
5 hospital, which was McGhee Women and Children's. There was
6 also little interest shown, I believe at DOJ in that
7 transaction.

8 So, after doing the field work, I was asked to
9 economically model the transaction and determine whether, in
10 fact, consumer welfare could fall as a result of a
11 transaction of this type. Now, I had with me the information
12 or the opinions of the two major payors who thought they
13 would be worse off from this transaction. Although I will
14 tell you that neither payor did a very effective job of
15 explaining why this type of merger would lower consumer
16 welfare. Their instincts were their customer accounts would
17 be worse off as a result and, therefore, they were opposed.

18 So, in thinking about how to model this, I thought
19 about a stylized type of model where health plans or
20 packagers or systems integrators, employers demand hospital
21 networks which offer access to both adult and pediatric
22 hospitals.

23 The Pittsburgh employers demanded a hospital
24 network which had to have one or both of the two premier
25 components; that is, you could not sell a health plan to

1 employers in the Pittsburgh area that lacked both UPMC and
2 Children's Hospital of Pittsburgh.

3 There was significant testimony and documents from
4 both payors that that was the case, and, in fact, I believe
5 that the enrollment shares of the health plans, who offered
6 neither UPMC or Children's Hospital of Pittsburgh as
7 participating facilities in their health plan products, were
8 virtually zero.

9 I'll also tell you that Highmark and Health
10 America both sold health plan products that actually excluded
11 UPMC. Highmark had one or two products which excluded UPMC
12 and featured West Penn Allegheny Health System plus
13 Children's Hospital of Pittsburgh; and Health America's
14 flagship product included West Penn Allegheny Health System
15 and Children's Hospital of Pittsburgh, but excluded UPMC.

16 There was clear, positive employer preference for
17 UPMC over West Penn Allegheny Health System. So, UPMC was
18 the premier component in the general, adult, acute care
19 segment. There was an even larger positive preference for
20 Children's Hospital of Pittsburgh over other hospitals who
21 had pediatric units. Now Children's Hospital of Pittsburgh
22 was the only specialized pediatric facility, but most of the
23 adult hospitals had pediatric units. Children's Hospital of
24 Pittsburgh was considered to be a near-essential facility by
25 employers in the Pittsburgh area.

1 The analytical setup that I used was premerger -
2 we have two components, little (a) and (b) -- they're
3 combined in fixed proportions to form a system, little (a)
4 plus (b). There is competition within each one of those
5 component segments. (a) is the premium brand component
6 within the little (a) segment, and (a) prime is the generic
7 component.

8 So, (a) would refer to UPMC, general, adult, acute
9 care hospitals and (a) prime would refer to West Penn
10 Allegheny Health System. (b) is the premium brand component
11 of little (b), so (b) would be Children's Hospital of
12 Pittsburgh and the (b) prime would be the general, acute care
13 adult facilities, all of which had their own, relatively
14 small, pediatric units.

15 The premerger packages that were sold by the
16 system's integrators or the health plans, were (a) and (b);
17 that is, the two premier components combined; (a) and (b)
18 prime and (a) prime and (b). You can tell there is virtually
19 no enrollment share for health insurance plans who sold (a)
20 prime and (b) prime.

21 And now we have this proposed merger where
22 University of Pittsburgh Medical College is proposing to
23 acquire Children's Hospital of Pittsburgh. The producers of
24 (a) prime are opposed; that is, West Penn Allegheny Health
25 System; the system's integrators are opposed, Highmark and

1 Health America; and to tell you more about the economic
2 analysis that I developed with my colleague, Dr. Serdar
3 Dalkir, also from MICRA, and two other economists. Serdar
4 will talk for a few minutes and then I'll pick up again at
5 the end.

6 DR. DALKIR: Thanks, David. I will try to make
7 this as fast as I can and, hopefully, the economic infusion
8 will come across and we can cover special questions after the
9 session, perhaps.

10 The basic proposition of the economic analysis was
11 we assumed that consumer valuations for the premium component
12 (b) and the premium component (a) were negatively correlated
13 and those valuations could be represented by (a) circle,
14 thereby the consumer preferences are represented by coins on
15 the circle; for example, this blue coin here might correspond
16 to consumer (I), whose preferences would be .8 of a premium
17 or the premium (a) component over the generic component; and
18 a .6 of a premium for the premium (b) component over the
19 generic (b) prime component.

20 When the premerger equilibrium for the component
21 (a) and component (b) each, maximizing its profit separately
22 before the merger, obviously. We found in this setup the
23 premerger component prices were each .65.

24 Who buys: Rich consumers buy rich components in
25 this model. The consumers who are on the upper side of the

1 circle -- upper part of the circle -- whose valuations for
2 (b) exceeds this price, .65, would buy (b). Similarly,
3 consumers located on the lower side of the circle -- lower
4 part of the circle -- whose valuations were (a) and exceed
5 the price of (a), would buy the component (a).

6 In equilibrium, if you look at the packages sold
7 in the market, you're going to see some segment of the
8 consumers buying a mixed package of (b) and (a) prime; the
9 corresponding segment of consumers buying the mixed package
10 (a) and (b) prime; and a third segment of consumers, located
11 in the middle, buying the premium package of (a) and (b), or
12 UPMC and Children's Hospital of Pittsburgh. So this is all
13 premerger.

14 If you wanted to ask what's the consumer's surplus
15 for these consumers, people whose valuation are about the
16 price (b) and who bought (b), we'll end up having this shaded
17 area as their consumer surplus.

18 Similarly, for consumers who bought (a), would be
19 represented by a similarly shaded area to represent their
20 consumer surplus.

21 Premerger prices for the systems, the recap for
22 the premium bundle or premium system, .65 plus .65 is 1.3,
23 and each of the mixed systems is priced at .65, assuming each
24 of the generic components is priced at zero.

25 MR. EISENSTADT: We assume that marginal costs

1 were zero and there was competition between the generic
2 components which would lead, of course, to price equals
3 marginal costs for them, equal to zero.

4 DR. DALKIR: When you got the post-merger market
5 and compute the equilibrium prices, what's going to happen is
6 the merging premium component manufacturers are going to
7 bundle their premium components and sell that at a price of
8 1.24. This is represented by this downward sloping heavy
9 line on the circle. And, in addition, they are going to sell
10 each of the components individually at a price of .96.
11 That's about a 50 percent of increase over the premerger
12 price of individual components.

13 So, the package price has changed from pre- to
14 post-merger. The premium package price decreases about 55
15 percent. And each of the mixed package prices increase by
16 about 50 percent.

17 In post-merger equilibrium, the consumers at the
18 northwest corner buy the mixed bundle, (a) prime and (b); at
19 the southeast corner, you have consumers buying (a) and (b)
20 prime; and a vast majority in the middle buy the premium
21 package.

22 When you go to the consumer surplus analysis, how
23 the welfare has changed in the market, when we analyzed it we
24 found that there is a welfare decrease from the merger. The
25 consumers, as a whole, lose from the merger.

1 Who are the gainers, who are the losers? A slight
2 majority of consumers in the middle were gaining from the
3 merger. Their consumer surplus increased, whereas the
4 majority of consumers located toward the edges of the circle,
5 lost.

6 Finally, we thought about modeling this as an
7 asymmetric framework where the preferences where one
8 component may not be as strong as the other. We have come up
9 with similar results and the results didn't change
10 qualitatively, if anything they were stronger.

11 MR. EISENSTADT: So, how did all of this play out?
12 The case was filed in August of 2001 or early September 2001.
13 Preliminary injunction hearing was set for October 2001.
14 This case settled out short of a trial one working day before
15 the preliminary injunction hearing was set to begin. The
16 resolution was a consent decree between UPMC and Children's
17 Hospital of Pittsburgh was entered with the State Attorney
18 General of Pennsylvania.

19 It's an involved decree, but some of the
20 provisions were: there's an access provision assuring payors
21 continued access to Children's Hospital of Pittsburgh; there
22 is a no-bundling provision. The interesting thing is the
23 decree does not address mixed bundling and, specifically,
24 whether there are limits on the component prices that
25 Children's Hospital of Pittsburgh and UPMC can charge to

1 payors after the transaction. And what Serdar just pointed
2 out, our analysis suggested that the component prices would
3 go up, although the bundle price would fall.

4 There is a provision in the decree that requires
5 UPMC and Children's Hospital of Pittsburgh to negotiate in
6 good faith with payors, but that, of course, is subject to
7 interpretation as to what good faith means, but there is no
8 specific pricing requirement for the component prices that
9 are set to payors.

10 I will mention, though, that when we modeled this,
11 using asymmetric preferences for the premium brands, we also
12 found that under pure bundling consumer welfare would fall,
13 under some conditions, which would then make the state's no-
14 bundling provision kind of more plausible. But this was work
15 that was done after the matter settled on the eve before
16 trial. All we had done was work out the mechanics and the
17 calculus for the unit circle, and our results suggested that
18 what the state should have been most concerned about was
19 mixed bundling and there should have been some requirement in
20 place put on the component prices as opposed to just a simple
21 no-bundling provision.

22 I will also mention there was a private settlement
23 between UPMC and each of Highmark and Health America and I'm
24 not sure I know all of the provisions of that private
25 settlement, but certainly what little I do know I'm not at

1 liberty to divulge but there were some pricing guarantees
2 that were made to both payors insofar as continued access at
3 specified prices to Children's Hospital of Pittsburgh and
4 UPMC.

5 Thank you.

6 (Applause).

7 MS. MELMAN: Thank you very much, David and
8 Serdar. I'll now turn this over to Jon Jacobs from the
9 Antitrust Division.

10 MR. JACOBS: Thank you. Those of us at the
11 Department of Justice who have been involved in litigating
12 hospital mergers certainly appreciate this morning's panel
13 and suggestions, modest or otherwise, that we've received
14 about how we should proceed in the future. There's no doubt
15 that these cases are very difficult ones to try, for the
16 reasons we've heard this morning, but I'd like to end this
17 morning's panel on a note of optimism, and I promise to be
18 brief, although not because there's not a lot of optimistic
19 things to say.

20 Despite all the difficulties that arise in these
21 cases, it's our view at the Department of Justice that we're
22 not overly concerned about the string of losses we've had in
23 the Courtroom since 1994. We certainly have not abandoned
24 the field, and we do intend to bring cases challenging any
25 competitive hospital mergers where we find them.

1 Now, in my view, and I will give the usual
2 disclaimer that these are my views and not the official view
3 of the Department of Justice, there's at least three reasons
4 why we don't view this string of losses in the Courtroom with
5 as much concern as you might think.

6 First, we look at the two cases we've tried and
7 lost in the broader context of our overall enforcement
8 agenda. It's our job to review the many hospital
9 transactions that come before us, let those that don't raise
10 competitive issues proceed, challenge those that do and
11 obtain effective relief.

12 So, how have we done? According to recent studies
13 since 1993, there have been approximately 1,500 hospital
14 mergers. And during that time we've challenged or been
15 prepared to challenge only four of those. So, clearly we
16 have been highly selective and we do agree that the vast
17 majority of these transactions don't raise competitive
18 problems.

19 How have we done in the four cases where we have
20 found problems? As you know, we tried and lost two of them,
21 in Dubuque, Iowa and Long Island, New York, but we
22 effectively stopped the other two. In 1994 we entered into a
23 consent judgment prohibiting the merger of the two premier
24 hospitals in North Pinellas County, Florida, Morton Plan and
25 Meese.

1 And in 1998, with the Missouri Attorney General's
2 Office, we investigated a merger of two hospitals in Cape
3 Girardeau, Missouri. We prepared for litigation in that
4 case, including retaining both economic and efficiencies
5 experts. What happened there is the Missouri Attorney
6 General communicated his concern about the deal and in
7 response to that the hospitals pulled out of the deal.

8 In both of those matters, in Florida and Missouri,
9 we worked in tandem with state officials, and we certainly
10 agree that that is an important thing to do in these matters.
11 And I'll also note the timing of the Cape Girardeau, because
12 that came after our loss in Long Island -- it came about a
13 year after that, so that shows that despite our two losses,
14 we certainly have not abandoned the field.

15 Moreover, even the Dubuque case, we don't view as
16 an unqualified loss. The hospitals in that case did pull out
17 of the deal while the case was on appeal. Now, why did they
18 do that? Well, the CEO of Finley Hospital, which was the
19 hospital that withdrew, was quoted as saying that "It was due
20 to the passage of time and also because he felt that Dubuque
21 had become large enough to support two competing hospitals."
22 So, today at least, in part, due to our efforts, Dubuque is
23 still a two-hospital town.

24 The second reason why we're not discouraged about
25 our litigation losses is that we did win important parts of

1 those two cases, Dubuque and Long Island, and helped to shape
2 the law for the better. Both judges -- each judge in those
3 cases -- recognized far fewer efficiencies than what the
4 defendants were claiming.

5 Yes, we do agree that the medical arms race is an
6 issue that comes up repeatedly in these cases, but we feel
7 like we've handled that pretty well. And we've also been
8 successful at limiting the impact of the hospital's nonprofit
9 status.

10 The third reason is that we really didn't lose
11 these cases for the same reason. Toby mentioned that the
12 same reasons do not keep coming up in these cases and we
13 agree with that. There have not been recurring issues that
14 we've just been able to overcome in case after case. We
15 don't view hospital merger cases as unwinnable, and now,
16 having more experience with the issues that we did lose them
17 on, we feel more confident about facing those same issues in
18 future cases.

19 Now, I'd like to expand on those last two points,
20 talk about the issues we won and the issues we lost, by
21 giving you just a little bit of detail about these two cases,
22 Dubuque and Long Island.

23 First I'll talk about Dubuque, which was litigated
24 in 1994. The home field advantage has been mentioned today.
25 I will say that the judge in this case sat in Cedar Rapids,

1 but he was a native of Dubuque, and decided to hold the trial
2 in a special courtroom that was in Dubuque. So, we actually
3 tried it in the city itself.

4 This is coming under the main screen, in a minute
5 here -- coming onto the screen in a minute here -- will be a
6 diagram of the tri-state area. Dubuque, Iowa is located at
7 the intersection of Iowa, Wisconsin and Illinois. This is a
8 merger between the only two general, acute care hospitals in
9 Dubuque, Iowa -- Mercy Health Center and Finley Hospital.
10 There were two sets of competing hospitals. Around Dubuque
11 and the rural areas, there were several small community
12 hospitals and, then, farther out from that, in the other
13 cities that you see identified -- Waterloo, Cedar Rapids,
14 Iowa City, et cetera -- were the closest hospitals that were
15 comparable to the mergering hospitals. And they were located
16 between 70 and 100 miles away.

17 Now, we've heard a lot earlier in this week about
18 the financial troubles that hospitals face and, so, I will
19 mention this: There was not the issue in this case. In
20 fact, it was stipulated that both Mercy and Finley were
21 financially sound and viable hospitals and would remain so
22 even in the absence of a merger.

23 We lost this case on the geographic market issue.
24 The judge agreed with us that the small rural hospitals were
25 too small to be viable alternatives, but included the

1 comparable so-called regional hospitals in these other
2 cities, 70 to 100 miles away, and did so primarily because of
3 the existence of outreach clinics that these other hospitals
4 had established in the rural areas between Dubuque and the
5 other cities.

6 The judge agreed that the effect of these clinics
7 had not been quantified, but he believed that they would only
8 be profitable if they referred patients back to the
9 sponsoring hospital.

10 Eighteen percent of Mercy and Finley's patients
11 lived within 15 miles of one of these outreach clinics, and,
12 so, the Judge believed that if the merger went through,
13 managed care payors could provide incentives for patients to
14 travel away from Dubuque towards these other cities and
15 thereby discipline a price increase.

16 There was virtually no physician/staff overlap
17 between the Dubuque hospitals and the other hospitals, but
18 the Judge disagreed with our view that there was a strong
19 loyalty on the part of patients to their physicians.

20 Now, we think, obviously, the Court got it wrong
21 and that we stood a good chance on appeal, despite the
22 existence of the Freeman appeal, which the Eighth Circuit
23 issued shortly after Judge Malloy issued his decision in this
24 case.

25 The effect of these clinics was speculative; it

1 was not clear whether managed care plans could profitably
2 steer patients towards these other cities. If a plan wanted
3 to -- as one example -- provide incentives for patients
4 living in the central lands between Dubuque and Cedar Rapids
5 to travel to Cedar Rapids, it would be difficult not to do
6 the same for those patients already living closer to Cedar
7 Rapids, already using those other hospitals. So, it's not
8 clear that the managed care plan could profitably do so
9 because it may well lose more money than it gains.

10 And there was evidence that many of these other
11 hospitals, including those in Cedar Rapids and the University
12 Hospital in Iowa City, were already more expensive than the
13 Dubuque hospitals. So, it was not clear that that kind of
14 strategy would work.

15 Today we view the issue of outreach clinics as
16 probably easier to address than in 1994. Today, anti-
17 steering provisions are more common in hospital contracts.
18 Certainly had this merger gone forward, the Dubuque hospitals
19 would have had substantial market power, certainly enough to
20 impose some sort of limits on managed care payors steering
21 patients away from Dubuque and towards these other cities.

22 And we're also more confident about taking on this
23 issue because we did so successfully in the Long Island case
24 three years after this. A large part of that trial was
25 devoted to this same issue. There, the defendants argued

1 that the Manhattan hospitals were in the geographic market
2 because they had begun what was called colonizing Long Island
3 by advertising, by setting up these outreach clinics and by
4 affiliating with hospitals on Long Island.

5 We argued in that case, among other things, that
6 what was going on there was that the Manhattan hospitals were
7 competing against other Manhattan hospitals and not Long
8 Island hospitals.

9 The managed care plans of concern there were
10 forming hospital networks centered on Long Island but they
11 would also include hospitals in Manhattan for those people
12 who lived on Long Island but worked in Manhattan, and the
13 Manhattan hospitals were competing against each other to be
14 THE Manhattan hospital in those kinds of networks.

15 These outreach clinics that they had established
16 were a part of that competition, but we didn't believe that
17 they were changing the referral patterns for primary and
18 secondary care. We argued that to the Judge and the Judge
19 agreed, ultimately finding that the Manhattan hospitals were
20 not in the relevant geographic market.

21 Now, turning back to Dubuque, we won two important
22 issues in this case: First, the Court found that the
23 potential efficiencies were no more than our expert found.
24 And, even with respect to those, he found that they could
25 well not be or may not well be realized because there was

1 significant doctor opposition to some of the clinical changes
2 that would have been necessary to realize those. And,
3 second, he discounted the nonprofit status of the hospitals
4 for the reason that Toby explained earlier.

5 So, in sum -- with respect to the Dubuque case --
6 we, obviously, feel that we were right in bringing that case.
7 We learned from our setback on losing the geographic market
8 issue. We won important parts of the case, and certainly in
9 the future, if we find a case like this, we won't hesitate to
10 file a case and try to preserve competition in a two-hospital
11 town such as this.

12 Let me see if I can go to the Long Island case
13 now, which was in 1997. And this, obviously, was a very
14 different market. What you see here are the two merging
15 hospitals, again, in red -- Northshore University at
16 Manhasset and Long Island Jewish Medical Center. The other
17 hospitals on the map that you see are those located in Queens
18 and Nassau Counties in New York, which was the relevant
19 geographic market that the Judge ultimately found.

20 Our theory in this case, as you know, was that the
21 two merging hospitals competed to become the anchors of
22 managed care networks, that they were critical components of
23 managed care networks. And, therefore, despite the existence
24 of all of these other hospitals you see on the map, the
25 competition between the merging hospitals was important. As

1 in the Dubuque case, the hospitals here did not raise a
2 failing or even flailing company defense. Each hospital was
3 financially sound.

4 First, our victories in this case. As I mentioned
5 before, we kept the Manhattan hospitals out of the market.
6 In addition, the Judge recognized only a third of the
7 efficiencies that the defendants claimed and he gave only
8 limited and nondeterminative effect to their nonprofit
9 status. So, he relied on it in part but not entirely.

10 We lost, of course, on the product market. The
11 Judge rejected our anchor hospital product market because in
12 all of the other previous cases the relative product market
13 had been general acute inpatient services. He also found
14 that 85 percent of the primary and secondary care services
15 offered by the merging hospitals were provided by these other
16 hospitals you see on the map and, in his view, the reputation
17 of the two merging hospitals did not set them apart.
18 Although he only cited one other hospital, Winthrop Hospital,
19 as having an equally high reputation.

20 Despite our loss here, we do believe that anchor
21 hospital markets exist. We believe that managed care plans
22 often look for anchor or flagship hospitals to build their
23 network around, to be attractive to employers. The fact that
24 there are so many other hospitals on the map, in our view,
25 does not mean that the competition between the two merging

1 hospitals here was unimportant. Not all hospitals are
2 created equal. We're talking about a highly differentiated
3 product market here and highly differentiated services.
4 Hospitals differ not only in the range of services that they
5 offer, but in their reputation and in the role that they play
6 in managed care networks.

7 There was evidence in the case that we introduced
8 that the two hospitals -- North Shore and LIJ -- competed
9 vigorously to be the anchor in these managed care networks
10 and, in fact, the CEO of Long Island, LIJ, conceded that he
11 considered his site as an anchor site.

12 We also believe that mergers in urban markets like
13 this, while difficult to win these types of cases at trial,
14 can cause anticompetitive effects. And, of course, the issue
15 of effects was hotly contested at trial.

16 This is one of those cases where we had a
17 community commitment. The hospitals had agreed with the New
18 York State Attorney General's Office not to raise prices for
19 at least two years.

20 So, the question was, what would happen after this
21 community commitment expired? We argued that prices would go
22 up substantially as the merged hospital eliminated discounts
23 to managed care plans. And we introduced intent evidence
24 from the hospitals' internal documents that the reason for
25 the merger -- a key reason in one document -- the first

1 reason for the merger was to gain greater leverage over HMOs
2 and other managed care plans.

3 The defendants argued that prices would not go up
4 as a result of the merger because there were so many other
5 hospitals in the area providing the same services.

6 The court found, despite the intent documents that
7 we introduced, that -- and I quote -- "The record is totally
8 devoid of any evidence that the merged entity would raise
9 prices in the future."

10 So, what happened? Well, we have not done a
11 formal retrospective on this case. However, there is
12 anecdotal evidence suggesting the prices did go up as a
13 result of the merger, in year three after the community
14 commitment expired.

15 And while there's been some disclaimers about the
16 persuasiveness of anecdotal evidence, we think one piece of
17 anecdotal evidence I am about to show you is particularly
18 persuasive because it comes from a fairly persuasive source.
19 This is an article from the New York Times on December 17,
20 2000. The picture you can't make out very well; the title is
21 "After Merger's Bumpy Start, Northshore/LIJ is Clicking."
22 And the gist of this article is that the hospitals had
23 difficulty in the first couple of years integrating and they
24 did incur some financial losses, but in the third year they
25 had turned it around, and they had solved their financial

1 troubles. And on the second page, Jack Gallagher, the CEO of
2 the merged hospital, describes how this was possible.

3 If I can get to that, we can all read it. Mr.
4 Gallagher, the system CEO, was attributed as saying that the
5 improved financial picture to the system's ability to
6 negotiate better reimbursement rates with the 40 insurance
7 companies with which it deals. It was this promise of
8 negotiating clout that gave impetus to the merger of the two
9 hospitals, fierce rivals since it was founded in the early
10 1950s.

11 So, apparently, the other hospitals you saw on the
12 map were not sufficient to stop this and we do believe that,
13 as I said, mergers in urban markets like this can cause
14 anticompetitive harm. And, certainly, if we find another
15 market such as this, where we believe that such harm might
16 occur, we won't let our one loss, our one failure at defining
17 an anchor hospital product market, won't let that deter us
18 from trying to prevent this sort of harm in the future.

19 So, to conclude, while we're sensitive at the
20 Department to the fact that these are hard cases to try, we
21 won't let our two losses in the last nine years deter us from
22 bringing cases in the future.

23 Thank you.

24 (Applause.)

25 MS. MELMAN: Thank you very much, Jon. At this

1 point, we're going to take exactly a 10-minute break, and
2 then we reconvene for a roundtable discussion.

3 (Whereupon, there was a brief recess.)

4 MS. MELMAN: Okay. So, why don't you start off?

5 MR. MARTIN: Okay. I guess we are all ready to
6 lob some questions your way. I'm Richard Martin from the Lit
7 One Section of the Antitrust Division.

8 The first question I'd like to ask Bob to first
9 comment on but then all others to feel free to comment on.
10 Bob, you had mentioned that the Elzinga-Hogarty test has been
11 too rigidly applied. Now, there's been a lot of shooting
12 going on about geographic market -- in Dubuque, in Freeman,
13 in LIJ - and Elzinga-Hogarty has come under a lot of fire.

14 My question is why don't we just toss out the
15 Elzinga-Hogarty and not disregard patient origin data and the
16 fact that you have to look at it, but go more towards looking
17 at managed care payor testimony, employer testimony, and seek
18 to support that by data, but namely base the geographic
19 market definition on the basis of those who should know best
20 what hospitals are appealing to local consumers, which will
21 work in a network, which will not?

22 So, that was a very long question, but I love to
23 ask them because I'm not in Court.

24 MR. LEIBENLUFT: I think that's probably a good
25 idea. What I was concerned about -- I think it was the

1 Sutter opinion -- where I thought the Court was looking as if
2 the Elzinga-Hogarty test was something more concrete and
3 clear and established more than it should be. I agree,
4 basically, with the question.

5 It makes sense to look at what's going on.
6 Partly, you need a beginning point, so I think patient flow
7 data really helps to get a starting point. But beyond that,
8 I mean, the hard part in these cases is that you're trying to
9 ask what will happen if there's a price increase, and that's
10 also an issue with the critical loss. Everyone can calculate
11 the critical, which is typically preload, and then the
12 question is, well, does it tell you much if you know that 20
13 or 30 percent of the patients were going somewhere else, what
14 does that tell you about more patients going somewhere else
15 in a dynamic analysis if prices went up?

16 And then you begin to have to ask why were the
17 first 20 or 30 percent of the patients going to hospitals in
18 a broader market? Was it because they couldn't get services
19 in the vicinity, were they working there and new patients
20 wouldn't particularly go to those markets because they're not
21 working?

22 And those are hard questions to ask and harder
23 questions to answer. And do you survey patients? So,
24 there's no easy answer how to do this, but I think all that
25 has to be looked at.

1 So, obviously, yes, I agree, I mean, let's get
2 past Elzinga-Hogarty and look at more what's going on and
3 what's likely to go on dynamically.

4 MR. MARTIN: In part, what I'm getting at is you
5 can look at patient origin data, but when you starting
6 talking about tests, which is based on arbitrary numbers, in
7 the first place, and that was developed in order to determine
8 whether different locations, where the only variable was
9 transportation costs, what places were in the market, and now
10 it's being applied to, of all places, hospital services,
11 which couldn't be more differentiated in terms of product.
12 You know, what in the world have we been doing in getting
13 that embedded in the case law?

14 MR. LEIBENLUFT: And I agree, except the only
15 reason why it's ever attractive is its number and people can
16 figure out the number and then it's easier for them to try to
17 convince the fact-finder to say, you passed or haven't passed
18 that number. But I agree entirely with what you're saying.
19 We need to be broader in what we're looking at.

20 MR. MARTIN: Of course, the difficulty now, in
21 trying to walk away from that is the problem that Toby
22 alluded to earlier, which is the fact there's now some
23 precedent and I have no doubt that in the event that we try
24 to take an approach that differs from Elzinga-Hogarty that
25 the other side will point that out and it will be viewed as

1 attempting to walk away from unfavorable data and unfavorable
2 law.

3 MS. SINGER: I have a couple of thoughts on that.
4 The first is that it's the Government who has always used
5 Elzinga-Hogarty, starting back with HCA/Chattanooga and
6 continuing through Sutter. And the only point in Sutter was
7 if you're going to use Elzinga-Hogarty it was to do it right.

8 I think that the question on all of the statistics
9 -- critical loss, Elzinga-Hogarty - whatever you do with the
10 patient origin data is the right one that Bob asked, which
11 is: "Are people going to switch in response to a price
12 increase?" And what you need to do is couple the data with
13 what are the mechanisms that the health plans and others can
14 use to make patients make that choice or persuade them to
15 make that choice and persuade them to change to a different
16 provider.

17 And if those mechanisms exist in the market, and
18 if critical loss is low, and if you can demonstrate, as in
19 Sutter, that there are already thousands of people crossing
20 that bridge or going through that tunnel, it's not a very
21 hard link to say, yes, people would switch.

22 But I think you've got to really look at the
23 mechanisms and if the answer is there are not those
24 mechanisms to make them switch, then you have a better case
25 that they're not going to switch.

1 MR. ARGUE: If I could just add a couple of
2 comments specifically related to the patient origin data and
3 I had addressed the mechanisms issue to a certain extent in
4 my talk, but getting back to what Bob said about Sutter,
5 certainly the judge had made this distinction between an 88
6 percent and a 90 percent, or whatever the numbers were. But
7 the court went beyond that in using the patient origin data
8 and talked about service areas, overlaps and flows into and
9 out of the area. To some extent they were spanking the
10 Government on the use of Elzinga-Hogarty, but not throwing
11 out the patient flow data, as well.

12 And, then, one other point is about -- Bob raises
13 a fair question of why are people using other hospitals? And
14 is it for other services or are there some peculiar reasons
15 to it? And, again, I think that one of the advantages of
16 patient origin data is that you can cut it and you can refine
17 it really quite well, so that you can get down to a set of
18 similarly situated patients, so that you've got the same
19 services, you've got the same managed care plans, you're got
20 the same geographic area. You can take it right down to a
21 zip code.

22 And from there it's less of a link to say, what
23 sort of behavior could you expect from other people in that
24 same situation in the event of a price increase?

25 MR. MARTIN: Let me ask a follow-up question,

1 before we hear from the other panelists on this, because no
2 matter how finely you cut the patient origin data, you find
3 out from a certain zip code that "X" number of patients are
4 going to one hospital; "Y" are going to the other hospital.
5 How do you find out whether "X" are going in one direction
6 because they work there in that area or because the doctor is
7 in that area -- how do you find out that the people are
8 indifferent as to -- or at least contestable -- as consumers
9 for the opposite hospital?

10 The analogy that I would use is that in a zip code
11 you could find out that "X" number of people go to Shalom
12 Temple for religious services and "Y" go to St. Patrick's.
13 If one of the two institutions closed, I don't think you
14 would conclude that you were going to have an influx to the
15 other institution.

16 (Laughter).

17 MR. MARTIN: I mean, I use the analogy to make the
18 point. What do you really ever know, no matter how finely
19 you cut the data?

20 MR. ARGUE: I think that's a fair question to
21 raise, that there may be some particular reasons why some
22 patients are choosing one hospital to another, and there are
23 a couple of points that I would raise on that.

24 One is to go back to what Toby said that this is
25 just one of the elements that you look at. You want to go in

1 and find out other things. You can find out commuting
2 patterns, you can find out where doctors' offices are
3 located. To a certain extent you can find out who the
4 admitting physician is. But more importantly than that is
5 that the patient flow data -- if you found -- let's say the
6 critical loss is 10 percent and you found that 10 percent was
7 all you consider was in contestable zip codes -- you added up
8 your contestable zip codes and you had 10 percent -- that
9 would be an awfully darn close call.

10 If, on the other hand, you added up the
11 contestable zip codes and found it was 40 percent, that's a
12 lot different than you not saying that every patient would
13 need to switch. Only a small number of patients would need
14 to switch. And, what's more, that excludes the possibility
15 of patients within the noncontestable zip codes having to
16 switch. So, it's not requiring everybody from Temple Shalom
17 to go to St. Patrick's.

18 UNIDENTIFIED MALE: Even a few would be a problem.
19 (Laughter).

20 MR. MARTIN: David, do you have a comment?

21 MR. EISENSTADT: I have just two short comments
22 about Elzinga-Hogarty as a construct. The first is people
23 talk about the Elzinga-Hogarty as though it's always applied
24 the same way with the same standards. And it's not.

25 The Elzinga-Hogarty test requires a hypothesized

1 starting area, an algorithm for adding zip codes to that
2 starting area. If there's too much inflow or outflow from
3 that starting area, you need a preset threshold. There
4 should be some effort to try to clean the data in question so
5 that noncompetitive inflows should be eliminated, as well as
6 noncompetitive outflow should be eliminated. These are all
7 things that an analyst can do with the proper data.

8 So, I'm concerned here that when people talk about
9 the test, maybe what they're really referring to is the blind
10 adherence by the courts to a 90 percent threshold. Often
11 when Elzinga-Hogarty really isn't used at all, this is just a
12 90 percent threshold that's used to define a primary service
13 area as a minimum-sized market. And the Elzinga-Hogarty
14 isn't actually executed at all beyond that.

15 So, I think people have to be clear when they
16 criticize Elzinga-Hogarty, (a) what it is they're criticizing
17 about the test. But second just let me say that the test is
18 in many ways like Dark Ages economics. This is a test that
19 was developed years ago that has flaws. I tell clients that
20 this is a test that's akin to using an x-ray to find a tumor.
21 It has false positives and negatives. I often think that the
22 test actually has too many false positives -- I'm sorry, too
23 many -- the test is designed to define markets that are
24 larger than actually occur in the real world, especially when
25 you use the 90 percent standard, because there are just so

1 many gaps in the chain of substitution that are missed.

2 But, in any event, the reason that the test is
3 often used in antitrust analysis is because when analysts are
4 retained by hospitals to analyze a merger, they don't have
5 the luxury to go to payors and ask questions about what you
6 would do because the transaction itself may not be public.

7 So, your clients are often looking for a quick
8 shorthand as to whether there would be antitrust exposure,
9 and I think the test contains some value just as a screening
10 device. But it should not be used exclusively as a way to
11 define markets when there is other information available,
12 especially from payors.

13 MR. JACOBS: And that's how I think the Department
14 of Justice has used it. I'll just rebut any inference that's
15 out there that we've relied on it exclusively to define
16 markets in our past cases. I'll give Dubuque, again, as an
17 example. Our testifying expert did rely, in part, on the
18 Elzinga-Hogarty test, but relied on many other things. We
19 were criticized, in the Judge's opinion, for using a very
20 static and not dynamic analysis but I think criticized
21 unfairly in that respect.

22 I'm not aware of any cases in our past where we've
23 relied exclusively on this test, and we've been -- and our
24 economists certainly have been -- very aware of the
25 limitations on the data, which is you simply don't know why

1 patients are traveling.

2 UNIDENTIFIED MALE: Thank you.

3 MS. MELMAN: I have a question for Mel and anyone
4 else can jump in after that. Mel, it sounds like there's
5 some disagreement between you and Toby as to the role of home
6 court advantage and not-for-profit status. Do you have any
7 thoughts in response to that?

8 MR. ORLANS: Well, I guess I would say that I
9 think it's hard to ignore some of the direct statements that
10 have been made by judges, by district court judges, such as
11 the statement made by Judge Whipple off the record, or the
12 statement made by Judge Bowen on remand. I don't think that
13 it's contestable that there is a home court advantage; there
14 clearly is. It has different applications under different
15 circumstances, and it isn't always there, but I think the
16 government in these hospital mergers typically is at
17 something of a disadvantage as a result of that.

18 Toby was sort of talking about the past when we
19 did it right, but one of the cases, for example, is the
20 HCA/Chattanooga case. I'm not sure that's a case we would
21 even bring today. There were, as I recall, it had something
22 in the range of seven other hospitals. It was a coordinated
23 effects case, not a unilateral effects case. And, basically,
24 on appeal, Judge Posner essentially said, well, under the
25 standard of review here, which of course is one of deference

1 to the agency, as long as there was substantial evidence
2 supporting the agency's views. Said, under the standard, he
3 recognized that the agency's position was a reasonable one,
4 although obviously not the only reasonable one.

5 I certainly from that didn't have the impression
6 that in that case that Posner would have necessarily ruled
7 the same way if he had been ruling de novo. So, again, that
8 there clearly is a home court advantage to be considered
9 here. I don't think it necessarily is dispositive, but I
10 think it's hard to deny that exists in many of these cases.

11 MS. MELMAN: Toby, do you want to --

12 MS. SINGER: I have a couple of thoughts. I think
13 everybody would agree that there was a home court advantage
14 in Butterworth, probably in Freeman, as well. But I don't
15 think that you can explain most of the other cases that way,
16 including the cases where the game was not played in the
17 hospital's home court. So I think that's just too much of an
18 easy out.

19 Ironically, I think the Chattanooga case should be
20 brought today. And the reason why I think that was a
21 persuasive story is, you know, first of all, unless you're
22 going to throw out coordinated effects in hospital merger
23 cases, you would bring that case again. That was a situation
24 where there was actually a history of collusion in the
25 market. And if you're ever going to win a hospital merger

1 case, it's going to be in a situation where you can point to
2 actual examples of wage and price surveys of a market
3 allocation, new agreement of things, or real-world examples
4 of where hospitals do do anti-competitive things. So, I
5 think that's exactly the kind of case that ought to be
6 brought.

7 MS. MELMAN: Bob, do you have any other thoughts
8 on home court advantage and not-for-profit status?

9 MR. LEIBENLUFT: Well, I think I tend to -- I
10 mean, obviously it isn't dispositive. I mean, there are
11 cases. And I don't think it necessarily means that judges
12 have to be explicit, as Judge Whipple was. I mean, I think
13 there are ways -- and that was partly what I was trying to
14 say, there's this overlay. There are lots -- there's, you
15 know, a hundred ways you can lose a merger; there's a hundred
16 ways you can lose a hospital merger case. And it's so hard
17 to win those for the government. I think with the home court
18 disadvantage, probably you're going a little bit upstream
19 with a judge who may be more inclined to find on the merits
20 for the hospitals, partly because of that home court
21 advantage.

22 MR. ORLANS: And let me just clarify, by home
23 court advantage, maybe I'm talking about something a little
24 different than what Toby was talking about. I don't
25 necessarily mean that the judge had to be sitting in the

1 city. In fact, if you use that test, it wasn't home court
2 advantage in Butterworth-Blodgett because we tried the case
3 in Lansing, not in Grand Rapids.

4 I mean more in the sense that you have a judge who
5 is cognizant of the community needs and is viewing the
6 Commission, the Department of Justice as essentially an
7 officious interloper, and who is in sympathy with the desire
8 of the community to control its own health care needs.

9 MS. MELMAN: I still remember Judge McKeeg's
10 welcome to me, which was, "Another lawyer from Washington."

11 MR. LEIBENLUFT: Let me just add, though, you
12 know, the home court disadvantage, you can call it litigation
13 risk, you can call it whatever you want, but it's something
14 that I don't think we should just dismiss as saying the
15 judges always get it wrong because they have the home court
16 advantage. I mean, they perceive the hospitals, they know --
17 I mean, this is the flip side of that.

18 Maybe there's -- the complexity of it means that
19 maybe there's something that they know about these
20 institutions or that people perceive about these
21 institutions, which should cause everybody to think twice
22 about some of the cases. Whether it's right or wrong,
23 whether you can say -- you know, it's an unacceptable
24 litigation risk, even though we think we're right, if you're
25 in the government, of course. Or maybe you just say well,

1 maybe there's something here that we just don't understand
2 enough about the dynamics of the market. But I think it's a
3 real factor out there.

4 MR. JACOBS: I would agree it's a factor as well.
5 It's not hard to see it operating in the Freeman case, but I
6 agree with Bob that sometimes there may be -- it's hard to
7 figure out whether it's happening in other cases where it's
8 not as easily identifiable. You could certainly argue that
9 there was a home court disadvantage we faced in the Dubuque
10 case, but I think having gone through that trial, the judge
11 was very frank with us at closing argument, or before closing
12 argument, as we prepared for it. He said, "I'll tell you
13 where I am right now," at the end of when the record was
14 closed. He said, "I'm skeptical of the government on the
15 geographic market issue and I'm skeptical of the defendant's
16 argument on efficiencies."

17 And I think if he was -- he was a native of
18 Dubuque, and if he wanted to come across as a fellow who
19 believed the hometown folks and was skeptical of those
20 Washington lawyers, I think it would have been easier for him
21 to say, "I believe that this deal, which was put together by
22 the community leaders here, will result, it's a good deal, it
23 will result in tremendous efficiencies." But he didn't do
24 that.

25 I tend to think that his problem was probably more

1 with being inexperienced in this area of the law where we
2 have the burden to show a geographic market and have to show
3 that in the future patients won't move if financial
4 incentives are put in place. And the defendants have the
5 burden of showing another somewhat speculative -- another
6 speculative task of showing that certain efficiencies will
7 occur in the future. So, I think he was really struggling
8 with more of speculation on both sides, as he saw it.

9 MR. MARTIN: Asking a more general question, but
10 somewhat related to what we've just been talking about, I'm
11 wondering whether what Bob was talking about is a key
12 consideration, which was we have the confluence of antitrust
13 law before a general judge, a judge who, you know, hears a
14 lot of other matters. And then we have the acquired taste of
15 health care and on top of it hospital mergers. And that's a
16 lot to get a judge acquainted with. I was on a panel with
17 one of the judges who ruled against the government. And he
18 kind of was pleading for the idea that you've got to give me
19 something bigger than a bread basket to look at. You can't
20 expect me to get up on antitrust law and health care, you
21 know, for a few-day hearing.

22 Now, having said that, though, I think it is
23 possible also that the court -- is it possible that the
24 courts are raising the bar in these cases and maybe not so
25 obviously sometimes. For example, in the Freeman case and

1 the Tenet case on appeal were both written by the same Court
2 of Appeals judge. In Freeman, he went out of his way to talk
3 about the deferential standard to district courts, subject to
4 abuse of discretion, which is legal error clearly -- clearly
5 erroneous standard. No such statement is made in the Tenet
6 case. In fact, you will not find the words "legal error" or
7 "clear factual error" in that case.

8 And, so, I'm just wondering whether, and maybe
9 address this to Toby, aren't there ways by which, you know,
10 judges for whatever reason can, you know, raise the bar and
11 make it a little bit more difficult for the government and
12 why, you know, is that happening here and does it happen in
13 other industries, for those of you who have experience in
14 litigating other merger cases.

15 MS. SINGER: I think it's too easy to use the
16 excuse of the judges didn't get it. There's lots of cases
17 the government wins and lots of cases the government loses.
18 And in every kind of case, the government or a plaintiff or
19 whoever is bringing the case has the burden of proving the
20 case. And one of the things you have to do is take into
21 account what court you're in. Every case a litigator is
22 involved in, when they're coming in from out of town into a
23 local court, they have to take that into account. And, you
24 know, how you deal with that is one of the pieces of
25 litigation strategy.

1 And going back to the theme of my earlier remarks,
2 I think one of the things you can do to combat the perception
3 that, oh, the hospitals are all good guys, is to bring in
4 real-world examples of why anticompetitive conduct can occur
5 in a hospital market, starting with explaining how
6 competition works in the first place, and not just blindly
7 relying on oh, all the health plans think it's bad,
8 explaining exactly, you know, how it is that these bad things
9 are going to happen, and the mechanism -- and why the
10 particular mechanisms that the health plans have to inject
11 competition aren't going to work in this case.

12 MR. MARTIN: Anybody else have any comments on it?

13 MR. ORLANS: One final comment, I guess, is to say
14 that there certainly are strategies for trying to deal with
15 this issue, and Toby has suggested some. I think that
16 doesn't indicate that the issue doesn't exist; it merely
17 indicates that given those problems and recognizing that
18 there are some steps we could take in the future and if taken
19 to some degree in the past in order to try to cope with them.

20 MR. LEIBENLUFT: It also is a little bit hard
21 sometimes in the context of a PI hearing, which may have a
22 limited time period to get into the kind of review that the
23 FTC was able to do with Chattanooga. So, I think that's
24 another -- maybe sometimes you get a judge who's willing to
25 listen to that, and I think that's -- obviously if you can do

1 that I think that's a good idea.

2 MS. MELMAN: That limited time was probably a
3 factor in Tenet, wasn't it, Bob? As I recall.

4 MR. LEIBENLUFT: Yes, we had five days.

5 MS. MELMAN: Just five days?

6 MR. LEIBENLUFT: Yeah, five days. We had five
7 days.

8 MS. MELMAN: Five days of trial.

9 MS. SINGER: But you won in the five-day trial.

10 MR. LEIBENLUFT: We did win in the five-day trial.

11 MS. SINGER: So, I don't think you can blame the
12 losses on the short time.

13 MR. LEIBENLUFT: Well, I think it's the Eighth
14 Circuit, actually, that's the problem.

15 MS. MELMAN: We should have asked for permission
16 to file a larger brief.

17 MS. SINGER: Or another circuit.

18 MS. MELMAN: That's right.

19 David, I wonder if you could possibly address the
20 mergers you had worked on, Carillon and especially
21 Butterworth-Blodgett. Do you think those are cases the
22 government should not have brought?

23 MR. EISENSTADT: No, I think -- actually, I think
24 both cases should have been brought. And let me start with
25 Carillon. The sense in which I was a little bit agnostic at

1 the time Carillon was brought was we had done some modeling,
2 and of course everyone, all the economists in the room here
3 are aware that when there's health insurance, there's moral
4 hazard, and that causes over-consumption. And there's
5 actually an article from the American Economic Review back in
6 the late '60s that shows how actually a monopolist by raising
7 price can eliminate that over-consumption externality. And,
8 so, total welfare is actually improved, but consumer welfare
9 might fall.

10 And, so, I remember when I was going in to see
11 Rich in the late 1980s about the Carillon transaction,
12 because Rich was one of the staff attorneys. And I asked the
13 question, look, I've tried to measure this using consumer
14 welfare or total welfare; now, can you tell me what welfare
15 standard you're using here in order to analyze this
16 transaction. And Bob Bloch, who was the section chief at
17 that time, wasn't able to really answer the question. I'm
18 not sure there was a good answer at the time. So, I had --
19 and for total welfare, I thought there was a reason to
20 believe that welfare would improve with the merger, but
21 consumer welfare would fall with the merger.

22 So, just if you kind of modeled it theoretically,
23 what actually happened at trial was the economist who is
24 opposite me had relied on some Blue Cross pricing data for
25 the proposition that there would be a significant price

1 increase after the merger, and I believe he had made an
2 econometric error, and when that error was corrected, his
3 results, which he thought were mildly statistical significant
4 were not statistically from zero at all. And, so, that was
5 just a very narrow point-counterpoint between the experts,
6 and I had no idea at the time the proceeding was launched
7 that it would play out that way. I didn't even have the Blue
8 Cross data at the time the case was filed.

9 So, I can't say I disagree with the filing in the
10 case, and the same for Butterworth-Blodgett at the time the
11 case was filed. I can understand what the concerns were and
12 I think if I were one of the agencies today I might have some
13 of those same concerns. But that's not to say when evidence
14 plays out at trial and all of the different formats that just
15 because from a prosecutorial point of view the case should be
16 brought doesn't mean you're always going to win.

17 MR. MARTIN: David, I wonder if you could -- David
18 Argue -- expand upon the critical loss calculation in the
19 sense of -- I take it it has to do with trying to determine
20 to what extent patients can be steered to other hospitals,
21 making some calculation as to how -- what percentage would
22 make it unprofitable. What I'm most interested in is how do
23 you go about proving or getting relevant evidence that is
24 likely to occur in a particular market, because it's easy to
25 come up with theories of how you can get people money or

1 financial advantages, but how can that actually be tested,
2 because managed care plans don't pick up and drop hospitals
3 routinely, so it's difficult to have longitudinal studies or
4 evidence on that point. So, how is that done so that you can
5 determine whether enough people would be steered away from
6 the hospitals if they raised prices?

7 MR. ARGUE: I think this gets back to the
8 fundamental question that comes up in any merger analysis is
9 whether enough customers would switch. And there are a
10 number of sources of information that you might rely on to
11 develop a position on that, and it may include any of the
12 sorts of information that we've talked about here before,
13 including just a sense of what the parties, the market
14 participants have to say about who their competitors are,
15 what the customers are perceiving as alternatives available
16 to them, and in the case of hospital services, you have to
17 worry about the third party payor and their ability to switch
18 people around.

19 If it turned out that, for example, there were a
20 state regulation that prevented various means of in-network
21 steering, or something to that effect, then that would work
22 against the notion that you could have some effective
23 movement of patients. And then we come back to the patient
24 origin data to say, not that -- you know, the patient origin
25 data are what happened yesterday. They're not going to tell

1 you with certainty what happens tomorrow. Neither would a
2 sophisticated econometric study, even an elasticity study may
3 be subject to some uncertainty. But the point is to take the
4 information that you've got today and make some prediction.
5 You'll never have certainty as to whether those patients will
6 actually move, but to develop a solid foundation or a basis
7 for believing that there's a good probability that they
8 would.

9 MS. SINGER: Can I just address that point? I can
10 give a real world example of the kind of evidence that would
11 amplify the statistical evidence. In the Sutter case, one of
12 the witnesses was the head of an IPA that was -- and
13 California being such a managed market, the IPAs have a lot
14 to do with steering patients to various hospitals. And while
15 on the one hand he was testifying that this merger was bad
16 because he relied on competition between these two merging
17 hospitals, we were able to produce evidence that that same
18 IPA had written letters to doctors who were members of the
19 IPA at one of the hospitals, suggesting or insisting that
20 they needed to send patients for particular kinds of things
21 to the following providers. And some of those providers were
22 outside the government's alleged market.

23 So, if you look at the kinds of competitive
24 activity that's already going on, I think you can learn
25 something about what would happen in the event of a price

1 increase.

2 MR. ARGUE: Rich, if I could just follow up on
3 that for one minute, you started off the question by saying,
4 well, it's a critical loss that needs to be exceeded, and I
5 think that's the right way to look at it. And in a hospital
6 market, the critical loss tends to be pretty darn small. So,
7 you're not talking about shifting large percentages of
8 patients for a specific price increase, but much smaller
9 ones, and it gives a higher level of confidence that you're
10 going to be able to shift some of the patients to beat the
11 price increase.

12 MR. MARTIN: But actually that gets right down to
13 a point that I've never understood, which is you have to come
14 up with the mechanisms. I mean, that's the trouble with the
15 critical loss analysis, it makes it sound so simple, but
16 you're not passing out coupons to people to leave Dubuque to
17 go to Iowa City, \$200 coupons that they turn in to the
18 hospital.

19 If you're a managed care plan, how do you go about
20 giving people incentives? Everybody in a plan has a one in
21 15 shot of being hospitalized in any given year. So, in
22 order to actually move small numbers of patients, you have to
23 provide incentives that are available to large numbers of
24 patients. And the question is how do you actually do that
25 and make it successful. How can a judge sit there and say,

1 you know, if the prices would rise, it's in the plan's best
2 interest, therefore they will find ways to move the patients,
3 because I can think of ways to move the patients. I mean,
4 how can you test that hypothesis?

5 MR. ARGUE: I think that again you go back to what
6 exists in the market or in the industry overall, and these
7 are some of the mechanisms that I talked about before. Now,
8 admittedly the industry's in a little bit of a transition,
9 maybe a major transition, from the older models where payors
10 - or providers, rather, were excluded from a network to
11 different methods where they want to have a broad network so
12 they have to find a different way to influence patient choice
13 of provider.

14 And they can set up financial incentives in terms
15 of higher deductibles and higher co-pays in the form -- for
16 the patients there are capitation arrangements and risk-
17 sharing arrangements for physicians, and there are new forms
18 of insurance coming out with these consumer-directed plans
19 that may end up in the same sort of result. You're never
20 going to know with certainty that any particular plan,
21 particular item will work, but as you evaluate those and take
22 them in the context of what the market or what the industry
23 is showing, you develop some reasonable belief that that can
24 be an effective way to shift patients.

25 MR. MARTIN: But in this context, I mean, one of

1 the problems is that mechanism may exist somewhere, it's
2 unlikely to exist in the market you're looking at, how do you
3 get information about other markets where this is being used?
4 How do you quantify whether despite the best intent or
5 efforts or hopes of the plan they've been actually able to
6 move people and save money? And I'm just getting at --

7 MS. SINGER: Well, why do you say it's unlikely to
8 exist in the market that you're looking at?

9 MR. MARTIN: Well, the particular --

10 MR. JACOBS: I think in particular in rural
11 markets, if you have a two-hospital town, they may be, you
12 know, six blocks apart, fairly easy to move patients between
13 the two merging hospitals, which would be the government's
14 point, but difficult -- really no need to until after the
15 merger occurs, to move patients beyond that.

16 MR. ARGUE: But that's exactly right. If there's
17 no need to move them beforehand, you wouldn't expect to see -
18 - you may very well -- it may make sense that you wouldn't
19 see some of those mechanisms. That's not to say they
20 wouldn't exist after the merger or after --

21 MR. LEIBENLUFT: But I think -- I mean, the issue
22 came up in Poplar Bluff, because there the managed care plans
23 testified they would not use those mechanisms. And the Court
24 of Appeals basically said we don't really trust what the
25 managed care plans say. We think that they exist elsewhere,

1 therefore they would be used. I think Rich's question is how
2 does one -- I mean, there's some second-guessing there of the
3 market participants, and the question is how does one decide
4 whether those market participants should be second-guessed.

5 MR. MARTIN: And the question then becomes if you
6 second-guess those market participants, do we then do
7 consumer surveys, you know, such as they do with people who
8 are going to buy a car next year. They ask people are you
9 going to buy a car next year, if so, what car are you going
10 to buy, and they're wildly unrealistic, because, you know,
11 people simply do not follow through and do what they say
12 they're going to do.

13 MR. LEIBENLUFT: I think our experience with those
14 surveyors from both sides is that they're so difficult to
15 construct and execute in a way that can withstand attack.

16 MR. MARTIN: That's exactly right, because people
17 are offered a financial incentive that seems very concrete,
18 \$500, would you consider going to a hospital outside? Yes.
19 Well, this is when they're not sick; it's very theoretical;
20 and it's very -- you know, it's simply difficult to take what
21 is said in that context seriously.

22 MR. ARGUE: I think that surveys were used in
23 Dubuque and they were used in Poplar Bluff. I don't think
24 they were used in Sutter or LIJ. And both of those were able
25 to develop arguments about the ability to shift patients

1 without relying on the surveys. And I agree, I think surveys
2 have some value, but they're probably not the strongest
3 evidentiary piece you could put forward.

4 MS. SINGER: The problem with this argument is
5 that sometimes it proves too much. If you rely too much on
6 the managed care plan thing, we can't shift, we can't shift,
7 we can't kick anybody out of the network, how does
8 competition work in the first place? You're never going to
9 have any competition if you accept at face value the managed
10 care plans saying we can't move patients.

11 MR. MARTIN: But why would a managed care plan
12 expose themselves to a plan they've got a deal with and say I
13 have no leverage if these two hospitals merge. What in the
14 world would --

15 MS. SINGER: Because they're trying to stop the
16 merger.

17 MR. MARTIN: Obviously. But why in the world
18 would they expose themselves?

19 UNIDENTIFIED MALE: Why are they trying to stop
20 the merger?

21 MR. MARTIN: The fact that they have not good
22 alternatives, unless that were really true. All I'm getting
23 at is for a court to, you know, summarily dismiss managed
24 care testimony, I don't know where you go to. If patient
25 origin data is no good; if managed care plans can't be

1 depended on; if employers depend on the managed care plans to
2 have the views as to what's a good network, now who do we go
3 to?

4 MR. MARTIN: And on that point, and I agree if you
5 look at the underlying data, the managed care plans are
6 already steering patients. That's fine, I mean, I have no
7 problem with saying that testimony is not credible testimony,
8 but to do what the Eighth Circuit did in Tenet and reject the
9 managed care testimony because of speculation that they could
10 steer when presumably the managed care testimony was that if
11 we try to steer in this fashion, nobody would buy our plan.

12 Certainly, that was the testimony in Butterworth-
13 Blodgett, that we need one of these two hospitals in the plan
14 and if we don't have it we won't have a saleable plan. Faced
15 with that testimony and absent some underlying, factual
16 justification for rejecting that testimony, it seems to me
17 that the court is just speculating in the other direction.

18 MR. ARGUE: I think that what the Eighth Circuit
19 said in Tenet was more that the testimony of the managed care
20 plans was not consistent with some of the factual data that
21 underlay it. And the testimony of the employers, as well.
22 There was an employer who said no, my employees would never
23 go to -- whatever the name of the little hospital was down
24 the street. And you run around and look at those employees
25 and find out half of them already are going to that one down

1 the street.

2 Or that there's managed care plans that say, "No,
3 we could never steer patients up to Cape Garret," but that in
4 fact was already happening. So that was part of the problem,
5 was not the testimony, they weren't throwing out the
6 testimony of the managed care plans, and they weren't
7 throwing out the patient origin data, but trying to use them
8 to corroborate each other.

9 MR. MARTIN: Well, we settled that one.

10 David, just a quick question actually, to see
11 whether given your approach on mergers of complementary
12 firms, would your general approach be receptive to the kind
13 of anchor hospital definition that DOJ used in LIJ? I'm not
14 asking you to endorse it in that case, but that approach
15 that, in other words, there can be anchor hospitals that are,
16 you know, one or the other is vital to a network and
17 therefore the merger of the two really is anti-competitive,
18 despite the presence of other, you know, good hospitals in
19 the area.

20 MR. EISENSTADT: Yeah, I don't have a problem with
21 defining an anchor hospital. I don't think it's related to
22 the issue of the mergers among complements. In the LIJ case,
23 you had an example where two competing anchor hospitals were
24 merging, and that was not right, so it's not a perfect
25 parallel.

1 MR. MARTIN: No, no, I recognize that, but just in
2 terms of -- it sounds like the kind of approach that gets
3 more at the competition among hospitals for inclusion in the
4 network rather than direct price competition, you know, at
5 some other level.

6 MR. EISENSTADT: Right, but when I say I don't
7 have a --

8 MR. MARTIN: The hearing is over. We're all in
9 the dark.

10 (Whereupon, there was a brief pause in the
11 discussion.)

12 MR. EISENSTADT: I think in all these cases the
13 issue is how you go about developing the evidence and
14 presenting it to a court in a way that's convincing and
15 cogent. But in theoretical construct, I don't have a problem
16 with the notion of anchor hospitals.

17 MS. MELMAN: We have just a few moments left. Are
18 there any questions that the experts on the panel would like
19 to ask of each other?

20 MR. JACOBS: I would, and that is we're struggling
21 here to try and solve the Catch 22 of having to speculate
22 about the future without, you know, data from the future.
23 And I'm wondering in any of the FTC's cases, I guess, whether
24 people have thoughts on this, whether one place where we can
25 draw evidence is from other markets where similar mergers

1 have occurred. This issue came up in the Dubuque case, where
2 we were relying on Ottumwa, Iowa, which a short time before
3 our merger in 1994 had been a two-hospital town. The two
4 hospitals merged; prices went up; managed care discounts were
5 eliminated; they were unable to steer; and so forth.

6 The judge discounted that evidence because he
7 didn't believe Ottumwa was similar enough to Dubuque for
8 reasons that we thought were incorrect, but in the absence of
9 challenging a consummated hospital merger, where you'd
10 actually have real data from that very same market, does
11 anyone here believe that going to other comparable markets to
12 try to predict what would happen in the relevant market in
13 question, is that a good source of information?

14 MR. LEIBENLUFT: I'm not sure. I think it's hard
15 if you look at -- just my initial reaction -- it's hard if
16 you look at one specific market. And there are lots of ways
17 to draw distinctions between that market and the one that
18 you're -- the one that's at issue. I think what might be
19 more relevant is to the extent that there's more and more
20 good economic analysis in published articles about the -- I'm
21 thinking for example on the non-profit issue or what happens
22 when there is -- to concentration -- high concentration lead
23 to higher prices.

24 That's a more broader set of data that I think
25 again going back to Toby's point where you could try to

1 educate the court about, in general, what happens when you go
2 to three-to-two or two-to-one with hospitals of a certain
3 sort. And I think that may be more persuasive than just
4 trying to say there's another town that looks exactly -- I
5 think it's hard to find the other town that looks close
6 enough to really make it relevant.

7 UNIDENTIFIED MALE: Mel, I'd like to know whether
8 you have any comment on Toby's skepticism about the prospects
9 for finding post-merger anti-competitive effects for proving
10 them. She seemed to express concerns about, you know, how do
11 you know what the prices are, there's agreement, and would
12 you know it's a super competitive price as opposed to a price
13 increase that's justified in some way.

14 MR. ORLANS: Well, obviously as in other areas of
15 antitrust and other kinds of problems like this, you can
16 never know with exactitude that a price increase is due to a
17 merger, due to a particular act or practice. Obviously, the
18 extent to which the price increase is contemporaneous with
19 the merger or something and you would look at it. You could
20 also look at things like past pricing history and what the
21 price increases have looked like in the past. You could look
22 at other indicia in the community of pricing to see whether
23 the prices seemed to outstrip those elsewhere in the
24 community.

25 It's never going to be done perfectly, but I think

1 that if you found a seemingly inexplicable price increase
2 that was inconsistent with the way the hospitals have priced
3 in the past that also happen to occur within some relatively
4 short time frame after a merger that it would be reasonable
5 to assume and that a court probably would be willing to carry
6 through with the idea that was attributable to the merger.

7 MR. ORLANS: Finally, perhaps this is the extra
8 question, I'd like to do a John McLaughlin and ask every
9 participant, if they want to, to say what issues do you think
10 is going to prove to be the most difficult? You know, what's
11 the one that you worry about if you were prosecuting a
12 hospital merger case a month from now? See if there's any
13 consensus on what kinds of -- I know markets are -- each
14 market is different, but is there any one that stands out
15 that you'd be more worried about?

16 MR. JACOBS: I would say the one that we haven't
17 come across yet, because it is -- there's a consensus that
18 this is a rapidly changing industry, and if you faced an
19 issue in one case, you know, you feel more confident about
20 addressing it in another, but there are always new issues
21 that come up in these cases that you have to address rather
22 quickly.

23 MR. EISENSTADT: I'm not sure that this fits into
24 the category, but following up on what Jon said, one of the
25 new issues that's going to be rising in hospital litigation

1 is product market, and that we haven't talked about. I know
2 that was a subject of a panel earlier this week.

3 MS. SINGER: I think that a tough issue that's
4 going to come up for defendants is as hospitals get more
5 sophisticated, they're starting to build into managed care
6 contracts, mechanisms to prevent the kind of steering that
7 we've been talking about. And, so, what happens in a market
8 where that kind of contracting is prevalent. Does that then
9 help the government's case on geographic market and effects
10 on competition?

11 MR. LEIBENLUFT: I guess I would go with the
12 consensus view that product market is the issue to be
13 concerned about, going forward. Market definition generally
14 and particularly product market, now that that will become
15 more of an issue in the future.

16 MR. EISENSTADT: I think I agree. I think we may
17 have more sophistication on the part of the courts with
18 response to these mechanisms for steering. And I think that
19 can work in either direction, but I think hopefully there
20 will be a more sophisticated view about whether these
21 mechanisms exist and how practical they are. And I think
22 it's going to very fact-specific.

23 MR. MARTIN: I think the next generation of
24 antitrust cases, along the lines of Staples/Office Depot,
25 will be whether markets can be proved indirectly from the

1 evidence of anticompetitive effects, or likely
2 anticompetitive effects. So, a lot of market definition
3 exercise that we go through, it takes a tremendous amount of
4 time and resources, can be circumvented.

5 MR. MARTIN: Is that a double-edged sword?
6 Because I remember when Staples came down, I was chagrined
7 because the evidence was so strong for the FTC, because it
8 has a tendency -- that courts expect to see more and more.
9 They want more smoking guns. And then mergers, I mean, do
10 you see that as potential problem, they want to see more
11 direct evidence of what is likely to occur.

12 MR. LEIBENLUFT: I was going to say I think one of
13 the issues, we're just going to allude to it, I think it's
14 attractive to think retrospectively we can tell if there's a
15 price increase. I think it's a very, very complicated issue
16 about measuring those increases and whether they're the
17 result of the merger, and I think if there is a trap, that
18 might be the trap. It's going to be very tricky to look at
19 that, but I think it's going to be tricky to analyze.

20 MS. MELMAN: Well, I think we've run out of time.
21 Just before we adjourn, I just wanted to note on the record
22 it's my understanding that the parties to the UPMC are going
23 to be given some opportunity, if they want to, to submit some
24 comments that would be included in the record.

25 And I want to thank all the experts on behalf of

1 the Department of Justice and FTC for the time that they
2 spent here this morning, as well as the time they put into
3 preparing their presentations. And give them a round of
4 applause.

5 (Applause).

6 (Whereupon, the hearing was concluded.)

7

8 **C E R T I F I C A T I O N O F R E P O R T E R**

9

10 MATTER NUMBER: P022106

11 CASE TITLE: HEALTH CARE AND COMPETITION LAW

12 DATE: MARCH 28, 2003

13

14 I HEREBY CERTIFY that the transcript contained herein
15 is a full and accurate transcript of the notes taken by me at
16 the hearing on the above cause before the FEDERAL TRADE
17 COMMISSION to the best of my knowledge and belief.

18

19 DATED: APRIL 7, 2003

20

21

22 _____
SONIA GONZALEZ

23

24 **C E R T I F I C A T I O N O F P R O O F R E A D E R**

25

1 I HEREBY CERTIFY that I proofread the transcript for
2 accuracy in spelling, hyphenation, punctuation and format.

3

4

5

DIANE QUADE