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I N D E X

P R O C E E D I N G S

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

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

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

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

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

Care Division.

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

On my right, I'd like to welcome Toby Singer, she's a partner in the D.C. Office of Jones Day, where her practice is devoted to antitrust counsel and litigation, principally on behalf of health care providers and payors. The litigated hospital mergers in which she has been involved

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

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

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

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

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

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

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

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

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

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

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

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

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

And, third, a critical loss analysis suggests that

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

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

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

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

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

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

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

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

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

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

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

I want to emphasize that not all nonprofits are

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

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

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

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

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

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

And, finally, we have the home court disadvantage. Unlike with most Government merger challenges, here we have in a typical hospital injunction case, it's tried in the backyard of the merging parties and the Judge is likely to have first-hand experience with, if not the hospitals, at least with hospital care. Judges know what hospitals are like, maybe they don't know what smokeless tobacco is, for example, as a recent case the FTC brought -- they may not, anyhow -- but, they certainly know what hospitals are about and they have experience with local community hospitals and they may not have a whole lot of experience with merger law in the sophisticated analysis we have about economic analysis. So,8.25 (or ei4 in the pe

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

Second, don't underestimate the complexities to be analyzed. I just talked about a lot of the traditional

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

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

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

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

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

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

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

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

Take into account nonprice issues -- quality competition, competition for doctors, competition for new

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

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

Thanks very much.

MS. MELMAN: Thank you, Bob.

(Applause).

MS. MELMAN: Mel will be our next presenter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Another factor that is a part of this inherently local nature of hospital mergers is that there's typically not major resistance from local employers or from the business community. Generally because we're looking at nonprofit hospitals, the local employers are often on the boards of these hospitals. But, at a minimum, even when local employers, other local businessmen are not heavily

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

has lost where courts were located elsewhere.

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

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

So, if these reasons don't stand up to scrutiny, what are the reasons for these losses? It's clear that the Government has just not been able to prove or to persuade the courts on the merits that competition will be lessened by

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

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

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

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

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

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

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

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

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

before going on to explore the competitive effects.

Then, once it did that, once it established the market and the market shares, it didn't stop with the market

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

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

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

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

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

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

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

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

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

But when you take their deposition, you discover

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

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

The nonhospital cases that rely on qualitative evidence, like testimony, like documents, tend to be cases in which that's not inconsistent with the statistical evidence; that cases in other arenas where the Government has been able

The other criticism on the reliance on statistical patient origin data is that it's a static kind of analysis and you can't assume just because there are certain people going to certain places that more people would go to those

from Dave Argue.

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

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

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

The right question is whether the existing tools,

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

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

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

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

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

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

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

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

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

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

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

and Freeman as well.

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

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

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

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

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

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

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

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

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

results for the sensitivity to variations in the assumptions.

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

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

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

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

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

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

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

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

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

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

Consumer-directed plans -- and sometimes these are a variation and this is defined contribution plans -- also are a means by which the managed care plans are g s1hpsndaed plan

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

Now, moving on to shares and concentration, to the extent that shares have any value at all, it has to be in the properly defined market. If the market is not defined properly, then the shares are void of any particular meaning. Moreover, the relevance of shares is not consistent with all models of behavior. That ties us back to the need to have internally consistent theories 1.5 -2E fset lacen.

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

More recently, entry has become a more important issue, I think, because of the rapid growth of some areas in population to fuel the ability to fill additional beds; aging populations have led to increased demand; the shift in managed care's ability to dampen patient days, leads to the possibility of entry. And entry doesn't necessary have to come in a gigantic hospital with a lot of bricks and mortar.

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

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

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

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

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

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

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

Now, I'm going to stylize this question, though,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, after doing the field work, I was asked to economically model the transaction and determine whether, in fact, consumer welfare could fall as a result of a transaction of this type. Now, I had with me the information or the opinions of the two major payors who thought they would be worse off from this transaction. Although I will tell you that neither payor did a very effective job of explaining why this type of merger would lower consumer

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. EISENSTADT: We assume that marginal costs

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

DR. DALKIR: When you got the post-merger market and compute the equilibrium prices, what's going to happen is the merging premium component manufacturers are going to

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

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

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

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

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

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

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

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

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

Thank you.

(Applause).

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

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

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

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

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

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

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

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

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

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

Now, I'd like to expand on those last two points, talk about the issues we won and the issues we lost, by

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

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

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

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

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

The effect of these clinics was speculative; it

was not clear whether managed care plans could profitably steer patients towards these other cities. If a plan wanted to -- as one example -- provide incentives for patients living in the central lands between Dubuque and Cedar Rapids to travel to Cedar Rapids, it would be difficult not to do

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

(Applause.)

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

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

(Whereupon, there was a brief recess.)

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. MARTIN: Of course, the difficulty now, in

attempting to walk away from unfavorable data and unfavorable law.

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

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

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

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

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

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

UNIDENTIFIED MALE: Even a few would be a problem.

(Laughter).

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

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

The Elzinga-Hogarty test requires a hypothesized

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

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

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

many gaps in the chain of substitution that are missed.

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

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

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

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

patients are traveling.

UNIDENTIFIED MALE: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. LEIBENLUFT: Let me just add, though, you know, the home court disadvantage, you can call it litigation risk, you can call it whatever you want, but it's something that I don't think we should just dismiss as saying the

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

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

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

I tend to think that his problem was probably more

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

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

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

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

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

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

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

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

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

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

that I think that's a good idea.

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

MR. LEIBENLUFT: Yes, we had five days.

MS. MELMAN: Just five days?

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

MS. MELMAN: Five days of trial.

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

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

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

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

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

MS. SINGER: Or another circuit.

MS. MELMAN: That's right.

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

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

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

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

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

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

So, I can't say I disagree with the filing in the

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

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

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

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

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

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

increase.

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

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

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

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

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

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

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

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

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

MR. MARTIN: Well, the particular --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the street.

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

MR. MARTIN: Well, we settled that one.

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

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

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

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

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

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

MR. EISENSTADT: I think in all these cases the issue is how you go about developing the evidence and presenting it to a court in a way that's convincing and cogent. But in theoretical construct, I don't have a problem with the notionsosISENSTADT: I Right, butSoveELMAWe'rWe 0 TDTD

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

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

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

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

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

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

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

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

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

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

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

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

MR. LEIBENLUFT: I was going to say I think one of the issues, we're just going to allude to it, I think it's attractive to think retrospectively we can tell if there’s a price increase. I think it's a very, very complicated issue about measuring those increases and whether they're the result of the merger, and I think if there is a trap, that

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

(Applause).

(Whereupon, the hearing was concluded.)

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

MATTER NUMBER: P022106

CASE TITLE: HEALTH CARE AND COMPETITION LAW

DATE: MARCH 28, 2003

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

DATED: APRIL 7, 2003

SONIA GONZALEZ

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