A "Check-Up" of Selected Health Care Activity at the Federal Trade Commission

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I. INTRODUCTION

Thank you so much for including me on this panel. Before I begin, I must issue the usual disclaimer: my comments today are my own, and do not necessarily reflect the views of the Commission or any other Commissioner.

Having said that, however, I think it is obvious that the Commission as a whole has been paying very close attention to the health care sector – as evidenced not only by the Health Care Report[1] itself, and the extensive series of hearings leading up to the Report,[2] but also by the agency's numerous enforcement and advocacy actions in the health care field in recent years.[3]

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[1] FEDERAL TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July 2004) [hereinafter HEALTH CARE REPORT], *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[2] A compilation of materials relating to the hearings, including agendas, written submissions, and transcripts of testimony, is available on the Commission's website at http://www.ftc.gov/ogc/healthcarehearings/index.htm.

[3] For a compilation of links that provide an overview of the agency's competition-related health care activities, see the Commission's website at http://www.ftc.gov/bc/healthindex.htm.

On the competition side, the Commission has been active in pursuing physician price-fixing agreements,[4] stopping anticompetitive mergers and agreements between pharmaceutical firms,[5] and even – despite our mixed history of success in this area – challenging hospital mergers.[6]

In addition, several of the Commission's initiatives on the consumer protection side of the agency also relate to health care. For example, in a keynote address last month at a World Congress Leadership Summit on health care, Chairman Majoras highlighted the Commission's recent sweep of fraudulent claims for bogus weight-loss products.[7] The Chairman also noted favorably the increased use of public and private "report cards" to help educate consumers about the quality of health care providers,[8] a topic that was discussed in the Health Care Report.[9]

Health care is an area of great personal interest to me, and has been since my days in the New York State Attorney General's Office. During my tenure there, I was involved in several high-profile health care matters, one of which I will discuss in greater detail later in my remarks. I am happy to see that state antitrust and consumer protection authorities have remained quite

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[4]*See infra* Part II.A.

[5]*See infra* Part II.B.

[6]*See, e.g.*, In the Matter of Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc., FTC Dkt. No. 9315 (administrative complaint issued Feb. 10, 2004) (Commissioner Harbour, dissenting), *available at* http://www.ftc.gov/os/adjpro/d9315/index.htm.

[7]Deborah Platt Majoras, Chairman, Federal Trade Commission, *The Federal Trade Commission: Fostering a Competitive Health Care Environment That Benefits Patients*, remarks before the World Congress Leadership Summit, New York, NY (Feb. 28, 2005), at 10-13, *available at* http://www.ftc.gov/speeches/majoras/050301healthcare.pdf.

[8]*Id.* at 14-17.

[9]*See especially* HEALTH CARE REPORT, Ch. 1 at 17-25 ("Informational Barriers to Improving Quality").

active in the health care field, especially with respect to mergers and other conduct with a particularly local impact.

I believe that this level of attention to the health care sector, by both federal and state enforcers, is not only justified but, indeed, critical to our nation's well-being. The dollar figures for health care spending in this country are staggering. According to recently-published projections, health care accounted for over 15 percent of Gross Domestic Product (GDP) in 2004.[10] This figure is expected to rise to almost 19 percent by the year 2014, because national health spending is forecast to continue growing at a faster rate than GDP.[11] That adds up to a lot of money coming out of the pockets of American consumers.

For this reason, I, as a Commissioner, take very seriously my responsibility to ensure that health care markets operate in a fair and free manner, so that consumers will be able to spend their health care dollars wisely. By preserving competition, the Commission helps to ensure that consumers will have a range of affordable, high-quality choices among various health care services and products. And by targeting deceptive and fraudulent health claims, and encouraging the dissemination of clear and accurate health care information, the Commission helps to ensure that consumers will be able to make smart choices and get the greatest "bang" for their buck.

In short, I believe that consumers generally are willing to pay for high-quality care – but they are also seeking value in their health care spending. They want their money going to skilled, law-abiding providers and effective, legitimate products, rather than to people who

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[10]Stephen Heffler et al., *Trends: U.S. Health Spending Projections for 2004-2014*, HEALTH AFFAIRS (Web Exclusive) W5-75 ex. 1 (Feb. 23, 2005), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.74v1.

[11]*Id.* at W5-74, 75 ex. 1.

violate the antitrust and consumer protection laws. As a Commissioner, I hope to help consumers achieve those worthy goals, and I think the Commission has an important role to play in that regard.

I will address three topics this afternoon. First, I will quickly highlight a few of the Commission's recent actions in the health care field, and explain how they relate to some of the major themes emphasized in the Health Care Report.[12]

Next, I will shift gears a bit – to the realm of economics – where I will discuss the use of critical loss analysis in merger review.[13] The Health Care Report suggested a cautious approach to the use of critical loss analysis, primarily in the context of geographic market definition in hospital merger cases.[14] More recently, the Commission's Part 3 administrative opinion in *Chicago Bridge & Iron* rejected a critical loss analysis proffered by the respondent to bolster its entry arguments.[15] I am decidedly *not* an economist – but as an antitrust lawyer and former litigator, I have worked with many talented economists over the years, and I have been following the critical loss debate with great interest.

Finally, I will reflect on the use of so-called "community commitments" in hospital merger settlements, which were roundly criticized in the Health Care Report.[16] As a former state enforcer, I may have a slightly different perspective on these settlement tools.

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[12] *See infra* Part II.

[13] *See infra* Part III.

[14] *See infra* Part III.C.

[15] *See infra* Part III.D.

[16] *See infra* Part IV.

II. HIGHLIGHTS OF RECENT FTC CASES AND ACTIONS

A review of the Commission's recent competition matters demonstrates that the health care industry continues to be a top priority. A significant percentage of the Commission's competition actions in the last year have involved health care products and services. Other speakers participating in other Spring Meeting programs no doubt will engage in a more comprehensive review of the Commission's health care enforcement activities over the past year. I will highlight just a few cases and themes, as they relate to the Health Care Report.

A. Physician Price-Fixing Cases

As evidenced by a long list of cases from the last few years, the Commission aggressively has sought out and challenged groups of physicians and other providers who, lacking financial or clinical integration that otherwise might justify their joint activities, appear instead to have nakedly fixed prices, allocated markets, or entered into similar types of anticompetitive agreements.

Most often, the targeted physicians have been participants in purported "messenger model" arrangements. If used appropriately, the messenger model can enable efficient contracting between payors and providers. In practice, however, it appears that some messenger models have simply facilitated unlawful collective bargaining agreements between physicians.

As the Health Care Report notes, the federal antitrust agencies consistently have opposed collective bargaining by physicians, even in response to perceived countervailing "buyer power" by insurance companies.[17] This is because the agencies have concluded – based on their review

[17] HEALTH CARE REPORT, Ch. 2 at 17-25 ("Physician Collective Bargaining").

of the research and, more importantly, their fact-intensive investigations in specific markets[18] – that physician collective bargaining only serves to increase the costs of health care, without improving quality. This is particularly significant because spending for physician and other clinical services is sizeable; it is projected to constitute nearly 24 percent of the over $1.6 trillion spent on health care services in 2004.[19] Moreover, as the Health Care Report reminds us, "the treatment decisions of physicians profoundly affect both the cost and quality of the other health care services that consumers receive."[20]

Hopefully, physicians are beginning to get the message articulated in the Health Care Report and backed up by recent challenges: the federal antitrust agencies do not look kindly upon physician price-fixing, absent some kind of efficiency-enhancing integration. I note that one case involving alleged physician price-fixing, *North Texas Specialty Physicians (NTSP)*, currently is in administrative litigation. In November 2004, an Administrative Law Judge (ALJ) upheld charges that NTSP had restrained trade by conspiring to fix prices in certain contracts to

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[18]*See, e.g.*, In the Matter of Preferred Health Services, FTC File No. 041-0099 (proposed consent agreement accepted for public comment March 2, 2005), *available at* http://www.ftc.gov/os/caselist/0410099/0410099.htm; In the Matter of White Sands Health Care System, L.L.C. et al., FTC Dkt. No. C-4130 (consent order entered Jan. 11, 2005), *available at* http://www.ftc.gov/os/caselist/0310135/0310135.htm; In the Matter of Piedmont Health Alliance, Inc., a Corporation, et al., FTC Dkt. No. 9314 (withdrawn from Part 3 adjudication July 2, 2004; consent order entered Oct. 1, 2004), *available at* http://www.ftc.gov/os/adjpro/d9314/index.htm; In the Matter of Southeastern New Mexico Physicians IPA, Inc., et al., FTC Dkt. No. C-4113 (consent order entered August 5, 2004), *available at* http://www.ftc.gov/os/caselist/0310134/0310134.htm; *see also* HEALTH CARE REPORT, Ch. 2 at n. 120 (cites to numerous enforcement actions challenging messenger model arrangements); *see generally id.*, Ch. 2 at 23-25 ("Physician Collective Bargaining Harms Consumers").

[19]Heffler, *supra* note 10, at W5-75 ex. 1.

[20]HEALTH CARE REPORT, Ch. 2 at 2 (citing Gail B. Agrawal & Howard R. Veit, *Back to the Future: The Managed Care Revolution*, 65 LAW & CONTEMP. PROBS. 11, 49 (2002)).

provide medical services to the patients of health plans.[21] The case is now on appeal to the full Commission.[22]

B. Pharmaceutical Mergers and Agreements

The Commission also has continued its practice of closely scrutinizing pharmaceutical mergers and agreements. In the past year, the Commission entered consent orders requiring sizeable divestitures in three different mergers of major pharmaceutical firms.[23] While the Health Care Report does not focus directly on pharmaceutical mergers, the Report indicates that competition is necessary to spur innovation in the pharmaceutical industry.[24] The report notes that increased consumer spending for pharmaceutical products has spurred an increase in

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[21]FTC News Release, *Administrative Law Judge Upholds FTC Complaint Against North Texas Specialty Physicians* (Nov. 16, 2004), *available at* http://www.ftc.gov/opa/2004/11/northtexas.htm; In the Matter of North Texas Specialty Physicians, FTC Dkt. No. 9312 (Initial Decision entered Nov. 15, 2004), *available at* http://www.ftc.gov/os/adjpro/d9312/041116initialdecision.pdf.

[22]*See generally* In the Matter of North Texas Specialty Physicians, FTC Dkt. No. 9312, *available at* http://www.ftc.gov/os/adjpro/d9312/index.htm.

[23]In the Matter of Genzyme Corporation & Ilex Oncology, Inc., FTC Dkt. No. C-4128 (consent order entered Jan . 31, 2005), *available at* http://www.ftc.gov/os/caselist/0410083/0410083.htm; In the Matter of Cephalon, Inc. & CIMA Labs, Inc., FTC Dkt. No. C-4121 (consent order entered Sept. 20, 2005), *available at* http://www.ftc.gov/os/caselist/0410025/0410025.htm; In the Matter of Sanofi-Synthélabo & Aventis, FTC Dkt. No. C-4112 (consent order entered Sept. 20, 2004), *available at* http://www.ftc.gov/os/caselist/0410031/0410031.htm.

[24]*See, e.g.*, HEALTH CARE REPORT, Ch. 7 at 5-7 ("The Role of Competition in Spurring Pharmaceutical Innovation"); *see also* In The Matter of Genzyme Corp. & Novazyme Pharmaceuticals, Inc., FTC. File No. 021-0026 (investigation closed Jan. 13, 2004), Statement of Commissioner Pamela Jones Harbour, *available at* http://www.ftc.gov/os/2004/01/harbourgenzymestmt.pdf (highlighting the importance of innovation competition, especially in the pharmaceutical industry).

research and development investments to develop and market new drugs, which is an important dimension of pharmaceutical competition.[25]

The Health Care Report also describes the important role of generic drug products in driving down drug prices,[26] and cites the Commission's numerous enforcement actions challenging conduct that otherwise might have denied consumers the benefits of generic drug competition.[27] The Commission settled one such case in August 2004. The Commission charged that Perrigo and Alpharma, the only two producers of generic, over-the-counter children's liquid ibuprofen, had entered into an agreement to delay Alpharma's entry into the market and keep prices from falling. The parties agreed to disgorge $6.25 million in illegally-obtained profits, and also agreed not to engage in such conduct in the future. The parties agreed to disgorge another $1.5 million to the fifty states and territories that filed their own complaint and reached a similar conduct settlement.[28]

As most of you no doubt are aware, the U.S. Court of Appeals for the 11th Circuit recently vacated a Commission order arising from the Commission's administrative opinion in the *Schering-Plough* case, which challenged a so-called "reverse payment" from a name-brand company to a generic competitor.[29] The 11th Circuit held that the Commission, contrary to

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[25]HEALTH CARE REPORT, Ch. 7 at 2-3.

[26]*Id.*, Ch. 7 at 6-7.

[27]*Id.*, Ch. 7 at 9-10 and n. 46-50.

[28]FTC News Release, *Generic Drug Marketers Settle FTC Charges* (Aug. 12, 2004), *available at* http://www.ftc.gov/opa/2004/08/perrigoalpharma.htm; Federal Trade Commission v. Perrigo Co. & Alpharma Inc., FTC File No. 021-0197 (D.D.C.), *available at* http://www.ftc.gov/os/caselist/0210197.htm.

[29]In the Matter of Schering-Plough Corporation, et al., FTC Dkt. No. 9297 (opinion of the Commission issued Dec. 8, 2003), *available at* http://www.ftc.gov/os/adjpro/d9297/031218commissionopinion.pdf; *vacated*, Schering-Plough

authority in that circuit, had insufficiently accounted for the potential exclusionary power of the name-brand company's patent, as well as the strong procompetitive potential of patent settlements. The Commission currently is exploring its options in response to the 11th Circuit's decision.

C. Childhood Obesity Project

While it is not directly related to the Health Care Report, I do not want to miss this opportunity to mention an exciting new research initiative that does relate to health care – specifically, the health of our nation's children. On March 11th, in remarks before the Consumer Federation of America's Consumer Assembly, Chairman Majoras announced a project to address the problem of childhood obesity,[30] in response to a fall 2004 Institute of Medicine report specifically recommending action by the Department of Health and Human Services (HHS) and the Commission.[31] This coming summer, in conjunction with HHS, the Commission will hold a two-day workshop to explore industry self-regulatory efforts regarding the advertising and marketing of food and beverages to children.[32]

Corp. v. FTC, No. 04-10688 (11th Cir. March 8, 2005), *available at* http://www.ca11.uscourts.gov/opinions/ops/200410688.pdf.

[30]Deborah Platt Majoras, Chairman, Federal Trade Commission, *The FTC: Using Multiple Tools to Empower Consumers*, remarks before the Consumer Federation of America Consumer Assembly (March 11, 2005), at 15-19, *available at* http://www.ftc.gov/speeches/majoras/050311faw.pdf.

[31]COMMITTEE ON PREVENTION OF OBESITY IN CHILDREN AND YOUTH, FOOD AND NUTRITION BOARD AND BOARD ON HEALTH PROMOTION AND DISEASE PREVENTION, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, PREVENTING CHILDHOOD OBESITY: HEALTH IN THE BALANCE (Jeffrey P. Koplan et al. eds., 2004), *available at* http://www.nap.edu/books/0309091969/html/.

[32]Majoras, *supra* note 30, at 15, 19.

I view the planned childhood obesity initiative as a perfect example of how the Commission fulfills its dual missions. First, greater dissemination of accurate nutritional information is expected to foster informed decisionmaking by consumers. Second, the wider availability of comparative information likely will spur additional competition to offer healthy, kid-friendly options – which, in the end, will increase the choices available to consumers.

A very similar theme runs through the Health Care Report itself. One of the Report's recommendations is to find ways to "furnish more information on prices and quality to consumers, in ways that they find useful and relevant," and to encourage consumers to use this information to make responsible health care choices.[33] A later section of the Report suggests that, when done appropriately, disclosure of data relating to quality measures may create powerful incentives for providers to actually improve the quality of the health care services they provide.[34]

Of course, the problem of childhood obesity is complex. As Chairman Majoras recognized in her speech, tackling the problem will require major and multifaceted efforts by parents and their children, and there will be no simple solution. Having said that, however, better advertising and marketing by the food industry can and should be part of the plan, and I am pleased that the Commission will be on the front lines in leading this research initiative. If parents are armed with more accurate information and more choices, they will be better able to help their children lead healthier lives.

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[33]HEALTH CARE REPORT, Exec. Summ. at 21 (Recommendation 1(b)).

[34]*Id.*, Ch. 2 at n. 106 and accompanying text.

III. CRITICAL LOSS ANALYSIS

As promised, I will now switch gears to discuss critical loss analysis, an area to which I have been paying more attention recently. It would be impossible not to. In more and more cases before the Commission – both in the health care industry and in other industries – defense economists are putting forth critical loss analyses to support their arguments against enforcement action.[35]

A. What Is Critical Loss Analysis?

Critical loss analysis is, in essence, a way to apply the hypothetical monopolist test articulated in the Merger Guidelines. It may be used to define markets. It may also be used more generally, as part of a competitive effects analysis, to determine whether a price increase would be profitable. I will use geographic market definition in hospital mergers as a simple example, since that is the context in which the Health Care Report discusses critical loss analysis.

One begins with a group of products that, arguably, constitute a relevant market. In the realm of hospital mergers, for example, one might begin with a candidate group of hospitals that allegedly compete with one another. One assumes that, if a hypothetical monopolist of this market were to raise prices, some sales would be lost. The question is, what percentage of sales

[35]The use of critical loss analysis has not been limited solely to defendants. In the Commission's successful *Swedish Match* merger challenge, for example, the Commission's expert economist used a form of critical loss analysis to apply the hypothetical monopolist test for product market definition purposes. FTC v. Swedish Match N. Am., Inc., 131 F. Supp. 2d 151, 160 (D.D.C. 2000). The court ultimately held that neither side's economic evidence was persuasive (and that the defendants' expert was, in fact, not credible). *Id.* at 161. Rather, the court relied heavily upon internal party documents, as well as testimony by third-party market participants, to arrive at a product market definition. *Id.* at 162-65.

could the hypothetical monopolist afford to lose, before the price increase would become unprofitable? That level of sales loss is called the "critical loss." The calculation of critical loss depends primarily on an assumed percentage price increase and an estimate of the profit margin on each unit of sales.

Under the Merger Guidelines' "SSNIP" test, one typically posits a "small but significant and nontransitory increase in price" of five percent. Under critical loss analysis, one would first calculate the critical loss for a five percent price increase, and then estimate the hypothetical monopolist's projected actual sales losses if prices were to go up by five percent. If reliable data were available, the projected actual loss would be calculated using estimates of demand elasticities and profit margins. Otherwise, one could estimate the actual percentage sales loss based on business documents, customer testimony, and the like. Going back to the hospital merger example, one would attempt to estimate what percentage of patients likely would switch to other hospitals in response to a five percent price increase.

If the estimated actual loss is higher than the critical loss – meaning that the loss of profits from lost sales would be greater than the increased profitability of the remaining sales at the new, higher price – one would conclude that a five percent price increase would *not* be profitable for the hypothetical monopolist. Therefore, under the Merger Guidelines, one would infer that the relevant market must be larger than initially proposed. Or, if one were using critical loss analysis to predict competitive effects, one would conclude that a post-merger price increase would be unlikely.

B. The Debate Surrounding Critical Loss Analysis

That is the simple story of critical loss analysis. Of course, in case-by-case practice, it becomes much more complicated, and relies on various assumptions about consumer behavior. I recommend several excellent articles about critical loss analysis, which go into far greater detail than I possibly could accomplish today.[36]

A series of recent articles has focused on one particular criticism of critical loss analysis: that it may not lead to the "right" result in markets with high profit margins. Proponents of critical loss analysis argue that, in such a market, the loss of even a few sales is likely to have a significant impact on profits. Therefore, the theory goes, a price increase is far less likely to be profitable. This tends to support a conclusion that the market is broader, or that the merged firm will not find it profitable to raise prices post-merger.

Critics of critical loss analysis suggest that one must tread more cautiously and explore the underlying reasons for high margins in a given market. They point out that there is an equally plausible way to view markets with high margins. Specifically, if margins are high because elasticity is low – i.e., because consumers are not very sensitive to price changes – this implies that a post-merger SSNIP is *not* likely to cause enough consumers to switch their purchases to outweigh the increased profits from charging a higher price. This would lead to the

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[36] *See especially* Barry C. Harris & Joseph J. Simons, *Focusing Market Definition: How Much Substitution Is Necessary?*, 12 RESEARCH L. & ECON. 207 (1989); Michael L. Katz & Carl Shapiro, *Critical Loss: Let's Tell The Whole Story*, ANTITRUST, Spring 2003, at 49, *available at* http://faculty.haas.berkeley.edu/shapiro/critical.pdf; Daniel P. O'Brien & Abraham L. Wickelgren, *A Critical Analysis of Critical Loss Analysis*, 71 ANTITRUST L.J. 161 (2003); David T. Scheffman & Joseph J. Simons, *The State of Critical Loss Analysis: Let's Make Sure We Understand the Whole Story*, ANTITRUST SOURCE, Nov. 2003, *at* http://www.abanet.org/antitrust/source/11-03/scheffman.pdf; Michael L. Katz & Carl Shapiro, *Further Thoughts on Critical Loss*, ANTITRUST SOURCE, March 2004, *at* http://www.abanet.org/antitrust/source/03-04/katzshapiro.pdf.

exact opposite conclusion – i.e., that the market is more narrow, or that a post-merger price increase would be profitable. In other words, focusing on high margins without accounting for relatively inelastic demand might lead to a distorted interpretation of how market participants actually would behave.[37]

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[37]This is related to the famed "Cellophane fallacy," which arises from the Supreme Court's opinion in *United States v. E.I. du Pont De Nemours & Co.*, 351 U.S. 377 (1956). In *du Pont*, the Court held that the market comprised all flexible wrapping materials, based on evidence of an apparently high cross-elasticity of demand between cellophane and other flexible wrapping materials. However, high cross-elasticity of demand may be caused by pre-existing market power, as the U.S. Court of Appeals for the Second Circuit has explained:

> The economic error allegedly committed by the Court in Cellophane was in failing to recognize that a high cross-elasticity of demand may, in some cases, be the product of monopoly power rather than a belief on the part of consumers that the products are good substitutes for one another. As the district court succinctly stated: "At a high enough price, even poor substitutes look good to the consumer. [Citation omitted.] That is, in the Cellophane case, the high cross-elasticity between cellophane and wax paper simply may have been a function of the high price that du Pont demanded for cellophane.

U.S. v. Eastman Kodak Co., 63 F.3d 95, 105 (2nd Cir. 1995) (citing U.S. v. Eastman Kodak Co., 853 Supp. 1454, 1469 (W.D.N.Y. 1994)); *see also* Eastman Kodak Co. v. Image Tech. Servs., 504 U.S. 451, 470 (1992) ("The sales of even a monopolist are reduced when it sells goods at a monopoly price . . ."). In other words, consumers who are being forced to pay supracompetitive prices likely are more price-elastic at those prices than they would be at competitive prices. Ideally, cross-elasticity of demand should be measured at a competitive price level instead.

Similarly, in a critical loss analysis, one must be cognizant that a market may have high margins precisely because customers perceive that they have so few options. Customers may occasionally switch, but this does not negate the possibility that the hypothetical monopolist (or merged firm) would be able to impose a price increase, without triggering sufficient losses to render the price increase unprofitable. The Commission made this observation in its recent *Chicago Bridge & Iron (CB&I)* administrative opinion:

> Like any other supplier, CB&I's pricing is constrained at some level. However, the mere fact that buyers switch awards to new entrants at some point tells us nothing about the effectiveness of the new entrants' ability to constrain CB&I's prices to pre-acquisition levels. This concept, commonly referred to as the "Cellophane Fallacy," derives from criticism of the approach taken by the Supreme Court in [*du Pont*].

C. Health Care Report Discussion of Critical Loss Analysis

As I read it, the Health Care Report supports a cautious approach to the use of critical loss analysis. According to the Report, while there is general agreement that the Merger Guidelines framework for market definition makes sense in the hospital merger context, there has been a great deal of controversy regarding how to apply the Guidelines to hospital markets.[38] In discussing critical loss analysis, the Report reaches the following conclusion: "Critical loss analysis has the potential to provide a useful way to implement the hypothetical monopolist test, but it must be applied with great care."[39] The Report reviews testimony by several witnesses who mentioned possible pitfalls of the critical loss technique, including the one I just described above.[40] In addition, because hospital pricing is so complex, it may be difficult to calculate reliable profit margins upon which to base a critical loss analysis.[41] Moreover, it becomes especially challenging to accurately quantify elasticity of demand for hospital services (based,

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In the Matter of Chicago Bridge & Iron Co., et al. [hereinafter *CB&I* opinion], FTC Dkt. No. 9300 (Commission opinion issued Dec. 21, 2004), at 86 n. 532 (citations omitted), *available at* http://www.ftc.gov/os/adjpro/d9300/050106opionpublicrecordversion9300.pdf.

[38] It is important to realize that this debate is not merely academic. Defendants in several hospital merger cases have successfully used critical loss analysis to argue in favor of broad geographic markets – which, as a practical matter, has led to agency losses in hospital merger litigation. In fact, as evidenced by many hospital merger cases litigated in the last ten years, geographic market definition issues often make or break a hospital merger case. *See, e.g.*, HEALTH CARE REPORT, Ch. 4 at n. 25 and accompanying text (citing cases where the federal agencies have lost on geographic market grounds).

[39] *Id.*, Ch. 4 at 10.

[40] *Id.*, Ch. 4 at 12-13.

[41] *Id.*, Ch. 4 at 11.

for example, on patient flow data), because it is so hard to predict how consumers actually would react to price increases.[42]

D. *CB&I* Discussion of Critical Loss Analysis

The critical loss debate is not limited to the hospital merger context, of course. The Commission's *Chicago Bridge & Iron (CB&I)* opinion includes a section on critical loss analysis, which was used by the respondents' expert to bolster an argument against anticompetitive effects.[43] The respondents argued that the ALJ had erred in disregarding their expert's conclusion, based on a critical loss analysis, that CB&I would not be able to raise prices.[44]

The Commission found that the results of the critical loss analysis were inconsistent with other evidence of likely anticompetitive effects, including "extraordinarily high concentration levels . . . , the state of pre-acquisition competition . . . , and the nearly insurmountable entry barriers that we found to predominate . . . ."[45] In its opinion, the Commission noted that, while it did "not doubt the soundness of the logic underlying critical loss analysis, . . . we are mindful that recent economic literature has cautioned that the analysis has certain vulnerabilities."[46] In particular, the opinion cited the example of a merger of two firms with high profit margins and relatively inelastic demand, whereby a post-merger price increase might be profitable because so

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[42] *Id.*, Ch. 4 at 11-12.

[43] *CB&I* opinion, *supra* note 37, at 82-87.

[44] *Id.* at 82.

[45] *Id.* at 84.

[46] *Id.* at 83.

few sales would be lost.[47] The Commission indicated that evidence on pre- and post-merger elasticities of demand would be an important determinant of whether the critical loss analysis was valid, and ultimately held that the respondents' critical loss analysis did not paint an accurate portrait of the markets at issue.

E. The Appropriate Role of Critical Loss Analysis

Based on my background prior to becoming a Commissioner, I approach most cases from the perspective of an antitrust litigator. When I am asked to consider authorizing an enforcement action, I immediately focus on how the case will sound to a judge – most likely, a judge who is not an economist or an antitrust expert. Therefore, I pay closest attention to the business documents and other contemporaneous, real-world evidence, and secondarily to the testimony of party witnesses and third-party industry participants who understand how the market works.

I recognize that antitrust doctrine is deeply steeped in economics, and that economic analysis must play an important role in determining the "right" course of action to protect competition and, ultimately, consumers. But I tend to look to economics to support, or refute, the impressions I have already formed based on the documents, the testimony, and the collection of "market facts" I have gleaned from various sources. My views are not, in any way, a denigration of economic analysis. To the contrary, I have high regard for economists. In fact, I think most of them are quite brilliant! But as I have learned over the years, precisely because they are so brilliant, most good economists can craft equations that, frankly, can make the numbers say whatever they want them to say.

[47] *Id.*

For this reason, when evaluating a potential enforcement recommendation, I approach economics with a great deal of respect tempered by a healthy dose of skepticism. In particular, when presented with a critical loss analysis, I will continue to look closely to ensure that it is being applied with sufficient rigor, based on sensible assumptions that mesh with real-world business dynamics. As the critical loss debate continues, I would be extremely interested in seeing some "natural experiments" or retrospectives to determine, with greater precision, the extent to which critical loss analysis adds value. For example, if the data were available, it would be interesting to see whether critical loss analysis would have accurately predicted competitive effects in past hospital merger cases.

IV. COMMUNITY COMMITMENTS

Finally, I would like to touch on a topic that received only brief mention in the Health Care Report, but which is, perhaps, closer to my heart than to those of the other Commissioners: community commitments.

Community commitments have been used in several hospital merger cases.[48] Typically, they are agreements with State Attorneys General, promising to pass along to consumers a specific amount of cost savings, and sometimes guaranteeing that prices will not go up for a specified period of time.

The Health Care Report makes the following observation about community commitments:

> The Agencies do not accept community commitments as a resolution to likely anticompetitive effects from a hospital (or any other) merger. The Agencies

[48] HEALTH CARE REPORT, Ch. 4 at 28-29 and n. 151 (citations to cases where community commitments have been used in the past).

> believe community commitments are an ineffective, short-term regulatory approach to what is ultimately a problem of competition. Nevertheless, the Agencies realize that in some circumstances, State Attorneys General may agree to community commitments in light of the resource and other constraints they face.[49]

I fully agree with the Health Care Report that, as a pure matter of antitrust principle, community commitments do not solve the competitive problems arising from an otherwise unlawful merger. When seeking relief, the primary goal should always be to obtain a structural remedy, which is a better long-term solution than a behavioral fix. But as a former state enforcer – who was personally involved in a case where the State of New York accepted such a community commitment – I am, perhaps, more sympathetic than others to the totality of circumstances that might lead a state to agree to this kind of remedy.

In 1997, both the U.S. Department of Justice (DOJ) and the New York State Attorney General's Office reviewed the proposed merger of Long Island Jewish Medical Center and the North Shore Health System. The deal would have combined two flagship not-for-profit academic hospitals. The DOJ challenged the merger in federal court, alleging that the transaction would eliminate competition between the only two "anchor hospitals" in Nassau and Queens Counties. Unfortunately, DOJ ultimately lost the case, based primarily on product and geographic market definition issues.[50]

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[49] *Id.*, Exec. Summ. at 27.

[50] United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997) (denial of federal government's request for permanent injunction).

The State of New York was all too aware that hospital merger challenges had not been faring well in the courts, particularly when they involved not-for-profit hospitals.[51] We were cognizant of our obligation to enforce the antitrust laws, but equally mindful of our broader responsibility to protect the state's citizens. Presented with the option of a community commitment, and in light of our resource constraints, the State of New York opted to accept a consent agreement rather than make an "all or nothing" bet by engaging in risky litigation.

I continue to believe that we made the best possible deal for consumers in New York State. Over a five-year period, the parties were required to pass along to consumers $100 million in cost savings they had argued would be achieved by the deal. They committed to provide new and incremental programs and services, examples of which were enumerated in the consent agreement. They also promised to use some of the funds to "provide quality healthcare to economically disadvantaged and elderly members of the community and to provide quality medical education," as an offset against anticipated reductions in Medicare and Medicaid

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[51]The district court's opinion in *Long Island Jewish* included a detailed discussion of the controversy surrounding the appropriate legal role of institutional status (profit versus not-for-profit) in merger cases. Based on a review of prior cases, the court "deduce[d] that while the not-for-profit status of the merging hospitals does not provide an exemption from the antitrust laws, this factor may be considered if supported by other evidence that such status would inhibit anti-competitive effects." *Id.* at 146. While the court agreed with "the defendants' contention that community service, not profit maximization, is the hospitals' mission," the court ultimately said that it had "give[n] only limited and non-determinative effect to the not-for-profit status" of the merging hospitals, recognizing that "if there is the potential for anticompetitive behavior, there is nothing inherent in the structure of the corporate board or the non-profit status of the hospitals which would operate [sic] to stop any anticompetitive behavior." *Id.*

The Health Care Report explicitly rejects the significance of institutional form as a relevant factor in predicting likely anticompetitive effects from a hospital merger. HEALTH CARE REPORT, Ch. 4 at 29-33; *see also id.*, Exec. Summ. at 27 ("The best available evidence shows that the pricing behavior of nonprofits when they achieve market power does not systematically differ from that of for-profits.").

reimbursement. Finally, the parties agreed to freeze hospital prices for two years, other than increases to keep up with inflation (as measured by a national index for medical care prices).[52]

I stand by the Health Care Report's conclusion that the resolution of hospital merger challenges through community commitments should be generally disfavored, at least by the federal antitrust agencies. But in light of my state enforcement background, I thought it might be illuminating to elaborate on the state perspective, beyond the extremely brief mention in the Health Care Report itself.

V. CONCLUSION

In closing, I have no doubt that the Commission will remain extremely committed to pursuing aggressive enforcement, advocacy, and policy agendas in the health care field. I look forward to being a part of those efforts, and I hope to see even more creative thinking as we grapple with the unique challenges of applying antitrust principles to health care markets.

[52]Settlement agreement by and among Dennis C. Vacco, Attorney General of the State of New York; John S.T. Gallagher, President, North Shore Health System; and David R. Dantzker, M.D., President, Long Island Jewish Medical Center (August 1997), *available at* http://www.abanet.org/antitrust/committees/state-antitrust/ny-lijnorthshore.pdf (web page of the State Antitrust Enforcement Committee, Antitrust Section, American Bar Association).