UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

COMMISSIONERS: Deborah Platt Majoras, Chairman
Thomas B. Leary
Pamela Jones Harbour
Jon Leibowitz

In the Matter of	)	Docket No. 9315
EVANSTON NORTHWESTERN HEALTHCARE CORPORATION,	)	Public Record
a corporation.	)	

AMERICAN HOSPITAL ASSOCIATION'S *AMICUS CURIAE* BRIEF IN SUPPORT OF EVANSTON NORTHWESTERN HEALTHCARE CORPORATION

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I. INTRODUCTION

The American Hospital Association ("AHA") is a national advocacy organization that represents and serves hospitals and health care networks of all types and sizes. AHA represents nearly 4,800 hospitals and health systems covering the entire spectrum of the field, from large urban hospitals to community hospitals to small and typically rural, critical access hospitals. For over 100 years, AHA has represented the interests of its members in legislative and regulatory debates and in judicial matters. AHA also has long represented the interests of its hospital members on antitrust issues before the Federal Trade Commission ("FTC") and the Department of Justice's Antitrust Division ("DOJ"). In recent years, AHA has placed particular emphasis on advocating on behalf of hospitals before the FTC as this body has focused on competition issues of direct consequence to the hospital field.

In August 2002, in response to numerous failed attempts by state and federal enforcers to challenge pro-competitive hospital mergers,[1] then-FTC Chairman Timothy Muris announced the creation of the Merger Litigation Task Force. Its stated purpose was to target completed (and previously unchallenged) hospital mergers for special retrospective review.[2] Upon learning of this initiative, the AHA met with Chairman Muris to voice its very strong concerns that such actions were wholly unnecessary, a significant waste of FTC resources, unfairly singled out the hospital field for punitive retrospective challenges, and given the way such investigations are

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[1] See In re Adventist Health Sys., 117 F.T.C. 224 (1994); Federal Trade Comm'n v. Freeman Hosp., 911 F. Supp. 1213 (W.D. Mo. 1998), aff'd, 69 F.3d 260 (8th Cir. 1995); United States v. Mercy Health Servs., 902 F. Supp. 968 (N.D. Iowa 1995); Federal Trade Comm'n v. Butterworth Health Corp., 946 F. Supp. 1285 (W.D. Mich. 1996), aff'd, 121 F.3d 708 (6th Cir. 1997); United States v. Long Island Jewish Med Ctr., 983 F. Supp. 121 (E.D.N.Y. 1997); Federal Trade Comm'n v. Tenet Health Care Corp., 186 F.3d 1045 (8th Cir. 1999); California v. Sutter Health Sys., 130 F. Supp. 2d 1109 (N.D. Cal. 2001).

[2] Chairman Muris defended this retrospective inquiry as an exercise in "update[ing] prior assumptions about the consequences of particular transactions and the nature of competitive forces in health care" based on "real-world information." Timothy J. Muris, Everything Old is New Again: Health Care and Competition in the 21st Century, Prepared Remarks before 7th Annual Competition in Health Care Forum, Chicago, Illinois, 19-20 (Nov. 7, 2002).

typically handled, likely to cost hospitals millions of dollars in compliance with FTC requests and subpoenas. Despite these well-founded objections, the Task Force undertook a lengthy large-scale review of consummated hospital mergers in numerous markets going back a number of years.

Predictably, this backward-looking review of unprecedented scale resulted in a challenge to a consummated hospital merger; the FTC chose the acquisition of Highland Park Hospital ("Highland Park") by Evanston Hospital ("Evanston") and brought suit over four years after the merger was completed and despite the fact that the agency failed to object prior to consummation of the merger. The merged entity, Evanston Northwestern Healthcare Corporation ("ENH"), is a relatively small hospital system operating in the nation's third largest metropolitan area and has been operating as an integrated hospital system for nearly five years. If ENH had merged a few years earlier—or later—it would not have been the subject of this enforcement action. But ENH's misfortune was that its merger coincided with the culmination of a protracted effort by the FTC to "reinvigorate the Commission's hospital merger program" after a series of unsuccessful challenges to hospital mergers.[3]

The timing of the Commission's challenge was not the only irregular aspect of its review; the substantive basis for the Commission's challenge was equally unorthodox. Apparently realizing that it would not succeed in bringing a conventional challenge to the merger based on a geographic market representing the realities of the competitive Chicago hospital marketplace in which ENH operated, Complaint Counsel instead proposed a geographic market consisting only of the ENH system (three hospitals in all) in one count of its complaint. The only other count

[3] See Press Release, Federal Trade Commission Announces Formation of Merger Litigation Task Force (Aug. 28, 2002), available at http://www.ftc.gov/opa/2002/08/mergerlitigation.htm.

alleging violations by ENH in the complaint advanced a novel anticompetitive effects theory that did not rely on *any* proposed geographic market. See FTC Complaint.

The ALJ declined to adopt Complaint Counsel's unrealistic geographic market and rejected the novel theory that anticompetitive effects can be found without reference to a relevant geographic market. But the ALJ ruled for Complaint Counsel nonetheless. In the process, the ALJ upended longstanding precedent and practice for defining geographic markets and evaluating quality improvements in the merger context, and with no coherent theory of anticompetitive effects ordered the break-up of a successful hospital merger years after consummation.

In reaching this result, the ALJ refused to engage in an empirical analysis in defining the geographic market, as years of precedent and Commission practice demand. Instead, the ALJ defined the geographic market relying exclusively on two inherently suspect types of evidence: selected and unsupported opinion testimony from health insurance companies, and an unscientific patient survey. That approach is unacceptable because it is neither reliable nor workable. Using mere opinion testimony and unscientific survey evidence to define the geographic market is bound to cause substantial confusion about the applicable standards for evaluating a hospital merger.

The ALJ also declined to consider the significant—and *verified*—improvements made by ENH following the merger to enhance quality. That, too, was error, and, if allowed to stand, will have similar effects on other hospital transactions going forward. Merged hospitals and those considering joint ventures or similar transactions will be much more reticent about undertaking costly but beneficial quality improvements if they fear their efforts will be unrecognized and perhaps undone years later by the FTC. Finally, the ALJ's failure to articulate a coherent theory

of anticompetitive effects is not only inconsistent with the requirements of the Merger Guidelines, it impermissibly empowers the FTC to undo any hospital merger it pleases without advancing a reasonable and defensible theory of anticompetitive effects.

This is not the kind of framework for evaluating hospital mergers that this Commission should endorse. This ruling should not stand; in addition to unfairly penalizing ENH, it establishes a new and completely unworkable framework for evaluating hospital mergers. The Merger Guidelines have succeeded in reducing the "uncertainty associated with the enforcement of the antitrust laws."[4] Permitting this analysis to stand—which leaves the Merger Guidelines far behind—will harm not just pro-competitive hospital mergers, but patients, as hospitals are forced to waste valuable resources fighting unfair enforcement actions and undoing tens of millions of dollars in quality improvements in response to tardy divestiture orders. This Commission should reject the Initial Decision, as well as any effort by Complaint Counsel to revitalize its challenge to the merger under Count II of its Complaint.

II. ARGUMENT

A. THE INITIAL DECISION ABANDONED THE ESTABLISHED FRAMEWORK FOR DEFINING GEOGRAPHIC MARKETS IN HOSPITAL MERGER CASES.

The cornerstone of every hospital merger case is a quantitative and empirical analysis of where patients can turn in the event of an anticompetitive price increase. See Federal Trade Comm'n v. Tenet Health Care Corp., 186 F.3d 1045, 1052 (8th Cir. 1999); Federal Trade Comm'n v. Butterworth Health Corp., 946 F. Supp. 1285, 1291 (W.D. Mich. 1996). The ALJ's Initial Decision, however, eschewed *any* empirical analysis in defining the geographic market; instead it relied exclusively on unsupported and selective testimony from health insurance companies and an admittedly unscientific patient survey. That approach introduces a new and

[4] Merger Guidelines § 0.

unreliable analysis that will create uncertainty and confusion for the entire hospital field as well as the courts for years to come.

1. The Geographic Market Posited in the Initial Decision Lacks Proper Empirical Foundation Because the ALJ Rejected Empirical Data in Favor of Opinion Testimony and Unscientific Survey Evidence.

Count I of the Commission's Complaint proposed an unsubstantiated—and unheard-of—three-hospital geographic market consisting entirely of the ENH network of hospitals. Count II of the Complaint attempted to eliminate defining relevant markets all together. See FTC Complaint § 28-32.[5] ENH, in contrast, offered a conservative nine-hospital geographic market that included the three ENH hospitals, as well as Lake Forest, Advocate Lutheran General, Rush North Shore, St. Francis, Condell and Resurrection hospitals.

The ALJ properly rejected Complaint Counsel's unsupported analysis of the geographic market, as well as the Complaint Counsel's novel contention in Count II that the market need not be defined at all in analyzing anticompetitive effects. But the ALJ rejected ENH's proposed geographic market as well, instead adopting a seven-hospital geographic market that arbitrarily excluded both Condell and Resurrection hospitals. The ALJ's failure to correctly construct the geographic market was due not only to a fundamental misunderstanding about the scope of the large and competitive hospital market in which ENH operates, but also due to his refusal to consider what courts consistently have found to be the most reliable evidence of the geographic market—quantitative, empirical evidence of where patients can and do turn for alternative hospital services.

[5] Under Count II, Complaint Counsel contends that "it is unnecessary to define a geographic market for the purposes of a claim under section 7 of the Clayton Act" if there is direct evidence of anti-competitive effects. See Initial Decision at 201.

a) Empirical Evidence of the Geographic Market is Critical to a Hospital Merger Analysis.

Empirical analysis has always driven the determination of the relevant geographic market in the hospital merger context. More than any other kind of evidence, reliable empirical data can help resolve the most fundamental question in any hospital merger case: "where consumers of acute care inpatient hospital services could practicably turn for alternate sources of the product" should prices become anticompetitive. See Federal Trade Comm'n v. Freeman Hosp., 69 F.3d 260, 268 (8th Cir. 1995); Butterworth, 946 F. Supp. at 1291; see also California v. Sutter Health Sys., 130 F. Supp. 2d 1109, 1120 (N.D. Calif. 2001); United States v. Long Island Jewish Med. Ctr., 983 F. Supp. 121, 136 (E.D.N.Y. 1997) ("A properly defined market includes potential suppliers who can readily offer consumers a suitable alternative to the defendants' services."); United States v. Mercy Health Servs., 902 F. Supp. 968, 975-76 (N.D. Iowa 1995), vacated as moot, 107 F.3d 632 (8th Cir. 1997).

One critical piece of empirical evidence in a hospital merger case is patient flow and origin data—meaning data collected by hospitals and insurance companies that empirically measure the geographic area from where patients travel to go to particular hospitals. Insurance companies use patient flow data to determine whether they can exclude a hospital from their networks, steer patients to other "in-network" hospitals, or encourage patients to go to different hospitals to receive different services.[6] If patients are willing and able to travel for health care services, after all, insurance companies need not keep any particular hospital in their networks. Instead, they can choose among any one of a number of hospitals to which the patient flow data empirically demonstrates patients are willing and able to travel. See Long Island Jewish, 983 F.

[6] The ALJ observed in the Initial Decision that health insurance companies use patient flow data to define their service areas and to determine where patients actually can and do go for hospital services. See Initial Decision at 139 ("Patient flow data is used by managed care organizations and by hospitals themselves to determine service areas and core service areas. Patient flow data . . . shows which hospitals patients actually utilize for services.").

Supp. at 130, 140-42 (rejecting argument that defendant was a "must have" hospital). Insurance companies also use patient flow data to determine if they can "steer patients to lower cost health care providers and away from the hospital imposing a price increase, thereby pressuring the hospital to eliminate the price increase." See Sutter, 130 F. Supp.2d at 1130.

Courts consistently look to patient flow and origin data to define the relevant market in hospital merger cases. Indeed, as one court has noted, the "geographic market is derived fundamentally from patient flow data." Butterworth, 946 F. Supp. at 1291-92. See also, e.g., Tenet, 186 F.3d at 1053 (patient flow data demonstrates "the apparent willingness of Poplar Bluff residents to travel for better quality care"); Sutter, 130 F. Supp. at 1127 ("a review of patient flow data . . . indicates that large numbers of patients travel . . . to hospitals located in Contra Costa County despite the alleged geographic barriers"); Long Island Jewish, 983 F. Supp. at 141 ("patient origin data" demonstrates that "large numbers" of Long Island patients will travel to Manhattan for certain health care services).

This reliance on patient flow data to define the relevant geographic market makes complete sense. Patient flow data provides the best empirical evidence from which to evaluate actual patterns of patients' choices, to identify the services for which patients are willing to travel, and to determine the true importance of patients' stated hospital preferences as reflected by their actual behavior. Put another way, patient flow and origin data provides the best evidence of the actual preferences of patients and the options available to insurance companies when negotiating with hospitals.[7] This in turn provides a basis from which to determine whether there is a substantial population of "similarly situated" patients that have demonstrated—by their *actual*

[7] The ALJ mistakenly assumed that the "need" to include a hospital in the network (which tends to result in most area hospitals being included in a network) is synonymous with such strong preferences on the part of all patients using a given hospital that essentially none are willing to use any other alternative. Patient flow data establishing that patients are willing to travel for hospital services will correctly define how strong patients' preferences are for local hospital services.

choices—a preference for using alternative hospitals. As such, the patient data provides a reliable empirical foundation for geographic market definition, against which other testimony and evidence can be tested.[8]

b) The ALJ Erroneously Rejected Reliable Empirical Data.

The ALJ recognized that "[p]rior cases have traditionally relied on . . . patient flow data to establish the geographic market for hospital services." Initial Decision at 138. Yet without any compelling justification, he then *rejected* empirical evidence of patients' willingness to travel for hospital care, concluding that "patient flow data . . . provides no useful information" for defining the geographic market in this case. Id. at 138-39.

The rejection of patient flow data turned largely on what the ALJ called the "payor problem." Id. at 139. The ALJ opined that "because patients do not set the price of hospital services, their willingness to travel *tells us nothing* about their sensitivity to price changes by the merging hospitals." Id. (emphasis added). Nor, he went on, does such evidence explain what "hospitals patients want available in their managed care organizations' hospital networks." Id. This analysis reflects a fundamental misunderstanding of the role that patients play as the ultimate consumers of hospital services (and on whose behalf health insurance companies negotiate) and the role that patient flow and origin data plays in the pricing of hospital services by both health insurance companies and hospitals.

The ALJ's rejection of patient flow data turns almost exclusively on its conclusion that health insurance companies are the *only* consumers of hospital services, and that patients have no

[8] For example, actual patient flow data provides a basis for determining that other hospitals provide alternatives for patients; other information can confirm then whether those hospitals have sufficient capacity to attract substantial additional volumes of patients. Similarly, once the patient flow data identifies the alternatives, other analysis can be used to identify the magnitude of diversion or usage of other hospitals. Collectively, this information can be used to determine whether and how payors can discipline hospital pricing or determine what mechanisms payors could use to constrain a price increase.

role to play in the competition for hospital services. This premise is wrong. Patients, not insurance companies, consume hospital services. Butterworth, 946 F. Supp. at 1299. Health insurance companies merely act as conduits between employers and patients and the hospitals that serve them. Patient preferences—demonstrated by actual behavior—drive the decisions made by both insurance companies and hospitals in all stages of competition. Health insurance companies have admitted in numerous cases, including this one, that their decisions as to which hospitals to keep in their networks and which hospital to "steer" patients towards are based on patients' preferences, not their own. See, e.g., Long Island Jewish, 983 F. Supp. at 141; see also, e.g., Initial Decision at 34, 142. The ALJ's stated reasons for rejecting patient flow data—long accepted as crucial empirical evidence in other hospital merger cases—therefore are erroneous.

c) The ALJ Inappropriately Relied on Inherently Suspect Opinion Testimony From Selected Health Insurance Companies.

Rather than follow years of precedent and practice by reviewing empirical evidence of where patients can and do go for hospital services, the ALJ looked to testimony from a select group of insurance companies to determine which hospitals were "must have" hospitals for an insurance company seeking to develop a viable network in and around Evanston. But the insurance company opinion testimony in this case is inherently suspect. To begin with, opinion testimony in general is by its nature less reliable than other types of evidence. Tenet, 186 F.3d at 1054. That is all the more so in the hospital merger context, where the complaining insurance companies all have a financial interest in the outcome of this litigation. See Initial Decision at 27. As the Eighth Circuit has explained, "the testimony of managed care payers . . . [w]ithout necessarily being disingenuous or self-serving or both . . . is at least contrary to the payers'

economic interests and is thus suspect."[9] Tenet, 186 F.3d at 1054 & n.15 ("Although the witnesses may have testified truthfully . . . market participants are not always in the best [position] to assess the market long term.").

The insurance company testimony on which the ALJ relied in this case is particularly suspect because the ALJ did not even consider all potentially relevant market participant testimony. BlueCross/BlueShield, the largest health insurance company in Chicago, did not testify. See Initial Decision at 73. Considering, as the Initial Decision noted, that BlueCross/BlueShield refused to pay a price increase in its contracts with ENH,[10] see id. at 74, it is not likely that its perceptions as to the scope of the geographic market would accord with that of the complaining insurance companies—which all have a significant financial interest in this litigation. Neither did the ALJ consider any testimony from employers or patients. Although the Initial Decision concluded that "senior executives and decision makers" who live near Evanston and Highland Park would reject any managed care plan that did not include at least one of these hospitals in its network, see id. at 31, 140, the ALJ did not consider testimony from a single senior executive or decision maker from the surrounding community, much less one who expressed such views. Instead, the ALJ relied exclusively on second-hand opinion testimony

[9] The Eighth Circuit simply refused to believe that "these for-profit entities would unhesitatingly accept a price increase rather than steer their subscribers to [other] hospitals." Tenet, 186 F.3 at 1054. Other courts have rejected self-interested market participant testimony in merger cases as well. For example, in United States v. Oracle Corp., the Northern District of California found "unpersuasive" the "self-interested testimony" of a select group of market participants because "[d]rawing generalized conclusions about a . . . customer market based upon a small sample [of market participants] is not only unreliable, it is nearly impossible." 331 F. Supp. 2d 1098, 1167 (N.D. Cal. 2004); see Federal Trade Comm'n v. Arch Coal, Inc., 329 F. Supp. 2d 109, 145 (D.D.C. 2004) ("antitrust authorities do not accord great weight to the subjective views of customers in the market"). The court further noted that "the most persuasive testimony from customers is not what they say in court, but what they do in the market." Oracle, 331 F. Supp. 2d at 1167; see also Federal Trade Comm'n v. Owens-Illinois, 681 F. Supp. 27, 38 (D.D.C. 1988) ("opinions of purchasers must be viewed in light of their actual behavior").

[10] This Commission has previously found that a health insurance company's refusal to pay a price increase is "inconsistent with a hypothesis of merger-related market power." See Statement of the Federal Trade Comm'n, Victory Memorial Hospital/Provena St. Therese Medical Center, File No. 011 0225.

from interested insurance companies to establish the views and preferences of employers and patients.

Even in the best of circumstances—that is, where insurance company testimony is not potentially tainted with bias—such testimony would still be inherently less reliable than empirical evidence such as patient flow and origin data that the ALJ refused to consider. Unlike insurance company opinion testimony—which, at best, is only a slanted guess as to patients' preferences—empirical patient flow and origin data evidences patients' *actual* behavior and their practical alternatives to the defendant's services. As one court has explained, "the perception of market participants is afforded considerably less weight than quantitative data addressing the practical alternatives available to patients." Sutter, 130 F. Supp. 2d at 1127; see Freeman, 69 F.3d at 270.

In the end, the insurance company opinion testimony in this case suggests very little. At most, it demonstrates that insurance companies prefer to have either Evanston or Highland Park in their networks—not that they "must have" these hospitals in their networks to satisfy patients' demonstrated preferences. Only patient flow and origin data would provide the empirical evidence of patients' preferences for hospital services and what hospitals, if any, insurance companies "must have" in their networks. And the ALJ ignored that data.

d) The ALJ Impermissibly Relied on Unscientific Survey Evidence and Effectively Redefined the Product Market to be Only for Emergency Services.

The only other "evidence" on which the Initial Decision relied to formulate its geographic market was a survey of *Lake Forest* hospital patients, which the ALJ cited to quantify how far *ENH* patients would be willing to travel for alternate hospital services.[11] The ALJ's

[11] Oddly, the ALJ used the survey data to establish the patient preferences that the ALJ had concluded were not relevant to defining the geographic market in this case and which justified not considering patient flow data.

decision to rely on survey opinion rather then empirical patient flow data is troubling enough. His decision to rely on a survey of one hospital to forecast the preferences of patients of another is even more unsettling. And his decision is still the more puzzling given that the ALJ himself describes the report as "not [ ] a scientific survey." Initial Decision at 142. This is too kind a description of the report. There is no indication that the survey data is at all a reliable reflection of patients' preferences. It is unclear who administered the survey, who was surveyed, what were the survey questions, or what steps were taken to assure that the results were representative of the community at large. All that is known is that the survey was "not . . . scientific." Id. Consequently it is by its very nature less reliable then quantitative and empirical evidence of patients' preferences—like patient flow data—that were before the ALJ and were explicitly not considered.[12]

Even assuming these survey results have some indicia of reliability—which they do not—the ALJ's use of these results to eliminate two hospitals from ENH's proposed geographic market was plainly arbitrary. The Lake Forest survey found that "consumers are willing to travel up to 16 minutes for emergency care and 35 minutes for an overnight hospital stay." Id. at 142. Both of the hospitals that the Initial Decision excluded from ENH's proposed geographic market—Condell and Resurrection—have driving times of 24 and 25 minutes respectively from either Evanston or Highland Park. Id. at 39, 143. This is a full 10 minutes *less* than the 35 minutes the Lake Forest survey results suggested that patients are willing to travel for non-emergency care.

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[12] Even if the survey data was somehow reliable, patient flow data would still be preferable because it provides a substantial base of information to assess the actual patterns of usage by consumers for specific services of specific hospitals. Particularly where the datasets are large and historical, it provides a means to examine "revealed preferences"—that is, preference for hospitals based on usage and consistency of usage over time, and particularly the magnitude of individuals making such choices. In this regard, they are similar to purchase or transactions data used in other industries to provide insight into actual purchases or preferences, with the caveat that changes in underlying conditions that affect choice may not be captured in the data.

The exclusion of these hospitals from the geographic market seems to turn on the fact that travel times to these hospitals are greater than what the unscientific Lake Forest customer survey suggests that patients are willing to travel for "emergency services." But the relevant product market here is not for "emergency services." As found in the Initial Decision, and as is the case in most hospital merger cases, the product market is for "general acute inpatient services," which broadly includes "primary, secondary, and tertiary inpatient services."[13] Id. at 135. By eliminating these hospitals from the geographic market based on patients' alleged preferred travel times for "emergency services," the ALJ in effect redefined the product market to be *only* for "emergency services." Redefining a product market through geographic market analysis is in sharp discord with the intent of the Merger Guidelines and federal case law. See Merger Guidelines § 1.1, 1.2 ("The Agency will first define the relevant product market" and then "[f]or each product market . . . the Agency will determine the geographic market or markets in which the firms produce or sell.").

Certain insurance companies' alleged need to provide for local "emergency services" in their networks does not justify eliminating hospitals from the geographic market based on travel times for emergency services. Looking only at the Initial Decision's narrow geographic market, there are no fewer than three other hospitals—Lake Forest, Rush North Shore, and St. Francis—within the 16 minutes travel time for "emergency services" allegedly preferred by Lake Forest survey respondents. Id. at 145-56. A network providing "general acute inpatient services" could "steer" patients to any one of these three hospitals for "emergency services," and then for non-emergency services allow patients to freely choose between any one of the numerous other

[13] Primary/secondary services include non-complex primary care and a variety of general surgical procedures. Tertiary care includes the most specialized and complex and expensive procedures like heart surgery and advanced cancer treatment. See Long Island Jewish, 983 F. Supp. at 125.

hospitals that are within the 35 minutes travel time preferred by Lake Forest consumers for such non-emergency care—including *at least* the nine hospitals in ENH's geographic market and several hospitals in downtown Chicago. That the Initial Decision did not even consider this possibility when rejecting ENH's geographic market makes its rejection of that market dubious at best.

2. The Initial Decision's Geographic Market Analysis, If Permitted to Stand, Will Lead to Uncertainty and Confusion for Hospitals.

The stated purpose of the FTC's Merger Guidelines and the accompanying Policy Statement on Hospital Mergers is to provide an "analytical framework and specific standards" for analyzing hospital mergers in an effort "to advise the health care community in a time of tremendous change, and to address, as completely as possible, the problem of uncertainty concerning the Agencies' enforcement policy that some had said might deter mergers, joint ventures, or other activities that could lower health care costs." Merger Guidelines § 0; 1996 DOJ and FTC Statement of Antitrust Enforcement Policy in Health Care at 1. In conjunction with years of federal case law, the Merger Guidelines and the Policy Statement on Hospital Mergers have largely achieved this goal. Hospitals have been able reliably to understand the scope of the geographic markets in which they operate. With this information in hand, hospitals have been able to construct pro-competitive mergers that have survived scrutiny by both the federal courts and this body.

The Initial Decision has reintroduced the very uncertainty the Merger Guidelines were designed to eliminate. And if it is allowed to stand, hospitals will not be able to predict how courts will define their geographic markets. When the geographic market is defined by quantitative and empirical information like patient flow and origin data, hospitals can reasonably predict with some confidence how a court will define the geographic market. This information is

easy to gather, is objective, and most importantly is consistent and provides some certainty. If, however, the geographic market is defined—as it was in this case—by unscientific survey evidence devoid of any indicia of reliability and the opinion testimony of only selected health insurance companies, hospitals will be certain only of one thing: the unpredictability of any market constructed by a court relying on such evidence.

Without a predictable, reliable and objective framework for defining the geographic market, hospitals will either be deterred from engaging in pro-competitive mergers designed to reduce patients' costs and increase the quality of hospital care, or they will be constantly at risk for enforcement actions based on geographic markets defined by the opinion testimony of self-interested health insurance companies. Such uncertainty is bad for hospitals and it is bad for patients. The Initial Decision in this case should be rejected.

B. THE INITIAL DECISION LACKS A COHERENT THEORY OF ANTICOMPETITIVE EFFECTS.

The Commission should also reverse the ALJ's decision on the separate basis that it fails to meet an essential requirement of antitrust jurisprudence—a well-reasoned theory of the anticompetitive effects resulting from the merger. The ALJ implicitly rejected a unilateral effects theory, and there is no apparent support in the record for a coordinated effects theory on which to condemn the merger.

1. The Merger Guidelines Recognize Two Theories of Lessening Competition: Unilateral and Coordinated Effects.

The Merger Guidelines recognize two theories of "potential adverse competitive effects of mergers:" Coordinated Effects and Unilateral Effects. Merger Guidelines § 2. The two theories are concerned with very different and largely incompatible means of exercising market power after a merger. Coordinated effects is concerned with a "[c]oordinated interaction . . . by

a group of firms" that evidences "tacit or express collusion" to raise prices or restrict output. Id. § 2.1. A successful coordinated effects case turns on evidence establishing that "market conditions, on the whole, are conducive to reaching terms of coordination and detecting and punishing deviations from those terms." Id.

The unilateral effects analysis, quite dissimilarly, is concerned with the monopolistic power of the merged entity and its ability to "unilaterally" elevate price and suppress output. Id. § 2.2. This theory of lessening competition turns on a finding that the pre-merger entities were substitutes for each other, that the merged entity exercises monopolistic market power, and that the remaining players in the market are unable to replace the lost competition. See id. §§ 2.2, 2.211, 2.212. Accordingly, if the remaining competitors in a post-merger market provide sufficient competition to the merged entity to replace the lost competition, a unilateral effects theory must fail. See id. § 2.212.

The ALJ implicitly rejected Complaint Counsel's unilateral effects theory by finding that in a post-merger world insurance companies are able to choose between any one of at least five hospitals besides ENH when constructing a viable network. That leaves "coordinated effects." But neither Complaint Counsel nor the ALJ posited a theory of coordinated effects, and the record is devoid of any evidence even suggesting the possibility of collusion between any of the hospitals in the geographic market. Consequently, the ALJ's finding that the merger lessened competition is unsupportable under either theory of anticompetitive effects endorsed by the Merger Guidelines. It is thus arbitrary and unreasonable.

2. The Initial Decision Necessarily Rejected Complaint Counsel's Unilateral Effects Theory, and Neither the FTC nor the ALJ Advanced a Coordinated Effects Theory.

Complaint Counsel presented a unilateral effects theory that turned on the presumption that Evanston and Highland Park were the only substitutes in a geographic market that consisted entirely of the ENH network of hospitals. See Complaint Counsel's Post-Trial Brief ("FTC Trial Br.") at 24-25. In Complaint Counsel's proposed geographic market, "ENH has the only hospitals, giving it a monopoly in the provision of inpatient services sold to health plans." Id. at 55. Complaint Counsel contended that this accumulation of 100% market power was the only explanation for the increase in ENH prices for some, although admittedly not all, health plans. Id. at 44-45.

The ALJ's rejection of Complaint Counsel's three-hospital geographic market in favor of a larger, although equally arbitrary, seven-hospital geographic market necessarily requires the rejection of Complaint Counsel's unilateral effects theory in this case. As the ALJ found with respect to the seven-hospital geographic market, at least five hospitals constitute direct substitutes for both Evanston and Highland Park and act as a constraint on ENH pricing. See Initial Decision at 142, 143 (rejecting Complaint Counsel contention that "no additional hospitals could constrain ENH's pricing"). Specifically, the ALJ found that Glenbrook, Lake Forest, Advocate Lutheran General, Rush North Shore, and St. Francis all compete with either Evanston or Highland Park or both such that insurance companies can develop a viable managed care network by including any one of these hospitals in their networks. Id. at 142. The competition between these hospitals is so severe that, as the ALJ found, "several physicians who had been admitting patients primarily to Highland Park shifted 'a lot' of their patients to Lake Forest." Id. at 143. The ability of the post-merger market to continue to provide alternatives to ENH for

insurance companies and patients alike demonstrates the inability of ENH to exercise monopolistic market power or lessen competition under any "unilateral effects" analysis.

The ALJ's finding that ENH enjoys a 40% market share does not suggest a different conclusion. As the Merger Guidelines note, "market share and concentration data provide only the starting point for analyzing the competitive impact of a merger." Merger Guidelines § 2.0. Actual evidence that other hospitals in the geographic market are using their market power to poach patients from ENH belies any finding that ENH has a monopolistic share of the geographic market or is acting to lessen competition. See id. § 2.212; Initial Decision at 143. Competition is clearly still quite strong. The fact that the competing hospitals have already attracted a full 60% of the patients in the area suggests that they are credible alternatives to ENH and further undermines a unilateral effects case; the Initial Decision does not suggest that these hospitals were constrained in their incentive or ability to attract sufficient additional patients by unilateral action.[14]

The ALJ's findings as to (1) the scope of the geographic market, and (2) the presence of numerous strong competitors and viable substitutes for both Evanston and Highland Park in that market, requires the rejection of any finding of the lessening of competition under a theory of unilateral effects. And the other accepted theory—coordinated effects—was not even advanced in this case. Complaint Counsel did not articulate a theory of coordinated effects, nor did it submit any evidence suggesting that ENH or any of the hospitals in the Initial Decision's geographic market had or intended to collude to restrain competition, or that they have the ability

[14] The ALJ also never explained why ENH's market share prevents health insurance companies from disciplining a ENH price increase by excluding ENH from their networks or steering patients to other less expensive hospitals in the geographic market. The ALJ identified no fewer than five hospitals that it found are substitutes for Evanston and Highland Park—not including the two hospitals that it arbitrarily excluded from the geographic market. These hospitals all provide insurance companies with the means of resisting a price increase from any hospital in the geographic market, including ENH, by restricting the flow of patients to that hospital and decreasing the revenues, profits, and ultimately market share of the offending hospital.

or the market incentive to artificially increase prices or restrain output. Accordingly, the Initial Decision could not and did not find that competition was lessened by the merger under a theory of coordinated effects.

The Initial Decision's failure to adopt either theory of anticompetitive effects belies its conclusion that there was an anticompetitive price increase. In fact, it suggests that ENH's more benign explanations for any apparent price increases—that they are reflective of the massive quality improvements ENH instituted post-merger and that ENH updated prices to reflect current market demand after not raising prices for a number years—should be accepted.

Because the ALJ's conclusion that the merger lessened competition is not based on any recognized theory of anticompetitive effects, it is by definition arbitrary and unreasonable and should be rejected.

C. THE ANALYSIS OF "QUALITY OF CARE" EVIDENCE IN THE INITIAL DECISION IS FUNDAMENTALLY FLAWED.

It is well-accepted that price and quality comprise important aspects of competition analysis for hospitals. See Initial Decision at 176; see also Tenet, 186 F.3d at 1054 (addressing hospital competition on price and quality); Butterworth, 946 F. Supp. at 1299 (same); In re Adventist Health System/West, Dkt. No. 9234, 117 FTC 224, 267-68 (Apr. 1, 1994) (same); United States v. Rockford Mem'l Corp., 717 F. Supp. 1251, 1283-84 (N.D. Ill. 1989) (same), aff'd, 898 F.2d 1278 (7th Cir. 1990). As a result, both must be assessed as part of the competitive effects analysis of hospital mergers under Section 7. See Brown Shoe Co. v. United States, 370 U.S. 294, 321-22 (1962) (reflecting on various competitive factors and stating "all were aspects, varying in importance with the merger under consideration, which would properly be taken into account"); United States v. Baker-Hughes, 908 F.2d 981, 986 (D.C. Cir. 1990) (finding that consideration of all relevant competitive factors was not only appropriate, but

imperative, to the analysis of competitive effects). For example, a hospital merger that resulted in enhanced quality might not, on balance, be anticompetitive even if it was accompanied by somewhat higher prices.

In the case at hand, the need to address quality is all the more compelling because of the undisputed evidence that ENH spent more than $120 million on improvements to its system, and that these improvements were designed both to improve quality at Highland Park and to enhance its ability to compete more effectively with teaching and other highly regarded hospitals. This, in and of itself, is demonstrative evidence that ENH faced competitive pressures to make investments that increase quality.

In assessing these improvements, the ALJ asserted that "it is not clear whether [quality of care] should be considered a procompetitive justification, an affirmative defense, or an efficiency." Initial Decision at 177. While assessing the economics of how price and quality affect each other can be difficult given the multitude of complex market forces at play in and the many singular characteristics of the hospital field,[15] this difficulty does not excuse the failure of

[15] The complexity of the markets in which hospitals compete is due to, among other things, the differentiated nature of hospital services, the complexity of hospital reimbursement systems, and the role of third-party payers and physicians in choosing hospitals. See Initial Decision at 16 ("[C]ompetitive dynamics of healthcare markets are distinguishable from other markets in the United States economy."). For example, hospital services themselves are highly differentiated in that they involve a cluster of different services that are not substitutes for each other (e.g., the medical services and costs that comprise an appendectomy are fundamentally different from those provided in connection with childbirth, yet both are considered primary or secondary acute care services). Moreover, the nature and extent of services furnished to patients with the same diagnosis may vary substantially depending on the severity of the patient's illness, his age, and other underlying medical conditions. And numerous studies have shown that even when one attempts to control for diagnosis and severity, the extent of services furnished to treat the condition vary greatly across hospitals—with no clear evidence as to whether those hospitals that provide more services are inefficient, or those that are providing fewer services are furnishing inadequate care. See, e.g., John Wennberg et al., Use of Medicare Claims Data to Monitor Provider-Specific Performance Among Patients with Severe Chronic Illness, Health Affairs – Web Exclusive, at VAR-5 (Oct. 7, 2004); Elizabeth McGlynn et al., The Quality of Health Care Delivered to Adults in the United States, 348 N. Eng. J. Med. 2635 (June 26, 2003); Mark Chassin & Robert Galvin, The Urgent Need to Improve Health Care Quality, 280 J. Am. Med. Ass'n 1000 (Sept. 16, 1998); John Wennberg & Alan Gittelson, Small Area Variations in Health Care Delivery, 182 Science 1102 (Dec. 14, 1973).

A second factor complicating the analysis of hospital markets is that hospitals are paid under varying reimbursement schemes—including discounted charges, per diems, and case rates. Those reimbursement mechanisms may be subject to different kinds of "stop-loss" and other conditions, and will vary across payers. See

the ALJ to adequately address the issue of quality. Specifically, the ALJ's conclusion that the merger was anticompetitive must be rejected because his evaluation of quality is plagued by at least three fundamental flaws.[16]

First, contrary to the ALJ's conclusion, the analysis of competitive effects under Section 7 does not mandate that quality improvements be merger-specific. What is especially troubling about the ALJ's conclusion is not just the clearly erroneous departure from established precedent on the analysis of competitive effects factors, but that the ALJ appeared to arrive at the conclusion because he could not comprehend how quality should be analyzed in merger analysis; therefore, it was easier to simply throw out much of the evidence on quality on the grounds of lack of merger-specificity. See Initial Decision at 179-80. It is simply inappropriate for any court to throw up its hands because the quality issue is difficult to assess.

Second, competitive effects analysis—especially in a consummated merger—calls for a careful and diligent examination of the evidence. By considering only select measures on which to consider overall quality improvement relative to other hospitals, and then finding that the evidence on overall increases in quality was inconclusive in some respects and failed to demonstrate improvement in another, the ALJ failed to account for the full range of quality

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Initial Decision at 24-26. Some contracts may reflect recently negotiated rates, while others may have "evergreened" for several years without substantial updates. Finally, hospital markets are complex because health plans, employers and patients are all involved in various ways in choosing hospital providers. Indeed, another factor in hospital competition, one totally ignored by the ALJ, is the extent to which hospitals compete with each other for referrals from physicians. See Initial Decision at 16-19 (discussing institutional relationships relevant to understanding competitive dynamics of hospital services, but failing to discuss the physician/hospital relationship). A primary way in which hospitals seek to increase business is by being attractive to physicians who will admit patients to their facilities. See, e.g., Rockford, 717 F. Supp. at 1283 ("Traditionally hospitals competed on the basis of their attractiveness to physicians.").

[16] Although the AHA's main focus in this section is on quality, it is important to note that the ALJ's treatment of the pricing evidence appears to be superficial at best and plainly wrong at worst. The Initial Decision finds a Section 7 violation on the basis of relative changes in price without fully addressing the starting points for prices at each hospital and the extent to which the ENH hospitals were more "overdue" for a price increase than the hospitals to which they were compared. See Initial Decision at 170-72. Moreover, the ALJ also found a violation even in the absence of conclusive evidence that ENH's prices achieved supra-competitive levels. See id. at 155.

improvements offered by ENH. Indeed, the entire analysis of the quality evidence in the Initial Decision is remarkably sparse given the substantial evidence introduced by ENH regarding changes in process, structure and outcomes. And while it may be the case that outcomes are really "what we all care about," FTC Trial Br. at 68, quality improvement practices developed for and currently being implemented within the hospital field rely most heavily on changes to process and structure.[17] It was, therefore, clearly erroneous for the ALJ to focus only on a few selected measures and then conclude that ENH "did not provide sufficient evidence to determine whether Highland Park improved its overall quality relative to hospitals generally." Initial Decision at 180.

Third, by discounting certain improvements on grounds that they lacked merger-specificity and by failing to account for the full range of quality improvements, the ALJ completely sidestepped the competitive effects analysis of the interplay between quality and price. See id. at 177-92. As a result, the true extent of any increase in price allegedly achieved by ENH post-merger—and whether it was anticompetitive—are fundamental issues that remain unresolved in the Initial Decision.

The failure to adequately address the role of quality in the Initial Decision is of particular concern given that the Commission's stated purpose in investigating consummated hospital mergers on a retrospective basis was to gather "real world information" in order to "update prior

[17] See, e.g., Center for Medicare & Medicaid Services ("CMS"), Hospital Quality Initiative Overview (Dec. 2005), at http://www.cms.hhs.gov/quality/hospital/ (setting forth 20 hospital quality measures used by CMS and others in the hospital field to asses quality on the basis of improvements to *process*); Medicare Payment Advisory Comm'n Rep. to the Congress: Medicare Payment Policy, Strategies to Improve Care: Pay for Performance and Info. Tech., at ch. 4, p. 189 (Mar. 2005) ("The most promising types of measures for . . . hospitals are measures of process known to improve care. The quality experts we consulted said that clinicians support process measures because they are based on evidence showing that the process increases the chances of positive patient outcomes and at the same time provide guidance on how to improve."); id. at 189-92 (discussing measures of structure, process and outcomes); Robert Brook et al., Part 2: Measuring Quality of Care, 335 N. Eng. J. Med. 966, 967 ("the assessment of quality should depend much more on process data than on outcome data, especially when those systems are used" for comparison purposes); id. at 966 ("Process measures are usually more sensitive measures of quality than outcomes data, because a poor outcome does not occur every time there is an error in the provision of care.").

assumptions about the consequences of particular transactions and the nature of competitive forces in health care."[18] Instead of helping to clarify hospital merger analysis, the fundamental flaws in the ALJ's treatment of real world information regarding quality in this case will only confuse and obscure how this crucial dimension of hospital competition should be assessed.

1. The ALJ Erred by Imputing a Merger-Specificity Requirement Into the Analysis of Competitive Effects.

ENH offered evidence of quality improvements to show that any alleged price increases may be less significant than they might otherwise facially appear. Although the ALJ acknowledged that ENH offered its quality of care evidence as part of the competitive effects analysis—and agreed to treat the evidence in that context—he erroneously analyzed quality as if it were an efficiency that would justify or outweigh the anticompetitive effects of the merger. See Initial Decision at 177-80. By conflating competitive effects analysis with efficiencies, the ALJ arbitrarily departed from established case law in which courts have analyzed competitive effects evidence in a substantially different manner than efficiencies evidence. At the heart of the ALJ's error in this regard was limiting his consideration of quality improvements to only those that were merger-specific.

Under traditional merger analysis, courts judge a merger based on whether it will "substantially . . . lessen competition" in a relevant market. 15 U.S.C. § 18; see also United States v. Philadelphia Nat'l Bank, 374 U.S. 321, 362 (1977). Whether a merger will lessen competition in a relevant market depends on the totality of the circumstances, which require a weighing of various "salient competitive factors" such as, inter alia, market shares and

[18] It is also relevant to highlight the emphasis that the FTC and DOJ placed on quality in their joint report on competition in health care. See FTC & DOJ, Improving Health Care: A Dose of Competition, at ch. 3, p. 21 (July 2004). For example, the first recommendation the Agencies make in the report relating to improving competition in health care markets is "to improve incentives for providers to lower costs and *enhance quality* and for consumers to seek lower prices and *better quality*." Id. (emphasis added).

concentration, nature of competition, entry barriers and efficiencies. Rockford, 717 F. Supp. at 1278.

In some cases, the merger may result in certain efficiencies (e.g., improved quality, enhanced service, new products) that outweigh the anticompetitive effects of the merger, or are procompetitive justifications for an otherwise illegal combination. See Merger Guidelines § 4; Federal Trade Comm'n v. University Health, Inc., 938 F.2d 1206, 1222-23 (11th Cir. 1991). In this context, evidence of efficiencies must not be of the type that can "be achieved by either company alone because, if they can, the merger's asserted benefits can be achieved without the concomitant loss of a competitor." Federal Trade Comm'n v. H. J. Heinz Co., 246 F.3d 708, 722 (D.C. Cir. 2001); see also Merger Guidelines § 4 (providing that efficiencies must be merger-specific). Accordingly, efficiencies must be merger-specific to be relevant to the analysis of competitive effects.

In other cases, competitive factors relate to the *nature of competition* in the market, and may explain why market concentration statistics inaccurately portray the post-merger company's competitive capabilities. See United States v. General Dynamics Corp., 415 U.S. 486, 503-04 (1974). For example, as noted above, hospitals can compete on the basis of *both* quality and price. See, e.g., Tenet, 186 F.3d at 1054; Long Island Jewish, 983 F. Supp. at 142; Butterworth, 946 F. Supp. at 1299. Thus, it may be the case that a hospital merger may improve quality and negate the probability that a merged entity would be able to exercise market power. For example, if the merged hospitals improved quality by offering additional services, the result may be that they now compete against additional other hospitals in the region that also offer those services. Indeed, in this case there is evidence that one of the goals in improving both the scope and quality of the services furnished at Highland Park was to attract local residents to the hospital for

more complex services, where prior to the merger such patients went to teaching or hospitals in downtown Chicago and elsewhere with a reputation for providing such services. See, e.g., Respondent's Post-Trial Brief, ("ENH Post-Trial Br.") at 95; Respondent's Reply to Complaint Counsel's Proposed Findings of Fact, ("ENH Reply") at 879, 887.

In addition, the very fact that a merged firm makes investments in processes and structures that are generally accepted means of improving quality is reflective of competitive constraint. For example, in Long Island Jewish, the court's competitive effects concern was whether the merged hospital would, with "its increased market share and leverage, reduce the quality of care, treatment and medical services rendered." 983 F. Supp. at 142. The court's focus not only acknowledges that hospitals compete on quality, it also asks a more fundamental question: "Will the merged hospital act like a monopolist and reduce investments and output?" In this case, there is substantial, verified evidence of $120 million in investments to clinical processes and structure that ENH did not act like a monopolist—that ENH actually increased output. See Initial Decision at 177-78.

In these contexts, there is no need for quality improvements to be merger-specific; they simply must exist in the market place as a competitive force.[19] Whether or not some—or even many—of the improvements that Highland Park made could have been done without a merger is irrelevant. Rather, a crucial inquiry is what impact those improvements—which the ALJ admitted were substantial—had on competition in the market. Another equally important question is whether ENH made credible commitments, by accepted standards in the hospital field, to improving quality. These are analyses that the ALJ apparently never made, and on this basis alone, the Commission should reject the ALJ's determination.

[19] In a similar vein, for example, courts have contemplated non-profit status and the sophistication of health insurance plans as competitive factors that could restrain the anticompetitive effects of a merger, but none imposed a merger-specificity requirement in order to do so. See, e.g., Tenet, 186 F.3d at 1054; Freeman, 911 F. Supp. at 1227.

2. The ALJ Erred by Failing to Give a Comprehensive Analysis of the Evidence of Quality Improvement.

In assessing whether overall quality of care improved at ENH, the ALJ stated, "The Court has carefully considered the parties' arguments and evidence on quality of care, including the extensive data on outcomes, structure, process measures and patient satisfaction." Initial Decision at 180. However, the ALJ's treatment of the quality evidence belies this assertion. In fact, he failed to consider the full range of the quality improvements claimed by ENH. As a result, his finding that ENH's evidence was inconclusive in some regards and failed to demonstrate improvement is highly questionable and should be discarded.

First, in determining that the evidence was inconclusive, the ALJ acknowledged that ENH presented evidence of improvements in no fewer than sixteen individual areas identified by ENH. See Initial Decision at 180. However, rather than evaluate the improvements claimed in all sixteen areas, the ALJ deemed the entire body of evidence to be inconclusive from a comparison of only two indicators of quality, which showed conflicting findings.[20] See id. at 180-81.

Second, while overall quality improvement is important to the competitive effects analysis, the ALJ inexplicably focused on two very narrow measures of overall quality. Specifically, he looked to insurance companies' opinions of overall quality improvement and to scores the hospitals received before and after the merger from JCAHO. See id. The ALJ found that insurance companies were not aware of any significant increase in overall quality because

[20] In finding that the quality improvement evidence, "in many instances" is inconclusive, the ALJ highlighted two indicators of quality. See Initial Decision at 181-82. Complaint Counsel's quality expert relied on Agency for Healthcare Research and Quality ("AHRQ") measures for assessing improvements in the particular areas of quality, and ENH's quality expert pointed, in selected instances, to measures from JCAHO to disprove the reliability of the AHRQ measures. See, e.g., ENH Reply at 903-05, 909-911. The ALJ, however, used the comparison of AHRQ and JCAHO results in the two selected clinical areas to find that the entire body of evidence in sixteen different areas of clinical quality was inconclusive and that it "cannot be reconciled on the record provided." Initial Decision at 181. The ALJ's initial error was to take the comparison of AHRQ and JCAHO results out of context, and then he erred again by suggesting that all other quality evidence suffered from the same or similar conflicting results.

ENH allegedly did not inform them of the improvements. See id. That there may have been a lack of communication between the insurance companies and ENH as to ENH's efforts to increase quality does not mean that investments and resulting improvements were not made. Thus, the relevance and reliability of such evidence is problematic, especially given the verified investments that ENH made for purposes of increasing quality.

In addition, the ALJ found that using "the only industry-wide and nationally recognized measure of overall quality [the evidence] did not demonstrate an improvement in Highland Park." Id. at 181. The referenced measure is the score that the JCAHO determines based on its assessment of "approximately 1200 measures of hospital performance." Id. Comparing Highland Park's JCAHO score pre-merger to the score it received post-merger, the ALJ found no evidence that overall quality had improved at Highland Park. Id. However, while JCAHO scores are important for accreditation purposes in order for hospitals to qualify for Medicare and participation in most managed care plans, they should not be relied upon for purposes of evaluating actual quality improvement—particularly to the exclusion of so much other evidence in this case. Additionally, JCAHO scores would not reflect a variety of innovative improvements in quality, such as the development by ENH of an electronic medical records system.

The ALJ's analysis of overall quality evidence, and his ensuing conclusions, are unsound largely because they fail to account for verified improvements, while at the same time give unwarranted weight to evidence that is unreliable. For instance, the analysis wholly fails to account for verified improvements in clinical process and structure. In fact, the ALJ seems to have determined that only changes in outcomes and patient satisfaction would be relevant to the

assessment of overall quality. See Initial Decision at 180-81. Quality improvement should not be assessed primarily on these factors alone.

Experts in quality improvement believe that changes in process and structure hold the most promise for changing practice patterns and, thus, improving the quality of care provided to patients.[21] Take, for example, the evidence ENH submitted regarding the improvements in the administration of aspirin and beta-blockers upon admission and discharge, which the ALJ virtually ignored. See ENH Findings of Fact at 203-205. Those two process measures are among a group of quality measures that enjoy consensus support among the health care community, including the Department of Health and Human Services ("HHS"), as recognized and well-accepted indicators of quality. HHS even collects and displays these measures—among other process measures—on an innovative website designed to *encourage* consumers to compare hospitals on the basis of quality.[22]

It is beyond dispute that focusing strictly on outcomes and patient satisfaction, without considering changes in process and structure, is out of step with how quality is assessed for and by hospitals.[23] In addition, the ALJ ignored his own finding that "significant improvements have been made to Highland Park and that those improvements can be verified." Initial Decision at 177; see also id. at 178. Casting aside $120 million in verified improvements to structure and process hardly reflects the type of careful assessment that such evidence commands under a Section 7 analysis, particularly when applied to hospital mergers. Because the ALJ failed to account for the full breadth of improvements achieved by ENH, his finding in this regard must be rejected.

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21 See supra note 17.

22 See HHS, Hospital Compare, at http://www.HospitalCompare.hhs.gov.

23 See id.

3. The ALJ Erred by Failing to Assess the Competitive Effects of Quality and Price.

Because of the ALJ's flawed treatment of the quality of care evidence, he sidestepped any meaningful competitive effects analysis of quality in relation to price. As a result, the ALJ "placed an inordinate emphasis on price competition without considering the impact of a corresponding [increase] in quality." Tenet, 186 F.3d at 1054. The Supreme Court's totality of the circumstances approach to merger analysis required the ALJ to weigh all relevant competitive factors to determine the effects of the merger on competition. See General Dynamics, 415 U.S. at 498-504. Thus, the ALJ should have evaluated the evidence of post-acquisition price increases in light of the evidence of post-acquisition improvements in quality. This he failed to do. As a result, the extent of any anticompetitive increase in price, if one occurred at all, is unknown and that uncertainty calls into question the weight of Complaint Counsel's pricing evidence.[24]

First, the ALJ found that "[t]he economic testimony in this case appears to view quality as part of the cost/price continuum." See Initial Decision at 105. Indeed, the ALJ cited testimony by economic experts from both parties addressing the notion of "quality-adjusted prices." See id. Quality-adjusted prices are relevant if both prices and quality increase. For instance, "if quality gets better, the quality adjusted price to the buyers declines." Id. However,

[24] The ALJ makes much of the argument that the price increases occurred prior to the improvements. Indeed, he concluded that because the quality improvements followed the price increases, the use of quality evidence was nothing more than unreliable, *post hoc* justification for the increases. See Initial Decision at 178-79. However, not only does such a conclusion fail to consider the extent to which relative price increases accounted for long overdue contractual price adjustments, the emphasis on timing of the price increases vis-à-vis the quality improvements is not particularly meaningful if the increases helped to fund the improvements. Implementing the type and range of quality improvements that ENH undertook requires planning and time. As a result, it is not at all illogical or surprising from a business perspective that, as ENH was budgeting and considering pricing, it would take into account future spending on planned investments in quality. It is not entirely clear from the decision whether these types of inquiries were taken, though they would have been relevant to the competitive effects analysis.

if quality increases at the same rate at all hospitals, "there is no need to adjust [prices] for quality of care." Id.

Thus, although the analysis in the Initial Decision of quality is largely devoid of any evaluation of quality-adjusted prices, the ALJ clearly recognized that such an analysis should be done. See id. However, he implied that the assessment could not be done because ENH "did not present an explanation of how to value the 'improvements' or how to compare them to the price increases to managed care organizations." Id. at 179. While assigning a dollar value to quality improvements for purposes of the analysis may be difficult, the ALJ erred by placing this burden on ENH. See id.; cf. Baker-Hughes, 908 F.2d at 991 ("A defendant required to produce evidence "clearly" disproving future anticompetitive effects must essentially persuade the trier of fact on the ultimate issue in the case – whether a transaction is likely to lessen competition substantially. Absent express instructions to the contrary, we are loath to depart from settled principles and impose such a heavy burden."). By presenting evidence that prices increased post-merger due to an illegal exercise of newly-attained market power, it was, in fact, Complaint Counsel's burden to prove that the increases were supracompetitive. See 16 C.F.R. § 3.43(a) ("[C]ounsel representing the Commission . . . shall have the burden of proof, but the proponent of any factual proposition shall be required to sustain the burden of proof with respect thereto."). As a result, because Complaint Counsel failed to engage in any assessment of quality-adjusted prices, the ALJ should have found that Complaint Counsel failed to meet its burden of proving that the price increases were due to ENH's exercise of market power.

Second, even if the ALJ found that the evidence was insufficient to render a conclusion regarding whether the improvements resulted in higher quality-adjusted prices, he should still have considered the relative improvements in quality between ENH and the comparison hospitals.

Such a comparison would not have required the valuation of the quality improvements, but it would have nonetheless provided a basis on which to determine whether it would be appropriate to adjust prices for quality. While the ALJ attempted to compare ENH to comparison hospitals, as explained above, he relied on inappropriate measures of overall quality to do so. *Overall* hospital quality is the sum of its parts; thus, the ALJ should have relied on the full scope of quality evidence, rather than just insurance company testimony and JCAHO scores, for assessing overall quality.

Thus, the ALJ's treatment of quality in the Initial Decision is fundamentally flawed and should be rejected.

D. DIVESTITURE AFTER NEARLY FIVE YEARS OF INTEGRATION IS NOT JUSTIFIED.

The Commission considers three elements when fashioning an appropriate equitable remedy for a Section 7 violation. See United States v. E.I. DuPont De Nemours & Co., 366 U.S. 316, 328-29 (1961). The relief: (1) must effectively redress proved violations of the antitrust laws, (2) must not be punitive in nature, *and* (3) must be necessary and appropriate in the public interest. See Ford Motor Co. v. United States, 405 U.S. 562, 573 (1972).

In ordering the divestiture of Highland Park as a remedy, the ALJ largely ignored each of these three elements. The first element—redress of proved antitrust law violations—has not been satisfied due to the above-described substantial flaws in the decision's analysis of, among other issues, geographic market, competitive effects, and quality. The second element has not been satisfied because divestiture is extraordinarily punitive to the long-since-merged hospital system and to the communities to which these hospitals provide health care service. Even the ALJ himself acknowledged the nearly five years of post-merger integration at the hospitals:

> ENH consolidated all corporate activities at the Evanston campus and eliminated all corporate functions at Highland Park – including human resources, purchasing, payor contracting, the business office, and information systems. ENH instituted one billing system and one business office. For example, ENH implemented a coordinated registration, scheduling, and charging system throughout its three hospitals.

Initial Decision at 14 (citations omitted). To unwind these critical aspects of operating a successful hospital system would create financial, clinical and logistical burdens on ENH and the surrounding communities that it serves that rise to the level of being punitive.

The ALJ further recognized that the post-merger integration of certain clinical services will be costly to undo regardless of whether they are merger specific. For example, the ALJ recognized that "through the Kellogg Cancer Center at Highland Park, ENH . . . brought together an oncology team . . . who were available to patients in one location," id. at 113-14; "ENH consolidated the adolescent inpatient services at Highland Park and the adult inpatient services at Evanston," id. at 117; "Highland Park would not be able to continue the cardiac surgery program on its own," id. at 205; and "[t]he EPIC system was implemented in order to integrate records from health care providers who practiced at all three ENH hospitals, at the faculty practice medical group, and at all the affiliated physician practices that were willing to participate." Id. at 190. These integrations will be costly to unwind, and the improvements will be difficult, if not impossible, for a divested Highland Park to maintain.

The third element—that any remedy sought be necessary and appropriate in the public interest—is of paramount importance to hospitals, particularly in this case where a merger consummated almost five years ago is being reviewed retrospectively after being passed over for pre-merger review. To begin with, it is difficult to imagine that breaking up a merger consummated nearly five years ago is *ever* "in the public interest," particularly when the merger

at issue is between two hospitals that have been integrated so successfully into a unified high-quality system. The evidence is clear that following the merger, the ENH hospital system was better able to increase and improve health care services and invest in state-of-the-art quality enhancements to benefit the communities it serves. Forcing the divestiture of a hospital within a fully integrated system is certain to disrupt critical healthcare services and put the communities it serves under unnecessary strain and risk. Furthermore, the costs of unwinding the existing hospital system will undoubtedly interfere with each hospital's ability to serve the community in the future through the development of comprehensive plans to address specific community health care needs. Thus, it is difficult to understand how the divestiture remedy at issue in this case could be in the "public interest."

In this particular case, moreover, as discussed in detail above, the hospital system at issue successfully completed numerous and significant quality enhancements. The ALJ admitted that "some benefits of the merger will be lost," id. at 205, but that others can be carried out by a divested Highland Park. This reasoning fails to consider the substantial capital investments that ENH put into improving Highland Park over the past five years: "the evidence demonstrates that ENH has, in fact, invested $120 million into Highland Park and has made many improvements to Highland Park that can be verified." Id. at 178. Therefore, significant losses will be felt from undoing many of these quality functions or failing to maintain them under a well-capitalized system like that of ENH.

Finally, the policy implications of such a remedy for hospitals as well as for others under the FTC's jurisdiction are tremendous. Hospitals and others that embark on mergers, and make quality or other post-merger improvements that benefit patients and consumers, could well be inhibited from doing so because of the disruption caused by a remedy of this kind, inflicted

nearly five years after the agency waived its right to a pre-merger review of the transaction. Through this decision, the ALJ has ignored precedent and created uncertainty among merging and merged parties about the risks of fully integrating and consolidating procedures and services.

It plainly would not be in the public interest to undo the significant integration and quality-enhancements that have occurred over the past five years at both ENH and HPH. Divestiture will assuredly *not* be "simple, relatively easy to administer, and sure." DuPont, 366 U.S. at 331. Quite to the contrary: divestiture risks impairing the delivery of health care services and the rapid development of further quality improvements, will be complicated and difficult to administer, and will create totally unnecessary upheaval in the communities that this hospital system serves.

III. CONCLUSION

For these reasons, AHA advocates overturning the Initial Decision, finding in favor of ENH, and rejecting any effort by Complaint Counsel to challenge the merger under Count II of its Complaint. This will allow ENH to continue to offer its communities the high-quality hospital services they have come to depend upon over the last five years.

Respectfully submitted,

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