

**Looking for Anticompetitive Price Effects:
FTC's Retrospective Studies of Hospital Mergers**

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Abstract

The Federal Trade Commission's (FTC's) Hospital Merger Retrospectives Project resulted in an administrative trial against Evanston Northwestern Healthcare in 2005 and an ultimate finding that the hospital system had gained market power and increased its prices more than it would have in a competitive market. Three recently released FTC papers describe in some detail the staff's model for estimating hospital price changes and the findings from four post-merger investigations. FTC staff attempts to control for many different demand-side and supply-side factors that could affect price by explicitly including those factors in the model and by using comparisons with control groups of hospitals. Nevertheless, some important factors—most notably changes in quality—are omitted. The results themselves leave some unanswered questions as well. Given the FTC's increasingly aggressive posture toward hospital mergers and some of the new empirical tools it is employing in its reviews, it is important that its analysis withstand scrutiny.

Has the FTC permitted mergers of acute care hospitals that resulted in above-competitive pricing for hospital services? That is the question that three recently

released studies conducted by FTC staff members and consultants attempt to answer.¹ Each study was the outgrowth of an initiative known as the Hospital Merger Retrospectives Project, launched by then-FTC Chairman Timothy J. Muris in 2002.² These three papers, which actually study prices related to four hospital mergers, contain many similarities in methodology and data sources, but also have some significant differences. Their conclusions range from findings of across-the-board, above-competitive price increases to more ambiguous results. While a detailed evaluation of the soundness of these studies would require a very involved analysis, a description of the studies and some observations about them provide a useful entree into the subject of the FTC's post-merger hospital pricing investigations.

Findings from the Hospital Merger Retrospectives Project shook the hospital industry in 2005 with the FTC's administrative trial against Evanston Northwestern related to its acquisition of Highland Park Hospital five years earlier. The FTC's study showed that the merging parties increased prices at a supracompetitive rate after the merger, and this was one of the main pillars in the case the Commission staff presented in the administrative trial. That hearing's ultimate outcome was an opinion by the FTC Commissioners in 2007 that Evanston Northwestern had gained market power as a result of the merger and had exercised that market power through above-competitive pricing.³

Heretofore, the only information about the pricing analyses conducted in the Hospital Merger Retrospectives Project was the heavily redacted discussion publicly available from the *Evanston Northwestern* administrative hearing. The publication of the three

¹ Steven Tenn, "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction," Federal Trade Commission Working Paper 293, November 2008 [hereinafter Sutter-Summit Study]; Deborah Haas-Wilson and Christopher Garmon, "Two Hospital Mergers on Chicago's North Shore: A Retrospective Study," Federal Trade Commission Working Paper 294, January 2009 [hereinafter Evanston Northwestern Study]; Aileen Thompson, "The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction," Federal Trade Commission Working Paper 295, January 2009 [hereinafter New Hanover Study].

² "Building a Strong Foundation: The FTC Year in Review," Federal Trade Commission, April 2002, p. 9 available at <http://www.ftc.gov/os/2002/04/ftcyearreview.pdf>; Timothy J. Muris, Chairman, FTC, "Everything Old is New Again: Health Care and Competition in the 21st Century," Prepared Remarks of Chairman Timothy Muris before the 7th Annual Competition in Health Care Forum (November 7, 2002) pp. 19-20 available at www.ftc.gov/speeches/muris/murisehealthcarespeech0211.pdf.

³ In the Matter of Evanston Northwestern Healthcare Corporation, FTC Docket No. 9315, Opinion of the Commission [hereinafter Opinion of the Commission], p. 78 available at www.ftc.gov/os/adjpro/d9315/070806opinion.pdf.

new FTC studies provides some additional insights into the strengths and weaknesses of the FTC's post-merger hospital price analyses. While the FTC has not announced plans to conduct additional such analyses, its posture regarding hospital mergers has become significantly more aggressive since the *Evanston Northwestern* opinion, making the strength of the analyses behind the decision a worthy subject for review. This aggressiveness was put on display in 2008 with the Commissioners' decision to vote out a complaint to stop the Inova-Prince William Health System transaction. The parties subsequently abandoned that transaction rather than face the administrative hearing.⁴

One of the difficulties facing antitrust enforcers in determining whether to challenge a proposed merger is that their analysis is necessarily prospective. The pre-merger assessment of a transaction cannot determine with certainty whether a merger will result in an increase in prices above competitive levels (or a reduction in quality below competitive levels) because, of course, the merger has not occurred at the time of the review. Because post-merger behavior cannot be observed *ex ante*, pre-merger antitrust analysis focuses on issues like market definition, changes in the structure of the market, and the likelihood of entry occurring in response to an above-competitive price increase. If, however, the FTC had so-called direct evidence of above-competitive prices (i.e., the prices themselves), it would not need to engage in the process of inferring whether market power has been created—it could see evidence of market power directly.⁵

Chairman Muris intended to use the studies of post-merger pricing to assess whether the FTC's approach for identifying market power prospectively was actually effective. The four hospital mergers examined are: Evanston Northwestern Healthcare's early 2000 acquisition of Highland Park Hospital in suburban Chicago, IL; the merger of St. Therese Medical Center and Victory Memorial Hospital in Waukegan, IL, to form Vista Health in 2000; Sutter Health's acquisition of Summit Medical Center in Oakland, CA, in 1999; and the 1998 acquisition of Columbia Cape Fear Memorial Hospital by New

⁴ In the Matter of Inova Health System Foundation and Prince William Health Systems Inc., FTC Docket No. 9326, Joint Motion to Dismiss Complaint, June 11, 2008, *available at* www.ftc.gov/os/adjpro/d9326/080611jointmodismisscmplt.pdf.

⁵ Opinion of the Commission, p. 78. The term "market power" refers to the ability of a firm or group of firms acting jointly to increase its profits by setting price above or quality below competitive levels for a non-transitory length of time.

Hanover Regional Medical Center in eastern North Carolina. Each of these transactions was subject to FTC pre-merger review but was permitted to proceed without a challenge by the Commission. The Sutter-Summit transaction was challenged by the Attorney General of the State of California, but a U.S. District Court allowed the transaction to proceed. The FTC papers do not explain why the FTC chose these four transactions for retrospective review or whether other studies will be released in the future.

Each of the studies analyzed the hospitals' pre- and post-merger pricing to managed care plans. Although the studies differ regarding the variables used in the statistical analyses and how those variables are measured, the studies use the same basic approach to determine whether the merging hospitals increased their prices significantly more after the merger than non-merging hospitals did. The Evanston Northwestern Study found that the merging hospitals' prices for three out of the four major health plans in the area increased significantly more after the merger than did other hospitals' prices. This finding proved to be of great importance in the FTC's decision to sue the hospitals and in the Commissioners' subsequent final opinion condemning the hospitals' pricing practices. The Summit-Sutter Study found a significant post-merger price increase at one of the merging hospitals, but not the other. Neither the New Hanover Study nor the analysis of the St. Therese-Victory Memorial merger found a pattern of price increases that was systematically greater for the merging hospitals than for comparable non-merging hospitals.

FTC's Economic Model of Hospital Competition

Each of the FTC retrospective studies appears to be built on the theoretical model of hospital pricing detailed in the Evanston Northwestern Study.⁶ The model describes a process of contracting in which managed care organizations construct hospital networks to serve the expected preferences of their enrollees. Simultaneously, the plans negotiate the lowest rates they can from the hospitals that they want to include in their networks. This type of selective contracting means that not all hospitals are necessarily included in the networks of all managed care products. Selective contracting ostensibly allows managed care plans to offer higher patient volume to contracted hospitals in

⁶ Evanston Northwestern Study, pp. 4-5.

exchange for lower rates from those hospitals. Consequently, hospitals compete on the basis of price to be included in managed care plan networks.

The model predicts that the contract price for a hospital's services depends on the "incremental value that hospital brings to the MCO's [managed care organization's] network."⁷ The value of the hospital to the managed care plan's network is determined by the extent to which other hospitals are available and how closely enrollees view the other hospitals as substitutes. Hospitals with few close substitutes, as perceived by enrollees, will have more bargaining power than hospitals with many close substitutes; greater bargaining power will result in hospitals being able to negotiate higher rates with managed care plans.⁸ Insofar as a merger combines hospitals that are close substitutes and no other close substitutes exist, the model predicts that "the threat of [the merged hospital's] withdrawal from the network may lead to significantly higher negotiated prices for the hospital."⁹

The model does not suggest that all hospitals have the same prices. In reality, hospital service markets are characterized by differentiated services. Hospitals can be distinguished in consumers' minds based on location, reputation for quality, the nature of their physician staff, and many other attributes. This type of differentiation often leads to differences in prices. Consequently, prices for one hospital that are higher than prices of another do not--on their own--signal a competitive problem. The Evanston Northwestern Study explicitly recognizes the benign nature of different prices in such a market. But it also appears to recognize that product differentiation complicates the process of estimating whether prices are above competitive levels.¹⁰ The FTC studies address this complexity by changing the focus: they estimate changes in prices (i.e., the difference between pre- and post-merger price levels) rather than price levels themselves. A focus on price changes rather than price levels, however, runs the risk of identifying an increase in price as being anticompetitive when it is actually the result of a shift in prices to, but not above, a long-run competitive equilibrium level.

⁷ Evanston Northwestern Study, p. 4.

⁸ Evanston Northwestern Study, p. 4.

⁹ Evanston Northwestern Study, p. 5.

¹⁰ Evanston Northwestern Study, p. 9.

Estimating Price Effects of the Hospital Mergers

To estimate a merger's effect on price in a hospital-services market, price must be measured in the first place. Each of the FTC studies eschews relying on hospital charges and uses measures more nearly approximating the actual price paid for hospital services. The Sutter-Summit Study and the New Hanover Study measure price as the total payment for a hospital's services paid both by the patient through co-payments and by the patient's insurance carrier.¹¹ The Evanston Northwestern Study's measure of price is characterized as being "the allowed amount (i.e., the total amount that the MCO and the patient together owe the hospital for that service[.])."¹² It is not clear from the papers whether there is a substantive difference between the "total payment" of the Sutter-Summit Study and the New Hanover Study and the "allowed amount" of the Evanston Northwestern Study.¹³ In each study, price is measured separately for each managed care plan.

As the model suggests, the prices that hospitals charge managed care organizations for inpatient hospital services are determined by the interplay of various demand and supply conditions. Some of these conditions are unique to specific hospitals or markets while others are likely to be common across hospitals or markets. One approach that is often employed to account for factors that are common across hospitals (such as changes in demand or regulatory changes) is to compare the merging hospitals to a "control group" of other hospitals that are not participants in the merger, but are otherwise as nearly identical to the merging hospitals as possible. The FTC studies use this approach and estimate what is known as a "difference-in-differences" model. Essentially, this approach compares the pre- and post-merger price differences of the merging parties with the pre- and post-merger price differences of the control group.

Constructing the control group of hospitals appropriately is of central importance. The FTC studies recognize the importance of the criteria to be used for determining which hospitals to include in the control group and undertake different tests for the sensitivity

¹¹ Sutter-Summit Study, p. 15; New Hanover Study, p. 7.

¹² Evanston Northwestern Study, p. 16.

¹³ The opinion of the FTC commissioners in the Evanston Northwestern matter articulates the measurement of price used by Professor Haas-Wilson to be payments made by patients and insurers to the hospital. (Opinion of the Commission, p. 30)

of their results to the make-up of the control group. One way to test the appropriateness of the control group in accounting for demand- or supply-side influences across all hospitals is to compare price movements of the merging parties and the control group prior to the merger. Insofar as merging parties' pre-merger prices move in a fashion that closely parallels the control group's contemporaneous price movements, the control group tracks the relevant market conditions suitably.¹⁴ The Sutter-Summit Study tests its control group with pre-merger data and finds that pre-merger price changes by both Summit and Sutter's Alta Bates Medical Center are statistically indistinguishable from the average price change of the control group hospitals.¹⁵ This result suggests that the control group can perform its function adequately. The Evanston Northwestern Study tests the sensitivity of its findings by using multiple control groups comprising different sets of hospitals. With the exception of one payor, the results are generally consistent across control groups, giving some assurance that the control groups are suitable.¹⁶ The New Hanover Study does not discuss any tests on the composition of its control group.

In principle, an analysis of prices that accounts for all of the relevant factors should be able to isolate the importance of each factor—including the merger itself—on price. As the Evanston Northwestern Study notes, “[t]o isolate the merger’s effect on price, it is necessary to control for all of the other factors, unrelated to the merger, that could cause a hospital’s price to change over time.”¹⁷ To this end, the three papers use regression analysis to account directly for many of the factors that are likely to affect prices of hospital services. Briefly, a regression analysis is a technique that allows the researcher to determine whether a relationship exists between one variable, such as price, and others, such as cost or for-profit status. These other factors may be referred to as “explanatory factors.” Regressions provide information as to whether the relationship is “statistically significant,” rather than being just as likely to be caused by pure chance, how large of an influence each of the explanatory factors has, and

¹⁴ Simpson and Schmidt, p. 632-633.

¹⁵ Sutter-Summit Study, p. 21. As is discussed below, even if the control group's average price increase is similar to that of the merging hospitals, some individual hospitals in the control group may have price changes that are very different from the merging hospitals' price changes.

¹⁶ Evanston Northwestern Study, p. 23.

¹⁷ Evanston Northwestern Study, p. 10.

whether that influence tends to increase or decrease the variable at issue (e.g., price). Table 1 below identifies the regression factors and the studies in which they were incorporated. The different ways each factor is measured are also shown, and several of the measurements are used differently in the different studies.

Table 1 Factors Used in Price Estimation				
Factor	Ways Factor Measured	Evanston		
		Northwestern	Sutter-Summit	New Hanover
Merger	identify post-merger period	x	x	x
Intensity of care	case mix, DRG, length of stay, diagnosis, cost category	x	x	x
Cost-shifting	Medicare share, Medicaid share	x	x	
Teaching hospital	status as teaching hosp., residents/interns per bed	x	x	
Type of insurance product	identify HMO, PPO, Indemnity	x	x	x
Patient demographics	age, sex		x	x
For-profit status	identify for non-profit, for-profit		x	
Hospital size	bed count		x	
Time trend	identify year	x		

An important question in this type of modeling is whether all of the relevant factors have been included in the price estimation. Relying on a control group of hospitals for making price comparison addresses some of the concerns, but that begs the question whether all of the relevant factors were considered in choosing the control group. A difference-in-differences estimation approach such as that employed in the FTC studies implicitly assumes that price changes in the control group fully account for unmeasured demand or supply changes that affect the merged entity. The estimation is refined by including important measurable variables directly in the regression analyses, as the FTC studies have done. It is not clear generally, however, that control groups fully account for other factors.¹⁸ Evidently, the FTC researchers in the Evanston Northwestern administrative trial judged that “it is not possible to test for all possible explanations of price increases,” so only “reasonable explanations” were considered.¹⁹ Of the eight plausible explanations cited regarding post-merger price increases at Evanston Northwestern, three of them are included explicitly in the model (changes in the mix of patients, changes in payor mix, and changes in teaching intensity), three others might be captured through a properly constructed control group (changes in industry-wide costs,

¹⁸ John Simpson and David Schmidt, “Difference-in-Differences Analysis in Antitrust: A Cautionary Note,” 75 *Antitrust Law Journal* 2 (2008), p. 624.

¹⁹ Evanston Northwestern Healthcare Corp., FTC Docket No. 9315, Initial Decision (Oct. 20, 2005), p. 88. [hereinafter Initial Decision] available at www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf.

changes in regulation, and changes in consumer demand), one was ruled out through separate empirical analysis (changes in outpatient prices), and the final one (quality) was omitted.²⁰ The Evanston Northwestern Study and the Sutter-Summit Study include one other variable—cost-shifting—and the Sutter-Summit Study also includes the hospital's for-profit status and its size.

Exclusion of a variable to measure real or perceived quality changes related to the merger could significantly affect the results. None of the studies develops or includes a quality variable. The Evanston Northwestern Study addresses the quality issue explicitly, stating that “it is beyond the scope of this paper to describe the various quality metrics and report their relative changes at the merged hospitals.” Instead, it relies on the opinions of the Administrative Law Judge and the FTC Commissioners that “ENH failed to show that quality improved.”²¹ This statement appears to be contradicted by the Commissioners' later acknowledgment that “this is a case in which a critical improvement was made to Highland Park after the merger was consummated (namely, the development and implementation of a cardiac surgery program).”²² The merging parties also argued that the merger had resulted in significant quality improvements.²³ The omission of a measure for quality thus both exposes a contradiction in the FTC's logic in *Evanston Northwestern* and undermines the validity of the staff's statistical results.

The Sutter-Summit Study acknowledges that hospital quality is one of three factors affecting consumer preferences (the other two being breadth of service and geographic location), and it also recognizes that Summit's inferior reputation may have been reflected in its much smaller commercial patient population than Alta Bates.²⁴ Nevertheless, the Sutter-Summit Study does not incorporate any measure of quality in its price estimation. Although included in the same study as the Evanston Northwestern

²⁰ Initial Decision, pp. 88-96.

²¹ Evanston Northwestern Study, p. 13.

²² Opinion of the Commission on Remedy, In the Matter of Evanston Northwestern Healthcare Corp., FTC Docket No. 9315 (April 24, 2008) [hereinafter Opinion of the Commission on Remedy], p. 11, available at www.ftc.gov/os/adjpro/d9315/080428commopiniononremedy.pdf.

²³ Post-Trial Reply Brief of Respondent Evanston Northwestern Healthcare Corporation, FTC Docket No. 9315 (July 1, 2005), pp. 69-70, available at www.ftc.gov/os/adjpro/d9315/050701resposttrialreplybrief.pdf.

²⁴ Sutter-Summit Study, p. 7.

analysis, the St. Therese-Victory analysis includes no reference to quality. The New Hanover Study does not discuss hospital quality at all. There is little question that measuring quality changes is difficult, but that does not mean that the effect of quality on price estimates can be safely ignored.

Related to the quality issue, one group of commentators on merger retrospective studies notes that other important competitive variables besides price may also be affected by a merger. These variables include product improvements, new product introductions, advertising and promotion, and repositioning of existing products. They state that “[a]ll else equal, the total competitive effect can be determined by analyzing quantity (or share) changes.”²⁵ However, none of the FTC studies includes share measures in their empirical work.

A step taken by each of the FTC studies to reflect more accurately the realities of the markets in which the studies were conducted is the time required for hospital prices to adjust. To account for the frequency and term of hospitals’ multi-year contracts with managed care plans, the studies excluded data for the period immediately following the merger. The Sutter-Summit Study excluded one year of data—thus keeping one year of data before the acquisition and one year after—and the New Hanover Study excluded two years of data—keeping two years before and two years after the transaction. The Evanston Northwestern Study excluded data in the transition period for managed care plans based on the effective date of the first post-merger contract if that contract was signed before the end of 2002, otherwise no data were excluded.

The data used in each of the studies to estimate prices is drawn primarily from two sources: claims data of large managed care plans that operate in the hospitals’ service areas and discharge and billing data of the hospitals themselves. For confidentiality reasons, none of the payors is identified and no summary statistics of the data are provided. The Evanston Northwestern Study relies on data from five managed care plans from which it extracted 747,000 usable hospital cases. Neither the Sutter-Summit

²⁵ Graeme Hunter, Gregory K. Leonard, and G. Steven Olley, “Merger Retrospective Studies: A Review,” 23 *Antitrust* 1 (Fall 2008), p. 34. These authors also point out that one study using a modified difference-in-differences approach found results with such “striking” differences that “the assumptions of the basic DID [difference-in-differences] approach are called into question.” (p. 40)

Study (using data from three managed care plans) nor the New Hanover Study (using data from four managed care plans) reports the number of observations included in their analyses.

Results and Observations

The findings of the FTC studies with regard to price changes are mixed. Some prices increased by a statistically significant amount; some did not change significantly; and some decreased. Table 2 below shows the number of times a variation (or specification) of the model found a significant price increase, no significant price change, or a significant price decrease. For example, the analysis of the Evanston Northwestern-Highland Park merger shows that post-merger prices increased by statistically significant amounts relative to the control group for three managed care plans in twenty-four out of twenty-four model specifications and twenty-two of twenty-four specifications for one plan. For the fifth managed care plan, however, it shows no significant increase in twenty-one of twenty-four model specifications. The Sutter-Summit Study found that prices paid for Summit's hospital services increased by statistically significant amounts relative to the control group of hospitals in both specifications for all five managed care plans, but none of the prices paid for Alta Bates' services increased by a significant amount. The New Hanover Study found that the New Hanover-Cape Fear transaction resulted in a statistically significant price increase (relative to the control group) for two payors, no change for one payor, and a statistically significant decrease for one payor. Finally, the analysis of post-merger pricing for the St. Therese-Victory transaction found one payor with statistically significant price increases, two with statistically significant price decreases, and

Table 2							
Results of FTC Estimations of Post-Merger Price Changes							
Number of Model Specifications Resulting in ...				Number of Model Specifications Resulting in ...			
Payor	Significant Price Increase	No Significant Price Change	Significant Price Decrease	Payor	Significant Price Increase	No Significant Price Change	Significant Price Decrease
Evanston Northwestern-Highland Park Analysis				New Hanover-Cape Fear Analysis			
A	24	0	0	1	1	0	0
B	24	0	0	2	1	0	0
C	3	21	0	3	0	1	0
D	24	0	0	4	0	0	1
E	22	2	0				
Sutter-Summit Analysis				St. Therese-Victory Analysis			
1*	2	0	0	A	10	8	0
2*	2	0	0	B	0	0	18
3*	2	0	0	C	0	0	18
1**	0	2	0	D	18	0	0
2**	0	2	0	E	0	0	18
3**	0	2	0				

* Summit Medical Center, ** Alta Bates Medical Center
Note: Statistical significance of at least the 10% level is used here.

one with a nearly even split between an increase and no increase in the eighteen model specifications. Based on these results (and other information), the FTC initiated an administrative trial regarding Evanston Northwestern, but not Sutter-Summit or either of the other two transactions.

A few observations arise from the empirical analyses in the FTC studies. A fundamental question is whether the analytical approach underlying the use of these results can properly support a conclusion of competitive harm. While the Evanston Northwestern Study results may have properly concluded that the merged hospitals' price increase was significantly greater than the *average* of the control group, for example, that does not answer the question of whether their price increase was significantly greater than those of *all* of the control group hospitals. Some of the control group hospitals may have had price increases greater than the merging hospitals' price increase. If so, there must be some explanation other than a merger for those hospitals' price increases. If the

other explanation is found in variables left out of the price estimations, then it casts doubt on the validity of the model specifications.

As discussed previously, one of the variables that the FTC staff acknowledges was left out of the price estimations is some measure of change in quality. This is not to say that the FTC does not recognize the importance of quality change in healthcare. Recently, an FTC staff assistant director stated that “if the evidence supports these claims [that the hospital merger will significantly improve the quality of care], the likelihood of the FTC challenging a proposed merger decreases substantially.”²⁶ Despite this assurance, however, it is apparent that the FTC has yet to determine how to integrate quality measures into an analysis of prices. The Evanston Northwestern Study notes the conceptual importance of a change in quality, but dismisses it by pointing to the Commission’s opinion in *Evanston Northwestern*. But the Commission contradicts itself regarding Evanston Northwestern’s quality improvements. In its opinion on the merits, the Commission states that Evanston Northwestern “produced little verifiable evidence that the changes it made at Highland Park improved quality of care.”²⁷ In its opinion on a remedy, however, the Commission specifically affirms the quality improvements at Highland Park Hospital.²⁸ In the end, the omission of a quality variable undermines the validity and credibility of the FTC staff’s price studies.

Another question concerns the significance of some payors avoiding a price increase while others end up paying it. In the Evanston Northwestern Study, for example, Payor C was not subject to a statistically significant price increase at Evanston Northwestern relative to the control group. The FTC Commissioners’ opinion identifies the one payor that did not have a statistically significant price increase to be Blue Cross Blue Shield of Illinois.²⁹ Presumably, this is Payor C in Table 2. According to the theoretical model in the FTC studies, a payor can prevent a provider from increasing prices by more than a competitive amount relative to the control group if its enrollees view other hospitals to be sufficiently close substitutes for the hospital at issue. By that logic, if Blue Cross was

²⁶ Matthew J. Reilly, Assistant Director, FTC Bureau of Competition, “Review of Hospital Mergers by the FTC: Tips for the Merging Parties and Counsel,” presentation to AHLA Mid-Winter Meeting, February 11, 2009.

²⁷ Opinion of the Commission, p. 84.

²⁸ Opinion of the Commission on Remedy, p. 11.

²⁹ Opinion of the Commission, p. 32.

able to avoid a price increase by Evanston Northwestern, it was because its enrollees viewed other hospitals to be close substitutes to the merged Evanston Northwestern-Highland Park hospital. It is then reasonable to query why Blue Cross' enrollees would have this perception, but other plans' enrollees would not.

Conclusion

The FTC staff's investigation of post-merger pricing in the hospital services industry has found what observers might view as reliable evidence that some pre-merger reviews of hospital transactions in the past failed to prevent some hospital mergers that resulted in above-competitive price increases. The findings of these post-merger studies and the FTC's resulting success in the administrative trial on the Evanston Northwestern-Highland Park merger have emboldened the FTC in its enforcement actions against hospital mergers. The FTC's ability to derail Inova Health System's proposed acquisition of Prince William Health System in northern Virginia in 2008 reflects the stiffening of the FTC's attitude (and reveals some new strategies the FTC is willing to employ as well). Insofar as the FTC's resolve is based on econometric estimation of prices, it is important that its empirical work withstands scrutiny.

It remains the case that most hospital transactions will avoid an in-depth investigation by the FTC. Yet, hospitals contemplating mergers should be wary of the agency's new assertiveness. Not only is the Hart-Scott-Rodino pre-merger review process conducted by the FTC likely to involve greater scrutiny than in the past, but it is evident that clearing the process and completing a merger does not ensure a hospital that it will remain free of FTC investigators. Significant post-merger price increases are especially likely to raise red flags in the FTC's eyes and could result in post-merger investigations. Nevertheless, the FTC staff's approach to analyzing hospital prices exhibits some important deficiencies that limit its ability to support conclusions of above-competitive pricing.

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"This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is provided with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought"—from a declaration of the American Bar Association