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

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

[3]For a compilation of links that provide an overview of the agency's competition-related

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

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

[6] *See, e.g.*, In the Matter of Evanston Northwestern Healthcare Corporation and ENH

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

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

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

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

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

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

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

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

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

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[12] *See infra* Part II.

[13] *See infra* Part III.

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

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

[16] *See infra* Part IV.

[18] *See, e.g.*, In the Matter of Preferred Health Services, FTC File No. 041-0099 (proposed consent agreement accepted for public comment March 2, 2005), *available at*

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

The Health Care Report also describes the important role of generic drug products in driving down drug prices,[26] and cites the Commission's numerous enforcement actions challenging conduct that otherwise might have denied consumers the benefits of generic drug competition.[27] The Commission settled one such case in August 2004. The Commission charged that Perrigo and Alpharma, the only two producers of generic, over-the-counter

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

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

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

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

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

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

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

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III. CRITICAL LOSS ANALYSIS

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

A. What Is Critical Loss Analysis?

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

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

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

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

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

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

[36] *See especially* Barry C. Harris & Joseph J. Simons,

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C. Health Care Report Discussion of Critical Loss Analysis

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

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

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

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

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

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

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

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

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

The Commission found that the results of the critical loss analysis were inconsistent with other evidence of likely anticompetitive effects, including "extraordinarily high concentration levels . . . , the state of pre-acquisition competition . . . , and the nearly insurmountable entry barriers that we found to predominate . . . ."[45] In its opinion, the Commission noted that, while it did "not doubt the soundness of the logic underlying critical loss analysis, . . . we are mindful

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

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

[44] *Id.* at 82.

[45] *Id.* at 84.

[46] *Id.* at 83.

few sales would be lost.[47]

[47] *Id.*

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

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

I fully agree with the Health Care Report that, as a pure matter of antitrust principle, community commitments do not solve the competitive problems arising from an otherwise unlawful merger. When seeking relief, the primary goal should always be to obtain a structural remedy, which is a better long-term solution than a behavioral fix. But as a former state enforcer

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

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

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

The Health Care Report explicitly rejects the significance of institutional form as a relevant factor in predicting likely anticompetitive effects from a hospital merger. HEALTH CARE REPORT, Ch. 4 at 29-33; *see also id.*, Exec. Sum003 Twt31.6(yat 297(p“he Hbes agvileabe tvidence tshows]TJ-1

[52]Settlement agreement by and among Dennis C. Vacco, Attorney General of the State of New York; John S.T. Gallagher, President, North Shore Health System; and David R. Dantzker,