Concurring Opinion of Commissioner J. Thomas Rosch
In the Matter of Evanston Northwestern Healthcare Corp.
Docket No. 9315

I concur with the Commission opinion's conclusion that Evanston Northwestern Healthcare Corp.'s acquisition of Highland Park Hospital violated Section 7 of the Clayton Act. There is much to be admired in the Commission opinion. However, particularly in light of Count II of the complaint, I believe the Commission opinion makes this case more difficult than necessary. I write separately to explain why that is so.

I depart from the Commission opinion in two fundamental respects. First, I believe the law and the facts in this case squarely support complaint counsel's theory of anticompetitive effects. That theory is based on the unique competitive dynamics of hospital markets, stemming from the bargaining between hospitals and managed care organizations ("MCOs") over inclusion in MCO networks that is described by the Commission opinion. *See* Comm. Op. 62-63 (describing the "bargaining model" involved here). Reflecting those dynamics, complaint counsel's theory of anticompetitive effects is multi-dimensional.

At one level, notwithstanding the physical and geographical differences between Evanston and Highland Park,[1] the two hospitals competed with each other in the sense that MCOs wanting to compete effectively for insureds located within the geographic triangle bounded by the three ENH hospitals viewed Evanston and Highland Park as each other's "next best substitute" in forming networks for that purpose. Complaint counsel's theory of anticompetitive effects was initially based on the merger's elimination of this dimension of competition, which enabled ENH to include Highland Park in its system and engage in system (all-or-nothing) supra-competitive pricing. *See* CPTB 4, 24; CB 14, 19-21.

At a second level, premerger, Evanston and Highland Park were also constrained in their pricing to MCOs by localized competition – *i.e.*, by the hospitals located closest to each of the two hospitals. Complaint counsel contends that the merger eliminated (or at least crippled) this localized competition because after the merger an MCO had to contract with all ENH hospitals in order to include one of them in its network, and that inhibited MCOs from playing Evanston and Highland Park off against their nearby competitors, as they could do pre-merger.

This multi-dimensional theory of liability, while unusual, is by no means unique. The Commission relied on similar theories when it challenged Rite-Aid's attempt to acquire Revco and Time Warner Inc.'s proposed acquisition of Turner Broadcasting System, Inc. *See* Jonathan

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[1] Evanston Hospital and Highland Park are located 13.7 miles apart and each has other hospitals located closer to it than they are to each other (though there are no other hospitals located within the geographic triangle formed between the two Evanston hospitals and Highland Park), and Evanston is a teaching tertiary care hospital, while Highland Park is a non-teaching, community primary-secondary care hospital. However, as the Commission opinion notes, the two Evanston hospitals and Highland Park each provided primary-secondary care services. Comm. Op. 12, 26, 72-73.

B. Baker, *Unilateral Competitive Effects Theories in Merger Analysis*, 11 ANTITRUST 21, 24-25 (1997).

Second, I believe the evidence that these unilateral anticompetitive effects have actually occurred has a significant impact on market definition. Specifically, the fact that this is a consummated merger means that ours is a retrospective analysis. We can look to see if there is any probative post-merger evidence that demonstrates whether or not the merger has been anticompetitive. We do not need to try to predict the future as would be necessary to analyze an unconsummated merger proposal. Where, as here, the post-transaction record establishes that the transaction has produced unilateral anticompetitive effects, it is not essential to define the relevant market upfront using the methodology described in the Horizontal Merger Guidelines. At least the "rough contours" of the relevant market can be identified on the basis of those effects, and that is sufficient as a matter of law.

I. Anticompetitive Effects

There is no dispute that immediately after the merger ENH increased prices for services at the ENH hospitals to a number of MCOs by many times the five percent increases described in the Horizontal Merger Guidelines as "significant" and that those price increases were "non transitory." *See* U.S. Dep't of Justice & Federal Trade Comm'n, *Horizontal Merger Guidelines* §1.11 (1992, revised 1997) ("Merger Guidelines"); Comm. Op. 16-17, 26-27, 64-65, 78. There is, however, a dispute over the cause of those price increases. Complaint counsel argued that this transaction created a hospital system that could and did obtain supra-competitive prices. *See* CPTB 2-4, 33-34; CB 14, 19-21. Respondent argued that its price increases at Evanston Hospital simply reflected its efforts to raise Evanston's prices to a competitive level, and did not reflect supra-competitive pricing. RB 3. It also maintained that the post-merger price increases at Highland Park reflected an increase in the quality of services provided at the hospital. RB 3-5.

I conclude that the merger materially changed the competitive dynamics that had theretofore existed in a fashion that violated Section 7.

A. The Law

Complaint counsel's theory of anticompetitive effects is viable as a matter of law. Respondent asserts that the Merger Guidelines description of unilateral anticompetitive effects in mergers involving differentiated products (Sections 2.21 and 2.211) does not squarely adopt that theory. RB 39-43; RRB 11, 22 (discussing Sections 2.21 and 2.211 and *In re R.R. Donnelly & Sons Co.*, 120 F.T.C. 36 (1995), embracing these provisions). I agree with respondent that the unilateral effects of a merger between producers of differentiated products (or services, like hospital services) cannot be considered illegal in all circumstances. I also agree that Sections 2.21 and 2.211 provide valuable guidance respecting the appropriate parameters. However, I disagree with respondent that complaint counsel's theory is outside those parameters.

The fundamental teaching of Sections 2.21 and 2.211 is that anticompetitive effects are

likely when differentiated products of the merging parties are each other's next best substitute.[2] To be sure, those provisions might not apply if the merger eliminated only pre-merger localized competition, considered in isolation. In that dimension of competition, Evanston and Highland Park were arguably not each other's best alternative within the meaning of Sections 2.21 and 2.211 of the Merger Guidelines. Advocate Lutheran General was arguably Evanston's closest local competitor and Lake Forest was arguably the closest alternative to Highland Park.

However, under complaint counsel's theory the merger's impact on localized competition cannot be considered in isolation. It was the *consequence* of the merger's primary effect, which was to eliminate competition between Evanston and Highland Park for inclusion in MCO hospital networks. To be specific, under complaint counsel's theory, before the merger MCOs who wanted to compete effectively for insureds located within the triangle considered Evanston and Highland Park to be each other's "next best substitute" in forming a network for that purpose, and the merger eliminated the competition between those next best substitutes. The lessening of the localized dimension of competition is an ancillary anticompetitive effect of the merger because the elimination of that dimension of competition resulted from the merger's elimination of competition between those next best substitutes. Thus, the unilateral effects provisions of the Merger Guidelines apply if the record sufficiently demonstrates that the transaction has had those anticompetitive effects.

This application of Sections 2.21 and 2.211 is not blunted by the language in Section 2.21 stating that "[t]he price rise will be greater the closer substitutes are the products of the merging firms." As the rest of that sentence makes clear, even products that are highly differentiated in terms of their physical and locational differences can be considered to be close substitutes with each other if "buyers of one product consider the other product to be their next choice." Thus, the elimination of the first dimension of competition – the competition between Evanston and Highland Park resulting from MCOs' desire to include one or the other of them in their networks – would represent an elimination of "close substitutes" within the meaning of Sections 2.21 and 2.211. And, since under complaint counsel's theory the injury to the second dimension of competition – the localized competition between each of the merging hospitals and its geographically more proximate rivals – was a consequence of the elimination of competition between those "close substitutes," those provisions of the Merger Guidelines would apply to that injury as well.

Conceptually, the effect of the elimination of the competition between Evanston and Highland Park is the same as if Evanston and Highland Park had entered into an agreement with each other as to the prices they would charge MCOs (or to be more blunt if they had entered into a price-fixing agreement). To be sure, a marketing joint venture could produce a similar result. We tolerate a marketing joint venture when it is shown to produce a new product that would not otherwise exist, absent the collaboration, and if it is shown that the joint venture will produce

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[2] The provisions also establish a safe harbor when the merger could not result in substantial market power. But under complaint counsel's theory, after the merger the merging hospitals here enjoyed substantial market power.

efficiencies that outweigh any pricing effects. *See* Federal Trade Comm'n & U.S. Dep't of Justice, *Antitrust Guidelines for Collaborations Among Competitors* §§ 3.3, 3.36 (2000). However, under complaint counsel's theory, neither can be said about this transaction. Before the transaction, MCOs could, if they chose to do so, create a hospital network like the post-merger system of ENH hospitals by bargaining with Evanston and Highland Park individually (and playing each off against the hospitals proximate to each – for example, Lake Forest in the case of Highland Park). Thus, the merger was not necessary to produce that kind of hospital network. Moreover, according to complaint counsel (and the Commission opinion), respondent failed to prove that any claimed efficiencies outweighed the pricing effects of the merger.

Most significantly, complaint counsel's theory fits snugly within the language of Section 7 of the Clayton Act. That provision prohibits any merger that has the effect of substantially lessening competition. Under complaint counsel's theory, this merger had the effect of substantially lessening both dimensions of the pre-merger hospital competition that MCOs could take advantage of in fashioning a network that would be attractive to insureds located within the triangle.

B. The Facts

As a factual matter, complaint counsel's view of the anticompetitive effects in this case is supported by MCO testimony, testimony of respondent's own principal economic expert, Professor Jonathan Baker, and the documents and testimony of the merging parties. MCO representatives described the pre-merger dynamics of competition among hospitals for inclusion in MCO networks. They testified that prior to the merger, MCOs wanting to compete effectively for insureds located within the geographic triangle formed by Evanston and Highland Park viewed those hospitals as "close substitutes" for each other when forming networks for that purpose. *See* Comm. Op. 18-25, 78.

For example, Jane Ballengee, PHCS' Regional Vice President for Network Development, testified that before the merger PHCS "could have one or the other hospital in their network." CB 21 (citing TR 166-67 (Ballengee)). Robert Mendonsa, a formal general manger at Aetna, testified that before the merger Evanston was "extremely desirable" and that Aetna's "walk-away point would have been pretty high . . . [but that Aetna] would have walked away because we still had Highland Park and we had Northwestern in the city and we had that coverage." TR 530 (Mendonsa), *in camera*. United's Jillian Foucre testified that Evanston and Highland Park would be the preferred choices of executives who lived in the triangle made up by the North Shore suburbs, and that executives who lived "within that area" made up by the triangle would not want to travel greater distances north or south to go to hospitals. TR 901-02 (Foucre). Foucre managed a team who negotiated with United's network providers in the Chicago area. TR 879 (Foucre); CX 5174, *in camera*.[3]

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[3] Patrick Neary, who at the time of the merger was One Health's Director of Network Development, also testified that he thought that ENH had purchased "their main competitor," although he did not specify why this was the case. TR 600-01 (Neary).

Additionally, MCO representatives testified that prior to the merger there was another dimension of competition: Evanston and Highland Park were also constrained in their pricing to MCOs by localized competition – *i.e.*, the hospitals located close to each (and not each other). For example, Foucre also testified that, prior to the merger, she viewed Condell and Lake Forest as competitors to Highland Park, and that Evanston competed with Advocate Lutheran General, Rush North Shore, and St. Francis. TR 941-44 (Foucre). Lenore Holt-Darcy, Unicare's Regional Vice President at the time of the merger, testified that Highland Park competed with Lake Forest and Condell hospitals, and that Evanston competed with a significant number of tertiary hospitals in the Chicago area, including Rush North Shore and St. Francis. TR 1595-97 (Holt-Darcy), *in camera.*

The changes in these competitive dynamics are directly reflected in the post-merger pricing applicable to ENH's hospitals. It is undisputed that after the merger ENH negotiated a system contract for all three of its hospitals; MCOs were not given the option of entering into separate contracts for the hospitals, to decline to use one or more of the hospitals, or to pay different prices for the care at any one of them. *See* IDF ¶ 449; TR 1528 (Holt-Darcy), *in camera* (Post-merger, ENH offered an "all-or-nothing deal" to Unicare in which there would be one rate for all three hospitals, regardless of the level of service at each facility, like the "Three Musketeers, all for one and one for all."); *see also* Comm. Op. 16. Furthermore, as the Commission opinion says, economic evidence proffered by Professor Baker shows that immediately after the merger, the system prices that ENH charged a number of MCOs increased by many times more than the five percent described in the Merger Guidelines as "significant." Comm. Op. 17, 27, 64-65.

Beyond that, the record refutes respondent's efforts to explain those price increases by factors divorced from the merger itself. First, while respondent claims that the pricing at Highland Park was attributable to the improvements that ENH made there, the record shows that price increases were imposed *before* these improvements were made. IDF ¶¶ 179, 457. Second, the econometric evidence presented by Professor Baker itself contradicted respondent's claim that the price increases only brought Evanston's prices up to competitive levels: as the Commission opinion says, the "control group" of hospitals against whose price increases Professor Baker compared ENH's post-transaction price increases contained only high-end very expensive hospitals that were not comparable to Evanston or Highland Park, Comm. Op. 39, 43-44, 69; IDF ¶¶ 817-19, 821, 824, and indeed, for several MCOs ENH's price increases exceeded even that "control group's" price increases. Comm. Op. 44.

The evidence of post-merger supra-competitive pricing at Highland Park is especially compelling. The evidence is undisputed that tertiary care teaching hospitals command substantially higher prices than do primary-secondary care community hospitals like Highland Park. RB 17-18, RRB 36-37; TR 156-59 (Ballengee). Evanston was (and is) indisputably a tertiary care teaching hospital, but Highland Park was (and is) indisputably a community hospital,

not a tertiary care teaching hospital. CB 54, n.57; ID 191.[4] Indeed, respondent repeatedly emphasized how different Evanston and Highland Park were from each other, RB 2, 7, 9, 10; RRB 28 n.6, 36, and also admitted that tertiary care teaching hospitals like Evanston command higher prices than primary-secondary care community hospitals like Highland Park. RB 17-18, 51; RRB 36-37.

These admissions by respondent and its expert were not gratuitous. They were amply supported by MCO testimony. *See* TR 158-59 (Ballengee); TR 622 (Neary); TR 935, 1112 (Foucre), *in camera*; TR 565 (Mendonsa), *in camera*; TR 1289 (Neaman), *in camera*; TR 1590 (Holt-Darcy), *in camera*; *see also* RRB 36-37; RB 51; TR 6065 (Noether), *in camera*. Thus, to borrow an economics term, the demand curves for teaching and community hospitals are materially different from one another, and as a consequence teaching hospitals can and do charge more for their services.

Yet respondent has essentially admitted that, post-transaction, MCOs were charged the same prices for Highland Park's services that they were charged for Evanston's services, and respondent's expert testified that Evanston's prices were "at the middle of the pack" of Chicago area academic hospitals. TR 6065-66 (Noether), *in camera*; RB 91-92. That ENH could and did charge teaching (and tertiary care) hospital prices at Highland Park is direct evidence that, as a result of the merger, it enjoyed and exercised market power sufficient to impose supra-competitive prices. *See* ID 171-72 ("[E]ven if the evidence demonstrates that Evanston deserved higher prices because of its teaching status, this does not provide any justification for charging the same higher rates for Highland Park, a non-teaching community hospital."); *see also* CB 47 n.49.

Finally, the record establishes that ENH did not suffer a "critical loss" – or indeed any loss – of sales to competing hospitals as a result of its price increases. Notwithstanding ENH's system-wide pricing at significantly increased prices, only one MCO (OneHealth) initially did not contract with ENH, and OneHealth ended up contracting with ENH after it concluded it could not afford to refrain from doing so. IDF ¶¶ 420-33. Thus, the record establishes that the price increases were the result of post-merger market power rather than of exogenous factors.

Indeed, respondent itself has said that ENH experienced no loss of business to competitors after the merger, citing the absence of any such output reduction as a reason why its price increases cannot be considered to be the product of an exercise of market power, as a matter of economics and law. RB 56; RRB 23-25. To borrow (respectfully) from Judge Diane Wood, this claim "has things backward." *Toys "R" Us, Inc. v. FTC*, 221 F.3d 928, 937 (7th Cir. 2000). Where, as here, there is evidence that the defendant has increased its prices significantly and the defendant's output does *not* decline, this in and of itself is evidence that the defendant enjoys market power. *See R.J. Reynolds Tobacco Company v. Cigarettes Cheaper!*, 462 F.3d 690, 695

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[4] While Evanston is not at the highest end of the teaching hospital spectrum (*see supra* p. 5), it is undeniably a teaching hospital. *See* Comm. Op. 43-44; CB 45. Evanston is affiliated with the Northwestern University School of Medicine, and this relationship was strengthened between 1992 and 1996. TR 1282 (Neaman); RX 584 at ENH JH 2951-52.

(7th Cir. 2006) (Easterbrook, J.) (rejecting the district court's ruling on summary judgment that the defendant lacked market power because *inter alia*, the summary judgment record did not demonstrate that the defendant "lacks power to make significant price increases without substantial loss of sales"); *Olympia Equip. Leasing Co. v. Western Union Tel. Co.*, 797 F.2d 370, 373 (7th Cir. 1986) (Posner, J.) (market power is "the power to raise prices without losing so much business that the price increase is unprofitable"); *see also* William M. Landes & Richard A. Posner, *Market Power in Antitrust Cases*, 94 HARV. L. REV. 937, 939 (1981).

The fact that ENH did not suffer any loss of business to other competitive hospitals in the face of its post-merger pricing also rebuts respondent's assertion that MCOs could easily assemble a hospital network excluding the ENH hospitals by contracting with a system of hospitals like the Advocate Lutheran system to serve insureds located within the triangle and thus constrain the post-merger pricing of the ENH system. RB 46. Respondent has relied for this assertion on the ALJ's conclusion that Advocate Lutheran could constrain ENH's pricing. ID 144, 149. However, that conclusion is not inconsistent with the ALJ's ultimate conclusion that the merger violated Section 7. The hospitals in a network excluding the ENH hospitals would be more distant from the triangle than the ENH hospitals, and, as such, that network would be an imperfect substitute at best.

The existence of an imperfect substitute might constrain ENH's pricing somewhat. However, the case law recognizes that even firms enjoying monopoly power may be somewhat constrained in their pricing by other products; that constraint does not mean that the firm lacks monopoly power. *United States v. Aluminum Co. of Am.*, 148 F.2d 416, 426 (2d Cir. 1945); *see also* IIA PHILLIP E. AREEDA, HERBERT HOVENKAMP & JOHN SOLOW, ANTITRUST LAW, ¶ 506a, at 104-05 (2d ed. 2002) ("IIA AREEDA, HOVENKAMP & SOLOW"). Indeed, Professor Baker has written that the imperfect substitutes in the proposed RiteAid-Revco and TimeWarner-Turner Broadcasting mergers discussed above were not considered to constrain post-merger market power (and hence pricing) sufficiently to avoid Section 7 liability. *See* Baker, *supra*, at 24-25. Similarly here, the record establishes that the ability of MCOs to assemble a network of non-ENH hospital systems did not prevent ENH from pricing the hospitals in its system at supra-competitive levels.

Nor does the direct evidence of post-transaction supra-competitive pricing stand alone. It is supported by the evidence described by the Commission opinion that senior officials at Evanston and Highland Park anticipated that the merger would enable them to raise their prices, that the merged firm did in fact implement an extraordinary price increase immediately after completion of the transaction, and that the same senior officials then attributed their success at raising prices to increased bargaining leverage produced by the merger. Comm. Op. 14-18, 65-67.

II. Market Definition

The Commission opinion also makes the market definition question more difficult than it needs to be in this case. As the Commission opinion says, Count II of the complaint in this case raised the question whether it is always necessary to define the relevant market in a Section 7 challenge at the time and in the fashion described in the Merger Guidelines. Comm. Op. 86. In

proceeding under Count II complaint counsel did not define a market upfront using the Merger Guidelines methodology. Rather, it relied instead primarily on the direct evidence of the transaction's anticompetitive effects, in accordance with Count II. CB 5. I agree with complaint counsel that especially when a merger has been consummated and the evidence shows it has had actual anticompetitive unilateral effects, the law allows liability to be established by direct evidence of those effects, without initially defining a relevant market using Merger Guidelines methodology, at least where, as here, the evidence of anticompetitive effects identifies the "rough contours" of the market.

A. The Law

The Commission opinion articulately describes the trend in the courts towards greater reliance on direct evidence in defining markets. Comm. Op. 86-88. In cases brought under Section 1 of the Sherman Act, the courts have analyzed the analogous issue of whether it is appropriate to determine the lawfulness of completed or ongoing conduct through direct effects evidence, in lieu of market definition. *See id.* (discussing *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986) ("IFD")); *Toys "R" Us*, 221 F.3d 928; *Todd v. Exxon Corp.*, 275 F.3d 191, 207 (2d Cir. 2001); *Ball Mem'l Hosp. v. Mutual Hosp. Ins.*, 784 F.2d 1325, 1336 (7th Cir. 1986)).

The purpose of market definition and the direct analysis of anticompetitive effects are consistent – both techniques seek to determine whether a planned agreement by competitors is likely to facilitate the exercise of market power, or whether a completed one has enabled the exercise of market power. *See Toys "R" Us*, 221 F.3d at 937. As the Commission opinion observes, for more than a decade the courts and scholars have recognized repeatedly that market definition is not an end in itself but rather an indirect means to assist in determining the presence or the likelihood of market power. Comm. Op. 86-88; *see also United States v. Baker Hughes, Inc.*, 908 F.2d 981, 992 (D.C. Cir. 1990); IIA AREEDA, HOVENKAMP & SOLOW, *supra*, ¶ 532a, at 190-91; HERBERT HOVENKAMP, FEDERAL ANTITRUST POLICY § 12.8, at 550 (3d ed. 2005) ("HOVENKAMP"). Market definition is a tool for analyzing market power, but it is not the only tool, either as a matter of law or economics. *Toys "R" Us*, 221 F.3d at 937.

As the Commission opinion also says, enforcement agencies and courts often need predictive tools like market definition in order to analyze market power in unconsummated merger cases because the transaction has not yet occurred. *See* HOVENKAMP, *supra*, § 12.4c, at 524-25. However, challenges to consummated mergers do not necessarily require predictive or inferential mechanisms because there may be a rich amount of empirical evidence that shows a transaction's actual anticompetitive effects. To the contrary, it would make no sense to adopt a rule providing that even when there is clear direct evidence that a consummated transaction has enabled the merged party to engage in supra-competitive pricing, the enforcement agency must nonetheless define with precision the relevant market upfront in order to establish liability under Section 7.

Like the Commission opinion, I recognize that *IFD* and its progeny did not "make a complete break from the market definition process." Comm. Op. at 88. In each of those cases, the courts also found there was sufficient evidence to identify at least the "rough contours" of the

relevant markets. *Id*. The Section 1 cases discussed by the Commission opinion permitted the use of direct effects evidence in order to determine whether ongoing conduct has facilitated the exercise of market power so long as the rough contours of the relevant market are identified.

There is no principled reason why the same analysis cannot be applied in Section 7 cases. Indeed, a decade and a half ago, Judge Posner observed that judicial interpretation of Section 1 of the Sherman Act and Section 7 of the Clayton Act had converged. *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1281-83 (7th Cir. 1990); *see also* IV PHILLIP E. AREEDA, HERBERT HOVENKAMP & JOHN L. SOLOW, Antitrust Law, ¶ 913b, at 64 (2nd ed. 2006) ("In cases where a merger facilitates a significant 'unilateral' price increase for a grouping of sales that was not a distinctive-looking market prior to the merger, the appropriate conclusion is that the merger has facilitated the emergence of a new grouping of sales capable of being classified as a relevant market. This formulation meets the statutory requirement [in Section 7] that the 'effect' of a merger is anticompetitive in some 'line of commerce' in some 'section of the country.'"); Comm. Op. 60-62 (citing authorities).

To be sure, a number of merger decisions – including several involving hospitals – have required that the relevant market be defined upfront and with precision. Indeed, several courts have rejected challenges to hospital mergers on the ground that the plaintiff failed to properly define the relevant market this way. *See, e.g., FTC v. Freeman Hospital*, 69 F.3d 260 (8th Cir. 1995); *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057 (N.D. Cal. 2000). However, the mergers in cases post-dating enactment of the Hart-Scott-Rodino ("HSR") Act three decades ago have been unconsummated mergers. Consequently, the analysis had to be prospective. The agencies and the courts had to predict what the consequences of the transaction would be. That is a different task than the task in a consummated merger case like this one. As previously discussed, predictive tools, such as market definition, are less necessary in a consummated case when we can determine by direct evidence whether the merger enabled the combined firm to engage in anticompetitive conduct.

This is not to say that the post-transaction behavior in this case lacks significance in future unconsummated hospital merger cases. To the contrary, it may be that the experience in this case will be important in predicting the likely effects in certain of those cases. Moreover, evidence of likely post-transaction anticompetitive effects may sufficiently identify the contours of the relevant market in other unconsummated merger cases. *See* Comm. Op. at 61-62, discussing, *inter alia*, *FTC v. Staples, Inc.*, 970 F. Supp. 1066 (D. D.C. 1997), an unconsummated merger case in which the relevant product market was defined principally on the basis of the evidence of likely anticompetitive effects. At all events, the evidence of actual anticompetitive effects that exists in this case distinguishes it from all of the cases requiring upfront and precise market definition, including consummated merger cases pre-dating enactment of the HSR Act.[5]

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[5] Also, in most of the pre-HSR Act merger cases requiring upfront and precise market definition the theory of anticompetitive effects has been a "coordinated effects" theory – *i.e.*, that the merger threatened to facilitate coordination in a highly concentrated market. *See, e.g., United States v. Philadelphia Nat'l Bank & Trust Co.*, 374 U.S. 321 (1963); *see also FTC v.*

In short, I believe that as a matter of law, it was not necessary that anything more than the "rough contours" of the relevant market be defined in order to establish the existence of a Section 7 violation in this case, where complaint counsel's theory of anticompetitive effects could be tested because the merger had been consummated. The evidence shows that this consummated merger enabled the merged firm unilaterally to engage in supra-competitive pricing, and that fact supports the propriety of relying on direct evidence in defining the rough contours of the relevant market.[6]

B. The Facts

In this case, respondent's documents and economic evidence described above, as well as the testimony of MCOs previously described, not only established the existence of anticompetitive effects resulting from the merger, but also identified at least the "rough contours" of the product and geographic markets alleged by complaint counsel. More specifically, complaint counsel asserted that the relevant product market is "general acute care hospital services, including primary, secondary, and tertiary services, sold to MCOs." CB 37. Complaint counsel contended that the relevant geographic market was the triangle bounded by the three hospitals in the ENH system. CB 38; ID 137.

As Areeda and Hovenkamp explain, a relevant market is "a market relevant to the particular legal issue being litigated." IIA AREEDA, HOVENKAMP & SOLOW, *supra*, ¶ 533c. Here the issue is whether the merger enabled ENH to impose supra-competitive prices on MCOs who wished to compete effectively for insureds located within the geographic triangle bounded by the three ENH hospitals. I agree with the Commission opinion that the relevant product market in this case is acute inpatient services, which hospitals alone can provide. As the Commission opinion points out, the record in this respect is consistent with the long line of cases that have reached the same conclusion. Comm. Op. 56.

I also conclude that complaint counsel demonstrated that the relevant geographic market consisted of the triangle bounded by the three ENH hospitals. That conclusion is based on the evidence previously described that MCOs considered Evanston or Highland Park to be next best substitutes in forming networks in order to compete effectively for insureds located within that triangle. *See supra* p. 4. That conclusion is also based on the evidence previously described that after the merger, ENH gained the power to control the price of all three ENH hospitals, and ENH

Elders Grain, Inc., 868 F.2d 901, 906 (7th Cir. 1989) (Posner, J.) (describing coordinated effects as the prevailing theory of anticompetitive effects in merger cases). As the Commission opinion points out, when that is the theory, it is important that all the competitors in the market be identified. Comm. Op. 59.

[6] Of course, if anticompetitive effects have not yet occurred because the merged party is aware of the antitrust risks of engaging in post-transaction anticompetitive conduct, or for some other reason, the upfront market definition methodology described in the Merger Guidelines may be useful to predict whether or not they are likely to occur in the future.

enjoyed and exercised this market power to impose extraordinarily high system prices on MCOs as the price for their effective competition in that geographic area. *See supra* pp. 5-7; CB 14, 19-21. And it is based on the evidence that, despite ENH's post-transaction system pricing and despite the extraordinarily high pricing that occurred at all three ENH system hospitals, none of the MCOs competing in that triangle ultimately declined to deal with ENH.

Again, respondent did not contest that the three ENH hospitals were uniquely located with respect to that triangle, or that ENH could and did engage in system pricing after the merger. Respondent instead argued that the triangle did not constitute the relevant geographic market because each of the ENH hospitals was located closer to other hospitals than to each other and that the pricing at these other hospitals would constrain the pricing at each. RB 2, 10. That is a *non sequitur*. It is correct that at one level of competition, prior to the transaction the pricing at Evanston and Highland Park was constrained by other hospitals that were located proximate to each. But that does not mean that same competitive constraint existed after the merger, when MCOs were forced to contract with all three ENH hospitals on ENH's terms, instead of confronting each constituent hospital with the local competition each faced, as MCOs could do before the merger. Indeed, respondent's argument simply underscores that injury to that localized pre-merger competition is another consequence of the merger, which strengthens the conclusion that the competitive forces affecting pricing vis-à-vis the triangle were lessened as a result of the merger.

In short, what the record demonstrates is that, as complaint counsel has claimed, the merger had the effect of lessening competition in a relevant market consisting of primary, secondary, and/or tertiary inpatient hospital care services in the triangular area bounded by the ENH hospitals. ENH's control of all three hospitals in the triangle enabled it to impose supra-competitive prices for inpatient hospital care services that could not have been charged prior to the merger when the hospitals forming the triangle bargained separately.

I would affirm for these reasons, and I agree with the Commission opinion's relief order.