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MESSNER'S EFFECT ON HOSPITAL CONSOLIDATION AND ANTICOMPETITIVE BEHAVIOR

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INTRODUCTION

The amount individuals spend on healthcare has increased significantly over the past thirty years. In 2010, healthcare spending was approximately one sixth of gross domestic product, and it is expected to increase to one fifth of gross domestic product by 2021.¹ Fixing America's healthcare spending problems is vital for the economy because these costs reduce business investment by placing downward pressure on the consumption of other goods.² To contain healthcare costs and improve quality, Congress passed the Patient

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¹ Louise Radnofsy, *Steep Rise in Health Costs Projected*, WALL STREET JOURNAL (July 12, 2012), <http://online.wsj.com/article/SB10001424052702303768104577462731719000346.html?KEYWORDS=medicare>.

² Christina D. Romer, *Only the First Step in Containing Health Costs*, N.Y. TIMES (July 21, 2012), <http://www.nytimes.com/2012/07/22/business/health-care-law-and-cost-containment-economic-view.html>.

Protection and Affordable Care Act (“ACA”) in 2010.³ Only the future will determine whether the ACA effectively achieves these goals.

This Note discusses trends in hospital consolidation and its influence on healthcare costs along with the impact that the Seventh Circuit’s decision in *Messner v. Northshore University HealthSystem* will have on healthcare spending in the private payor market. In *Messner*, the Seventh Circuit certified a class action in which the plaintiffs claimed that a Chicago area hospital network engaged in anticompetitive practices, and in doing so, raised prices for private payors.⁴ More specifically, the Note argues that the Federal Trade Commission (“FTC”) and the Department of Justice (“DOJ”) will have a more prominent role in policing hospitals’ monopolistic practices in light of (1) the ACA’s effects on consolidation in hospital markets; (2) plaintiffs’ ability to survive *Daubert* challenges on motions for class certification; (3) and trends in class action litigation.

Part I explains economic incentives and the effects of rapid consolidation in the healthcare industry. Part II discusses the history of antitrust enforcement actions and the legal issues that are unique to hospital antitrust cases. Part III recounts *Messner*’s history from an administrative action to a private class action, and Part IV explores *Messner*’s deterrent effect, or lack thereof, on hospital anticompetitive behavior.

I. ECONOMIC INCENTIVES IN THE HEALTHCARE INDUSTRY & RISING PRICES FOR PATIENTS

A. *The Role of the Third Party Payor*

The reasons for rising healthcare costs are as complex as the industry itself. The asymmetry of information among the patients,

³ Ken Glazer & Catherine A. LaRose, *Accountable Care Organizations: Antitrust Business as Usual?*, ANTITRUST SOURCE, Dec. 2011, at 1.

⁴ *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802 (7th Cir. 2012), *reh’g denied* (Feb. 28, 2012), *overruled sub nom. In re Evanston Northwestern Healthcare Corp. Antitrust Litigation*, 268 F.R.D. 56 (N.D. Ill. April 12, 2010).

providers, and payors that pervades the industry causes healthcare delivery to be incredibly inefficient.⁵ In most markets for goods or services, the customer pays the provider directly; however, in the healthcare market a third party, such as the government or an insurance company, generally pays for the patient's healthcare.⁶ This system is called the third party payor system, and it creates an asymmetry of information between the patient, who depends on the provider's advice, and the provider, whom the third party pays.⁷ Because providers are paid for each procedure they perform and the patient may never receive a bill, providers are tempted to prescribe more services than may be necessary while guising these services as beneficial to the patient.⁸ The troubling fact is that this system does not necessarily create better outcomes for the patient, and it lacks self-correcting cost control mechanisms.⁹

In addition, rapid hospital consolidation is compounding the healthcare spending problem, and this phenomena has been one of the less publicized causes for increasing healthcare costs.¹⁰ Consolidation has increased hospitals' local market power, particularly when rival hospitals, defined as hospitals located within seven miles of one another, merge.¹¹ This market power enables hospitals to raise prices

⁵ Len Nichols, *Making Health Markets Work Better Though Targeted Doses of Competition, Regulation, and Collaboration*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 7, 12–13 (2011).

⁶ In the Matter of Evanston Northwestern Healthcare Corp., No. 9315, 2007 WL 2286195, at *7 (F.T.C. Aug. 6, 2007) [hereinafter *Evanston Northwestern Healthcare Commission Decision*].

⁷ Nichols, *supra* note 5, at 12–13.

⁸ *Id.*

⁹ *Id.* at 13.

¹⁰ Avik Roy, *Hospital Monopolies: The Biggest Driver of Health Costs Nobody Talks About*, FORBES (Aug. 22, 2011), <http://www.forbes.com/sites/aroy/2011/08/22/hospital-monopolies-the-biggest-driver-of-health-costs-that-nobody-talks-about/>.

¹¹ Avik Roy, *Hospital Consolidations and Healthcare Costs*, YOUTUBE (Nov. 18, 2011), http://www.youtube.com/watch?v=Nq_-gzO1pZ0&feature=player_embedded#! [hereinafter *Hospital Consolidations and Healthcare Costs*].

for private payors and order doctors to prescribe additional unnecessary procedures while quality lags.¹²

Private insurers have ineffectively prevented hospitals' monopolistic practices because they can spread these costs across their networks, and they lack incentives to change their current contracting processes. Instead of negotiating contracts with thousands of doctors and hospitals individually to get the best prices, insurers prefer to set price schedules sufficiently high to entice providers to participate in their networks.¹³ Moreover, a patient who pays more for the monopoly-priced services may not even be effected because that patient's co-pay can remain unchanged while the insurer raises premiums or deductibles for participants within the insurer's other networks.¹⁴ These participants include employers that provide health insurance for their employees and individuals who purchase health plans for themselves.¹⁵ Employers can also pass the costs of more expensive premiums onto employees in the form of reduced compensation and benefits.¹⁶ This dynamic does not mitigate the effects of hospital price increases; it simply enables insurers to spread costs associated with monopoly pricing among their customers.¹⁷ In a word, every insured person pays.

B. Bad Side Effects: The Patient Protection and Affordable Care Act & Consolidation

To achieve the ACA's goal of delivering better quality at lower costs, the ACA promotes the formation of Accountable Care

¹² Julie Creswell, *A Hospital War Reflects a Bind for Doctors in the U.S.*, N.Y. TIMES (November 30, 2012), http://www.nytimes.com/2012/12/01/business/a-hospital-war-reflects-a-tightening-bind-for-doctors-nationwide.html?pagewanted=1&_r=0.

¹³ Nichols, *supra* note 5, at 11; Daniel A. Crane, *Optimizing Private Antitrust Enforcement*, 63 VAND. L. REV. 675, 681–82 (2010).

¹⁴ *Evanston Northwestern Healthcare Commission Decision*, *supra* note 6, at 7.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

Organizations (“ACOs”).¹⁸ ACOs are networks of hospitals and doctors that take responsibility for specific Medicare patient populations.¹⁹ The ACOs participate in the Medicare Shared Savings Program, which provides financial incentives to ACOs for reducing healthcare costs.²⁰ This new approach to care promotes the formation of regional integrated networks²¹ that will inevitably serve patients who are privately insured as well as Medicare patients.²² On a high level, the ACA forces the hospital sector to pursue cost-efficiency measures, which includes consolidating services and facilities and clinical integration.²³ However, a side effect of this integration is consolidation, and the ACA has caused a frenzy of hospital mergers as providers attempt to share savings and costs to cash in on incentives.²⁴ For instance, in 2011, 301 hospital and clinic merger deals were recorded, and healthcare deal volume is anticipated to remain active.²⁵

The ACA has prompted both horizontal and vertical mergers as well.²⁶ Horizontal mergers include primary care networks and hospitals buying out other hospitals to increase their geographic footprints.²⁷ Vertical consolidations include hospitals acquiring

¹⁸ Robert Pear, *Consumer Risks Feared as Health Law Spurs Mergers*, N.Y. TIMES (Nov. 20, 2011), <http://www.nytimes.com/2010/11/21/health/policy/21health.html?pagewanted=all>.

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² See Andrew A. Kasper, *Antitrust Review of Accountable Care Organizations: An Assessment of FTC and DOJ's Relaxed Approach to Regulating Physician-Hospital Networks*, 90 N.C. L. REV. 203, 207 (2011) (noting antitrust concerns can arise when ACO participants market their services to private payors).

²³ M&A International Inc., *Hospitals and Clinics M&A Outlook: What's the Prognosis for Deal Making?*, M&A INTERNATIONAL, 6 (2012) http://www.mergers.net/uploads/media/MAI_Healthcare.Report_2012.pdf [hereinafter *Hospitals and Clinics M&A Outlook*].

²⁴ Pear, *supra* note 18.

²⁵ *Hospitals and Clinics M&A Outlook*, *supra* note 23, at 4.

²⁶ *Id.*

²⁷ *Id.*

primary care facilities and insurers acquiring hospitals and primary care service providers to diversify operations.²⁸ Physician networks control the flow of patients to hospitals, and these networks are vital to making ACOs work by reducing readmissions.²⁹ Therefore, hospitals are seeking to acquire physician practices to strengthen their service lines as opposed to building new practices.³⁰

Hospital consolidations have both beneficial and detrimental consequences. The benefits of consolidation include generating operational efficiencies, which causes prices to decrease.³¹ These efficiencies are particularly important for struggling hospitals that need to realize savings to continue operations.³² Consolidation can also help hospitals access the capital needed to make necessary investments in healthcare technology and electronic medical records systems.³³ A significant detrimental effect of consolidation is that it can increase hospital bargaining power, which enables hospitals to raise prices even when the quality in healthcare delivery stagnates.³⁴

With so many causes for skyrocketing healthcare costs, determining whether consolidation has harmed or helped consumers is difficult.³⁵ Because of this problem, past studies were inconclusive as to whether consolidation actually caused price increases.³⁶ The lack of

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, HEALTH AFFAIRS, 23, no.2 (2004): 175–181, 175.

³² Toby Singer, Beth Heifetz & Tara Stuckey Morrissey, *The Pro-Competitive Benefits of Hospital Mergers*, HOSPITAL & HEALTH NETWORKS (Sept. 25, 2012), <http://www.hhnmag.com/hhnmag/HHNDaily/HHNDailyDisplay.dhtml?id=3070004> 128.

³³ *Id.*

³⁴ Creswell, *supra* note 12.

³⁵ Capps & Dranove, *supra* note 31, at 175.

³⁶ See Graeme Hunter, Gregory K. Leonard & G. Steven Olley, *Merger Retrospective: A Review*, 23–FALL ANTITRUST 34, 39–40 (2008) (citing three separate studies of hospital mergers that occurred in the late 1980s and early 1990s

evidence as to the effect of hospital consolidations is one reason for the industry being highly concentrated today.³⁷ More recently, post merger reviews that use better methods have confirmed that hospital consolidations contribute to price increases.³⁸ For instance, a 2004 study on the changes in hospital prices before and after a hospital merger found that consolidating hospitals tend to raise prices more than the median price increases in a given market.³⁹ The alarming fact is that neither the FTC nor the DOJ challenged any of the mergers analyzed in the 2004 study.⁴⁰

Additionally, a hospital's not-for-profit status is irrelevant in predicting whether it will exploit its market power.⁴¹ Not-for-profit hospitals are no more likely than for profit hospitals to increase spending on charity care resulting from their ability to charge higher prices.⁴² While true integration resulting from mergers can yield cost savings, the evidence shows that these cost savings are not passed on

that yielded different results with respect to the mergers' effects on pricing). *See also Hospital Consolidations and Healthcare Costs*, *supra* note 11.

³⁷ *Hospital Consolidations and Healthcare Costs*, *supra* note 11 (noting that the first generation of hospital merger studies showed that hospital mergers had no effect on prices).

³⁸ *Hospital Consolidations and Healthcare Costs*, *supra* note 11; Dr. David Dranove, *Changes in Health Care Financing & Organization: Viewing Health Care Consolidation through the Lens of the Economics of Strategy*, 3, (March 2010), available at,

<http://www.academyhealth.org/files/publications/HCFORReportMarch2010.pdf> [hereinafter *Changes in Health Care Financing & Organization*] (citing a joint DOJ and FTC study from 2004 as well as a study by the Robert Wood Johnson Foundation from 2006 finding that consolidation enables hospitals to charge higher prices).

³⁹ Capps & Dranove, *supra* note 31, at 179.

⁴⁰ *Id.* at 178, 180.

⁴¹ Martin Gaynor, *Health Care Industry Consolidation: Facts, Impacts, and Policy Options or "How do you Reform Health Care with an 800 Pound Gorilla in the Room?"* (Nov. 11, 2011), 18, 20, available at, <http://bakerinstitute.org/files/documents/event-presentations/hcreform2011/HPF-event-HCReformGaynorPresentation-111111.pdf/view?searchterm=gaynor>.

⁴² *Id.* at 18, 20.

to consumers,⁴³ and the courts have only exacerbated the problem.

II. ANTITRUST LAW APPLIED IN HEALTHCARE

The last 20 years of antitrust hospital litigation has resulted in varied outcomes.⁴⁴ In the 1980s until the early 1990s, the FTC and DOJ (collectively, the “Regulators”) successfully blocked every anticompetitive hospital merger.⁴⁵ However, starting in the mid-1990s through 2001, the Regulators lost seven successive cases,⁴⁶ and they stopped opposing hospital mergers in spite of their concerns about the mergers’ anticompetitive effects.⁴⁷ These challenges to hospital mergers were unsuccessful because the courts held that the hospitals’ geographic market definitions were too narrow,⁴⁸ or the defendants showed that the merger benefited consumers by exploiting efficiencies.⁴⁹ After these losses, the agencies focused their attention on post-merger reviews.⁵⁰ Due to mounting evidence of abuses of market power, antitrust enforcement efforts are once again intensifying.⁵¹

⁴³ *Id.* at 19.

⁴⁴ Toby G. Singer, *Mergers: Antitrust Issues for Hospitals and Health Plans Hospital Mergers*, AHLA-PAPERS P06300812 (American Health Lawyers Ass’n Seminar Materials, San Francisco, Cal.), June 30, 2008, at 24 [hereinafter *AHLA Seminar Papers*].

⁴⁵ Capps & Dranove, *supra* note 31, at 175.

⁴⁶ *AHLA Seminar Papers*, *supra* note 44, at 25.

⁴⁷ Capps & Dranove, *supra* note 31, at 175.

⁴⁸ *AHLA Seminar Papers*, *supra* note 44, at 25.

⁴⁹ Erica L. Rice, Note, *Evanston’s Legacy: A Prescription for Addressing Two-Stage Competition in Hospital Merger Antitrust Analysis*, 90 B.U. L. REV. 431, 442 (2010).

⁵⁰ Capps & Dranove, *supra* note 31, at 175.

⁵¹ Dr. David Dranove, *Viewing Health Care Consolidation through the Lens of the Economics of Strategy* (Mar. 2010), 1, available at, <http://www.academyhealth.org/files/publications/HCFOReportMarch2010.pdf>.

In most merger cases, the Regulators challenge mergers before they are consummated.⁵² Pursuant to the Hart-Scott-Rodino Antitrust Improvement Act, sizable firms that wish to merge must notify the Regulators.⁵³ The merger cannot be completed for another thirty days during which the Regulators review the merger to determine whether it will be anticompetitive.⁵⁴ If the Regulators find that the merger will have anticompetitive effects, they can seek a preliminary injunction to stop it.⁵⁵ Generally, the threat of litigation is sufficient to prevent a proposed merger.⁵⁶

However, hospitals took their pre-merger reviews to the courts, and did so with success.⁵⁷ When Regulators challenge a merger, the first and most crucial step is defining the market.⁵⁸ If the market is improperly defined, it is impossible to quantify a merger's effects.⁵⁹ Because market definition greatly impacts the outcome of antitrust litigation, it can be a complex, time consuming, and expensive issue to prove.⁶⁰

The relevant market is comprised of (1) the product market and (2) the geographic market.⁶¹ Product market boundaries are defined by "the reasonable interchangeability of use [by consumers] or the cross-elasticity of demand between the product itself and substitutes for it."⁶² Interchangeability is based on (1) the similarity of a substitute product to the product in question and (2) consumers' willingness to

⁵² Rice, *supra* note 49, at 433–34.

⁵³ *Id.* at 434.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ See *AHLA Seminar Papers*, *supra* note 44, at 25 (noting that of the seven hospital merger cases that the FTC lost from the mid-1990s to 2001, the FTC sought to enjoin proposed mergers in six cases).

⁵⁸ 1 JOHN MILES, HEALTH CARE AND ANTITRUST L. § 2:3 (2012).

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Evanston Northwestern Healthcare Commission Decision*, *supra* note 6, at 43.

⁶² *Id.* at 45 (internal quotations omitted).

buy the substitute product.⁶³ Hospitals generally do not challenge product market definitions in enforcement actions.⁶⁴ The geographic market is the “area of effective competition” where the seller operates and to which consumers can turn for products.⁶⁵ The geographic market is a region where a monopolist could impose a price increase without changing its terms of sale.⁶⁶ In winning court battles against the Regulators, hospitals have successfully persuaded judges to rely on inapplicable tests to define their geographic markets.⁶⁷

For example, courts frequently relied on the Elzinga-Hogarty test to reject the Regulators’ proposed geographic market.⁶⁸ The Elzinga-Hogarty test is premised on the idea that patient flow data will reveal which hospitals patients in a particular geographic area can use for their care.⁶⁹ If patients within a geographic market use hospitals outside the area, this use implies that hospitals outside the area act as checks on the local hospital’s exercise of market power.⁷⁰ Hospitals produced evidence that more than ten percent “of patients traveled outside the local community for care.”⁷¹ Hospitals argued that they, therefore, faced substantial competition outside their communities.⁷²

The problem with the Elzinga-Hogarty test is that it does not adequately address hospital markets’ idiosyncrasies because the test ignores patients’ insensitivity to hospital prices.⁷³ The reason for this lack of price sensitivity is that the third party payor shields patients

⁶³ *Id.*

⁶⁴ Rice, *supra* note 49, at 436.

⁶⁵ *Evanston Northwestern Healthcare Commission Decision*, *supra* note 6, at 48 (internal quotations omitted).

⁶⁶ *Id.* at 48.

⁶⁷ *AHLA Seminar Papers*, *supra* note 44, at 26.

⁶⁸ *Id.* at 25.

⁶⁹ *Hosp. Corp. of Am.*, 106 F.T.C. 361, ¶130–40 (1985).

⁷⁰ *Id.*

⁷¹ *Changes in Health Care Financing & Organization*, *supra* note 38, at 3.

⁷² *Id.*

⁷³ *AHLA Seminar Papers*, *supra* note 44, at 26.

from knowing hospital service costs.⁷⁴ Without this information, patients cannot compare prices among local hospitals.⁷⁵ The Elzinga-Hogarty test, which originally studied coal markets in 1973, does not account for patients' willingness to travel to hospitals based on factors such as proximity and reputation.⁷⁶ Economists watched these cases in disbelief.⁷⁷ It made little sense to rely on a test designed to study markets for homogenous goods and apply it to hospital markets, which are characterized by selective contracting and differentiation.⁷⁸

In addition to persuading courts to rely on irrelevant market definitions, hospitals also successfully claimed that their mergers would exploit efficiencies, the benefits of which will be passed to patients.⁷⁹ Generally, mergers that yield cost savings are not considered anticompetitive.⁸⁰ In determining whether efficiencies outweigh any anticompetitive effects, Regulators consider only efficiencies that are specific to the merger.⁸¹ Because delivering care is operationally complex, hospitals can easily show efficiencies ranging from decreased costs in providing laboratory services to administrative services, which can include operations as insignificant as the hospital cafeteria.⁸² At one time, courts viewed this defense with suspicion, and they would generally rule that operational efficiencies could be realized by other means.⁸³ However, from 1995 to 2002, this defense became significantly more successful for hospitals with courts ruling in their favor.⁸⁴

The Regulators' inability to stop hospital mergers has created

⁷⁴ *Id.*

⁷⁵ *See id.*

⁷⁶ *See Changes in Health Care Financing & Organization, supra* note 38, at 3.

⁷⁷ *Id.* at 4.

⁷⁸ *Id.*

⁷⁹ *See Rice, supra* note 49, at 441.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.* at 442.

⁸⁴ *Id.*

highly concentrated markets as measured by the Herfindahl–Hirschman Index (“HHI”), a measure that the Regulators themselves use to measure market concentration.⁸⁵ To calculate HHI, each firm’s market share is squared, and the results are then summed.⁸⁶ For instance, if a firm controlled 100% of the market, the HHI would be 10,000, or 100 squared.⁸⁷ On the other hand, if there were thousands of firms in a market, each firm’s market share would be approximately 0%, resulting in an HHI measurement of 0.⁸⁸

The Regulators have identified three types of markets: (1) unconcentrated markets where HHI is below 1,500; (2) moderately concentrated markets where HHI is between 1,500 and 2,500; and (3) highly concentrated markets where HHI is above 2,500.⁸⁹ In 1992, hospital market concentration averaged 2,440, which is equivalent to four equal sized firms in one market.⁹⁰ In 2006, the average HHI for hospital markets grew to 3,261, which is equivalent to three equal sized firms per metropolitan area.⁹¹ Today, 75% of metropolitan areas are highly concentrated.⁹²

⁸⁵ See U.S. Department of Justice and the Federal Trade Commission, *Horizontal Merger Guidelines*, (Aug. 19, 2010) §5.3, available at, <http://www.justice.gov/atr/public/guidelines/hmg-2010.html> (explaining that HHI measures market concentration).

⁸⁶ *Id.*

⁸⁷ *Herfindahl-Hirschman Index – HHI*, INVESTOPEDIA, <http://www.investopedia.com/terms/h/hhi.asp#axzz2AX6BbP7K> (last visited Jan. 12, 2013) (explaining how HHI is calculated).

⁸⁸ *Id.*

⁸⁹ U.S. Department of Justice and the Federal Trade Commission, *Horizontal Merger Guidelines*, (Aug. 19, 2010) §5.3, available at, <http://www.justice.gov/atr/public/guidelines/hmg-2010.html>.

⁹⁰ Gaynor, *supra* note 41, at 7.

⁹¹ *Id.*

⁹² *Id.*

III. THE NORTHSHORE LITIGATION: FROM THE ADMINISTRATIVE HEARING TO THE SEVENTH CIRCUIT

The predecessor to *Messner* was an FTC administrative action brought against Evanston Northwestern Health Corporation (“EHC”).⁹³ This case is significant for two reasons. First, until the EHC action, the FTC had not successfully challenged a hospital merger in over a decade.⁹⁴ Second, the FTC won the case by redefining the hospital market and using a two-tiered approach to analyze the merger’s anticompetitive effects.⁹⁵

Given the difficulty in persuading courts that hospital geographic markets should be narrowly defined, the FTC tried a new approach in its case against EHC.⁹⁶ On January 1, 2000, EHC, which was comprised of Glenbrook Hospital in Glenview, Illinois and Evanston Northwestern Hospital in Evanston, Illinois, merged with Highland Park Hospital in Highland Park, Illinois.⁹⁷ EHC changed its name to Northshore University HealthSystem (“Northshore”) after the merger.⁹⁸ In February 2004, the FTC initiated an administrative action against Northshore and claimed that the merger violated Section 7 of the Clayton Act.⁹⁹ In Count I of its complaint, the FTC defined the product market as “general acute care inpatient hospital services *sold to private pay[ors]*” as opposed to the consumers of hospital services, i.e., the patients.¹⁰⁰ Under this framework, hospital competition was analyzed under a two-tiered approach.¹⁰¹ The FTC argued that the first

⁹³ *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 809 (7th Cir. 2012), *reh’g denied* (Feb. 28, 2012).

⁹⁴ Rice, *supra* note 49, at 432.

⁹⁵ *AHLA Seminar Papers*, *supra* note 44, at 27.

⁹⁶ *Evanston Northwestern Healthcare Commission Decision*, *supra* note 6, at 27.

⁹⁷ *Messner*, 669 F.3d at 809.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *AHLA Seminar Papers*, *supra* note 44, at 27.

¹⁰¹ *Id.*

tier of competition occurs when hospitals compete to be included in private third party payor networks.¹⁰² The second tier of competition occurs when hospitals compete with each other for patients.¹⁰³ The FTC argued that the second tier of competition is often based on non-price criteria such as quality of care.¹⁰⁴ Count II focused on the merger's anticompetitive effects rather than the health network's newly formed geographic area.¹⁰⁵ According to the FTC, the geographic market was irrelevant in light of the merger's anticompetitive impact.¹⁰⁶ The administrative law judge ruled in favor of the FTC and ordered EHC to divest Highland Park Hospital.¹⁰⁷ EHC appealed to the Commission.¹⁰⁸

On appeal, the Commission determined that the merger allowed Northshore to use its market power to increase prices.¹⁰⁹ In reaching this decision, the Commission focused on the hospitals' pre-merger business records and testimony from the creators of the Elzinga-Hogarty test.¹¹⁰ EHC had hired Bain Consulting to assist with the merger's strategic planning, and Bain determined that EHC would be in a stronger position to renegotiate contracts with insurers after the merger.¹¹¹ EHC and Highland Park Hospital's pre-merger board minutes also included statements from their respective officers and directors in which they concluded that the merger would allow the new hospital network to strengthen its negotiating capabilities.¹¹²

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Evanston Northwestern Healthcare Corp.*, No. 9315, 2005 WL 2845790, at *16 (F.T.C. Oct. 20, 2005).

¹⁰⁵ *AHLA Seminar Papers*, *supra* note 44, at 27.

¹⁰⁶ *Id.*

¹⁰⁷ *Evanston Northwestern Healthcare Corp.*, 2005 WL 2845790, at *2.

¹⁰⁸ *Id.*

¹⁰⁹ *AHLA Seminar Papers*, *supra* note 44, at 28.

¹¹⁰ *Id.* at 28, 30.

¹¹¹ *Evanston Northwestern Healthcare Commission Decision*, *supra* note 6, at 11.

¹¹² *Id.* at 10–11.

More significantly, the decision “downplayed the use of patient origin data and suggested that such data will have only a limited applicability in FTC cases going forward.”¹¹³ The Commission heard testimony from the creators of the Elzinga-Hogarty test who testified that the model was inapplicable to healthcare systems because patients do not necessarily choose hospitals based on price.¹¹⁴ In fact, Professor Kenneth Elzinga explained that patients “rarely fully internalize the benefits and costs of their decision to purchase a medical product or service.”¹¹⁵

Because divestiture would have been costly, the Commission ordered independent contracting teams – one for Evanston Northwestern Hospital and Glenbrook Hospital and a separate team for Highland Park Hospital.¹¹⁶ The order required that the hospital network set up a firewall between Highland Park and the other two hospitals, and the negotiating teams were prohibited from sharing information with each other.¹¹⁷

In April 2008, Steven Messner filed a class action suit against Northshore.¹¹⁸ Other plaintiffs had filed similar actions that were consolidated into one case, and they moved for class certification pursuant to FRCP 23(b)(3).¹¹⁹ The plaintiffs defined their class as individuals and entities that purchased “inpatient hospital services or hospital-based outpatient serviced directly from Northshore . . . from at least as early as January 1, 2000 to the present.”¹²⁰ The plaintiffs claimed that the merger between Highland Park Hospital and EHC

¹¹³ *AHLA Seminar Papers*, *supra* note 44, at 31.

¹¹⁴ *Id.*

¹¹⁵ *Id.* at 31.

¹¹⁶ *Evanston Northwestern Healthcare Commission Decision*, *supra* note 6, at 79.

¹¹⁷ *Id.*

¹¹⁸ *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 809 (7th Cir. 2012), *reh'g denied* (Feb. 28, 2012).

¹¹⁹ *Id.* at 810.

¹²⁰ *Id.* (internal quotations omitted).

violated Section 7 of the Clayton Act.¹²¹ Plaintiffs sought class certification, along with injunctive relief and treble damages pursuant to Section 4 of the Clayton Act.¹²²

The first issue for the Seventh Circuit was whether the district court made a procedural error in failing to subject Northshore's expert report to a *Daubert* review.¹²³ According to the Federal Rules of Evidence, expert testimony must (1) assist the trier of fact in understanding the evidence or in determining a fact issue; (2) be based on sufficient data or facts; and (3) be produced with reliable methods that have been applied to the facts of the case.¹²⁴ *Daubert v. Merrell Dow Pharmaceuticals* interpreted the reliability prong to mean that an expert's methodology is reliable and scientifically valid if it is grounded in the scientific method.¹²⁵ Factors for reliability include whether the technique has gained widespread acceptance, been peer reviewed, and been published.¹²⁶

The plaintiffs in *Messner* moved to exclude Northshore's expert report by arguing that the "economic analyses are fundamentally defective."¹²⁷ The district court denied the plaintiffs' motion explaining that the report was given "the weight [the Court] believes it [was] due."¹²⁸ The Seventh Circuit held that when an expert's opinion is critical to certifying a class, the district court must conduct a *Daubert* review on any challenge to the expert's submissions or qualifications before ruling on a motion for class certification.¹²⁹

The second issue was whether the district court incorrectly applied the predominance requirement with respect to antitrust impact

¹²¹ *Id.* at 808; 15 U.S.C. § 18.

¹²² *Messner*, 669 F.3d at 808 (internal quotations omitted); 15 U.S.C. § 15.

¹²³ *Messner*, 669 F.3d at 811.

¹²⁴ FED. R. EVID. 702.

¹²⁵ *Daubert v. Merrell Dow Pharmaceuticals Inc.*, 509 U.S. 579, 592–3 (1993).

¹²⁶ *Id.* at 593.

¹²⁷ *Messner*, 669 F.3d at 812 (internal quotations omitted).

¹²⁸ *Id.*

¹²⁹ *Id.*

or “fact of damage.”¹³⁰ To become certified under FRCP 23(a), a class must show (1) numerosity, (2) commonality in questions of law or fact, (3) typicality of claims among the representatives, and (4) that “the representative parties will fairly and adequately protect the interests of the class.”¹³¹ A proposed class must always satisfy the FRCP 23(a) requirements before seeking certification pursuant to FRCP 23(b)(3).¹³² In order to certify a class under FRCP 23(b)(3), the court must find “that the questions of law or fact common to class members predominate over any questions affecting only individual members, and that a class action is superior to other available methods for fairly and efficiently adjudicating the controversy.”¹³³ FRCP 23(b)’s predominance requirement is satisfied when common questions representing “a significant aspect of a case . . . can be resolved for all members of a class in a single adjudication.”¹³⁴

The first step in a predominance analysis is for the court to examine the underlying elements of the cause of action.¹³⁵ In antitrust cases, plaintiffs must show that (1) the defendant violated an antitrust law and that (2) the violation caused an injury.¹³⁶ The Seventh Circuit disagreed with the district court as to how far the plaintiffs needed to go to show predominance with respect to antitrust injury, also known as antitrust impact, at the class certification stage.¹³⁷

To demonstrate antitrust impact, plaintiffs relied on a “difference in differences” analysis (“DID analysis”).¹³⁸ DID analyses are useful tools for studying the effects of mergers because such analyses compare prices before a given event, in this case a merger, to prices

¹³⁰ *Id.* at 814.

¹³¹ FED. R. CIV. P. 23(a).

¹³² *Messner*, 699 F.3d at 811.

¹³³ FED. R. CIV. P. 23(b)(3).

¹³⁴ *Messner*, 699 at 815 (internal quotations omitted).

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.* at 808.

after the event.¹³⁹ The analysis controls for other economic factors that may cause prices to change by first identifying other products or geographic markets in which economic factors other than the merger itself caused price changes.¹⁴⁰ The merger's effect is quantified by comparing the "control group's" price changes to the subject hospital's prices changes before and after the merger.¹⁴¹ Plaintiff's expert was Northwestern University economist, Dr. David Dranove ("Dranove").¹⁴² His DID analysis compared the percentage increase in prices for services after the merger to those of a control group, consisting of local hospitals that were subject to the same market forces as Northshore.¹⁴³ The district court declined to certify plaintiffs' class because it concluded that the expert's analysis needed to show that prices increased uniformly.¹⁴⁴ Due to a lack of uniform prices charged to payors, the district court held that the plaintiffs could not show predominance and denied class certification.¹⁴⁵

The district court focused on the fact that hospitals charge payors different prices.¹⁴⁶ For instance, prices for insurers that negotiate multi-year contracts for services may differ from those that renegotiate each year.¹⁴⁷ Moreover, insurers will negotiate contracts that cover bundles of services.¹⁴⁸ For example, a bill for a Caesarian section could include "anesthesia, operating room use, surgeon's fee, post-operative care for the mother, newborn care for the baby, etc."¹⁴⁹ Hospitals may unbundle and re-bundle these services so that two

¹³⁹ See Graeme Hunter, Gregory K. Leonard & G. Steven Olley, *Merger Retrospective: A Review*, 23 NO. 1 ANTITRUST MAGAZINE 34, 35 (2008).

¹⁴⁰ *Messner*, 699 F.3d at 810.

¹⁴¹ *Id.*

¹⁴² *Id.* at 810.

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 817–18.

¹⁴⁵ *Id.* at 818.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 818.

¹⁴⁸ *Id.* at 816.

¹⁴⁹ *Id.*

purchasers pay different amounts for the same Caesarian section.¹⁵⁰ Furthermore, the market prices of each individual component can vary depending on the standard of care and advances in technology.¹⁵¹ In particular, the district court focused on data in Dranove’s reply report detailing increases in prices for “Payor A.”¹⁵² In denying class certification, the district court judge asserted that “of the 18 prices listed in [Payor A’s] renegotiated September 22, 2002 contract, 6 increased at a uniform rate, 9 increased at variable rates, and 3 changed pricing methodologies from the previous contract, making it difficult to draw a comparison.”¹⁵³

The Seventh Circuit held that the district court misapplied Rule 23(b)(3)’s predominance standard because it required a test that was too stringent at the class certification stage.¹⁵⁴ The Court explained that the ability to use “common evidence and common methodology to prove a class’s claims is sufficient to support a finding of predominance on the issue of antitrust impact for certification under Rule 23(b)(3).”¹⁵⁵ Dranove claimed the he could use post merger price increases, which would constitute common evidence, to show that “insurers and individuals who received coverage through those insurers suffered some antitrust injury” caused by the merger.¹⁵⁶ Dranove further explained that he could adapt his methodology whenever price increases varied by conducting as many DID analyses as were required when the price increases were non-uniform.¹⁵⁷ “In this way, Dranove explained, he would be able to calculate ‘different

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.* at 821.

¹⁵³ *Id.* at 821 (*citing* Evanston Northwestern Healthcare Corp. Antitrust Litig., 268 F.R.D. 56, 86 (N.D. Ill. 2010)).

¹⁵⁴ *Id.* at 818.

¹⁵⁵ *Id.* at 819.

¹⁵⁶ *Id.* at 818.

¹⁵⁷ *Id.* at 820.

overcharges across different services categories’ despite any non-uniform increase in the prices charged for those services.”¹⁵⁸

For instance, the Court examined prices from 2000 and 2002 and noted that “[t]he prices for eight categories of inpatient services all increased by approximately 6.0 percent.”¹⁵⁹ During the same period, the price structure remained unchanged for two categories of outpatient services while a third category changed its price structure “from a flat rate per case to a percentage of the billed charges.”¹⁶⁰ Further, the Court examined price variations in cardiac services across nine sub-categories.¹⁶¹ Prices for five subcategories decreased between 9.3% and 13.0%; two subcategories increased 14.8% and 60%, respectively; and two subcategories changed their billing structure.¹⁶² On their face, prices for cardiac services appeared to decrease; however, a closer examination revealed that prices from 2000 included the physicians’ services whereas the 2002 prices did not.¹⁶³ The Court believed that “[t]hese superficially non-uniform changes in prices therefore merely pose the sort of manageable challenge that Dranove’s methodology can handle, [and] [t]hey do not undermine the methodology itself.”¹⁶⁴

The third issue was whether the class was defined appropriately.¹⁶⁵ Northshore argued that the class contained individuals “who were not injured by Northshore’s alleged exercise of market power.”¹⁶⁶ For example, Blue Cross Blue Shield of Illinois had submitted an affidavit stating that it was not affected by post merger price increases.¹⁶⁷ The class also included individuals who “met their

¹⁵⁸ *Id.* at 820–21.

¹⁵⁹ *Id.* at 821.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.* at 821–22.

¹⁶⁵ *Id.* at 822.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

annual plan out-of-pocket maximum or their deductible regardless of any price increase, as well as those individuals whose contracts protect[] against price increases.”¹⁶⁸ The Court stated that defining a class in such a way as to avoid being over and under-inclusive “is more of an art than a science.”¹⁶⁹ Because Northshore failed to specify the number of individuals in the class that could not have been harmed by the merger and only 2.4% of the class actually “paid only their out-of-pocket maximums or deductibles,” Northshore failed to show that the class was overbroad.¹⁷⁰ The Seventh Circuit vacated the district court’s order and certified the class.¹⁷¹

IV. *MESSNER*’S IMPACT

The purpose of antitrust laws is to eliminate anticompetitive practices and promote a competitive economy in which enterprises compete on the basis of service, quality, and price.¹⁷² The undesirable effects of hospital consolidation combined with the fact that the Commission’s civil penalty against EHC was considered a mere “slap on the wrist” seriously undermines competition and quality of care.¹⁷³ For these reasons, the Seventh Circuit’s decision in *Messner* has important consequences in that it provides a framework for how other hospital antitrust class actions can become certified. Whether *Messner* will actually deter anticompetitive conduct depends on (1) the effect of the Court’s *Daubert* ruling, (2) current trends in class action litigation, and (3) private payors initiating these actions. If *Messner* has no deterrent effect, the Regulators alone will police hospitals.

¹⁶⁸ *Id.* at 824 (internal quotations omitted).

¹⁶⁹ *Id.* at 825.

¹⁷⁰ *Id.* at 825–86.

¹⁷¹ *Id.* at 826.

¹⁷² Philip A. Proger, *Primer on Antitrust in Healthcare*, AHLA-PAPERS P05170101, 2 (2001).

¹⁷³ Telephone Interview with Dr. David Dranove, Professor of Health Industry Management, Kellogg School of Management, Northwestern University (Oct. 15, 2012) [hereinafter Dranove Interview].

A. The Effect of the Daubert Ruling

At first blush, the Seventh Circuit's *Daubert* ruling appears to impose another hurdle for class certification. However, I argue that the absence of a *Daubert* challenge to the plaintiff's DID analysis provides a framework for future antitrust class actions involving hospital mergers, which currently are extremely rare.¹⁷⁴ According to a 2002 study of trends in antitrust healthcare litigation, solo or small group physician practices were the largest plaintiff group by far, accounting for 53% of all plaintiffs, and hospitals constituted the largest defendant pool, accounting for 61% of all defendants.¹⁷⁵ These cases mostly concern disputes over staff privileges.¹⁷⁶ Because *Messner* is such a unique case, it paves the way for other cases that challenge hospital monopolies to become certified in light of the complex analyses that courts undertake in ruling on Rule 23 motions.

In deciding whether to certify a class, Rule 23 requires courts to walk a fine line – particularly in cases like *Messner* where the plaintiffs rely on expert testimony. Demonstrating common impact in class actions is a complex task, and yet, it is important that class certification not be turned into a trial on the merits.¹⁷⁷ The question of whether to grant certification is a procedural one, in which plaintiffs need only show that they can use common evidence to prove their claims after certification.¹⁷⁸ Because of these requirements, fact-finding is generally necessary to address issues pertaining to the plaintiff's proposed methodology.¹⁷⁹ But defendants often attempt to turn certification into a trial on the merits by asking the court to

¹⁷⁴ Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 570 (2002).

¹⁷⁵ *Id.* at 566.

¹⁷⁶ *Id.* at 568.

¹⁷⁷ Ellen Meriwether, *Rigorous Analysis in Certification of Antitrust Class Actions: A Plaintiff's Perspective*, 21-SUM ANTITRUST 55, 55 (2007).

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

perform “a rigorous Rule 23 analysis.”¹⁸⁰ These tactics usurp the jury’s role in resolving questions of fact.¹⁸¹ In *Anchem Products Inc. v. Windsor*, the Supreme Court noted that “no reading of Rule 23 can ignore the Rules Enabling Act’s mandate that ‘rules of procedure shall not abridge, enlarge or modify any substantive right.’”¹⁸² Therefore, questions pertaining to antitrust impact should be for the jury at trial, not the judge in ruling on a motion to certify.¹⁸³ Nonetheless, determining whether to certify a class may require courts to consider the merits because the legal issues surrounding Rule 23 are often enmeshed with factual questions.¹⁸⁴

Reconciling these concepts—avoiding fact-finding while determining whether Rule 23 requirements are met—is a muddy process in antitrust cases.¹⁸⁵ The major issue in certifying an antitrust class action is predominance, or antitrust injury, which is proven by running common evidence through an economic model to show how the defendant’s conduct impacted prices.¹⁸⁶ At the same time, that economic model can refute the notion that common impact exists.¹⁸⁷ Because this approach would violate the Rules Enabling Act, most courts require only that plaintiffs be able to prove their case with common evidence.¹⁸⁸

The tension between satisfying Rule 23 and avoiding fact-finding has caused disagreement among circuit courts as to how rigorously expert witness testimony should be scrutinized at the class certification

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *Id.* (citing *Anchem Prods. Inc. v. Windsor*, 521 U.S. 591, 613 (1997) (internal quotations omitted)).

¹⁸³ *Id.* at 55.

¹⁸⁴ *Id.* at 56–57.

¹⁸⁵ *Id.* at 57.

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

stage.¹⁸⁹ In *Behrend v. Comcast Corporation*, the Supreme Court is currently deciding whether expert testimony should undergo a *Daubert* review at the class certification stage.¹⁹⁰ In *American Honda Motor Company v. Allen* the Seventh Circuit held that a *Daubert* review is necessary whenever there is a challenge to expert testimony that is critical to class certification,¹⁹¹ and the Court again reinforced this ruling in *Messner*.¹⁹² However, not all courts follow this approach.¹⁹³ In refraining from dealing with “battles of the experts” during class certification, some courts hold that plaintiffs only need offer a valid method that they can use to prove common impact.¹⁹⁴ While these courts are more deferential to experts and scrutinize their findings less, they are becoming a rarity.¹⁹⁵ For instance, the Third Circuit, a court formerly known for being certification friendly, recently began requiring more rigorous scrutiny of expert testimony for class certification.¹⁹⁶ In *In re: Hydrogen Peroxide*, the Third Circuit held

¹⁸⁹ See Stephen Mahle, BUSINESS LITIGATION IN FLORIDA §13.48 (7th ed. 2012) (discussing the circuits where a *Daubert* review is required at the class certification stage when the opposing party challenges expert testimony).

¹⁹⁰ *Behrend v. Comcast Corp.*, 655 F.3d 182 (3d Cir. 2011) *cert. granted in part*, 133 S. Ct. 24 (U.S. June 25, 2012).

¹⁹¹ *Am. Honda Motor Co., Inc. v. Allen*, 600 F.3d 813, 815–16 (7th Cir. 2010).

¹⁹² *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 812 (7th Cir. 2012), *reh'g denied* (Feb. 28, 2012). See also Bruce D. Sokler, et al., *Antitrust and Class Action Advisory* (Jan. 26, 2012), <http://www.mintz.com/newsletter/2012/Advisories/1611-0112-NAT-AFR/index.htm>.

¹⁹³ The Supreme Court in *Wal-Mart Stores, Inc. v. Dukes* declined to rule on whether *Daubert* applied to expert testimony at the class certification stage. 131 S.Ct. 2541, 2553–54 (2011). However, the Court strongly hinted that it did. *Id.*

¹⁹⁴ Donald Hawthorne & Margaret Sanderson, *Rigorous Analysis of Economic Evidence on Class Certification in Antitrust Cases*, 24–FALL ANTITRUST 55, 55-56 (2009).

¹⁹⁵ See *id.* at 55 (noting that a majority of “federal courts of appeals no longer follow[] this deferential approach but now require[] a rigorous assessment of expert evidence and merits-related issues, supported by findings of fact to explain why class certification is or is not warranted”).

¹⁹⁶ *Id.*

that in determining whether to certify a class, each requirement of Rule 23 must be satisfied, and courts cannot merely rely on a “threshold showing” by a party.¹⁹⁷ In addition, the Third Circuit explained that it must also “resolve all factual or legal disputes relevant to class certification, even if they overlap with the merits—including disputes touching on elements of the cause of action.”¹⁹⁸

Even if the Supreme Court adopts the Seventh Circuit’s requirement for a *Daubert* review, such a ruling will not prevent hospital antitrust classes that rely on DID analyses from becoming certified. Indeed, expert testimony can be critical in motions to certify antitrust class actions. Plaintiffs must demonstrate that antitrust impact is capable of proof at trial, and this demonstration often involves an economic construct that establishes the defendant’s abuse of market power.¹⁹⁹ Though a *Daubert* review is the most stringent review for an expert’s methodology, DID analyses pass *Daubert* reviews with flying colors.

For economic models to withstand *Daubert* review, the expert who created them must rely on a methodology that is scientifically valid, an indicia of which is widespread acceptance.²⁰⁰ Though not much has been written about DID analyses in legal scholarship, this methodology has gained widespread acceptance as evidenced by the use of DID analyses throughout the EHC litigation. During the administrative action, both the FTC and EHC relied on DID analyses without any *Daubert* challenges on either side.²⁰¹ While the FTC does not abide by the rules of evidence in its hearings, the Commission does follow “the spirit of *Daubert*” in determining expert testimony

¹⁹⁷ *In re: Hydrogen Peroxide Antitrust Litig.*, 552 F.3d 305, 307 (3d Cir. 2008).

¹⁹⁸ *Id.*

¹⁹⁹ Interview with Hal Morris, Partner, Arnstein & Lehr, in Chicago, Ill. (Oct. 25, 2012).

²⁰⁰ *Daubert v. Merrell Dow Pharmaceuticals Inc.*, 509 U.S. 579, 592–3 (1993).

²⁰¹ *Evanston Northwestern Healthcare Commission Decision*, *supra* note 6, at 24; *Evanston Northwestern Healthcare Corp.*, No. 9315, 2005 WL 2845790 (F.T.C. Oct. 20, 2005).

admissibility.²⁰² Admittedly, an administrative agency's use of a particular methodology does not necessarily mean that the federal courts will accept it,²⁰³ but it does indicate that the methodology is widely accepted. Furthermore, if Dranove's DID analysis were truly flawed, Northshore would have challenged it²⁰⁴—just as the plaintiffs challenged Northshore's expert report.²⁰⁵

In addition to being widely used, DID analyses are very powerful in that they can control for other causes for price increase when studying a merger's effects.²⁰⁶ This attribute lends credence to the methodology's reliability. For instance, in the EHC litigation, the FTC identified ten factors, including the merger, that could account for EHC's price increases.²⁰⁷ These other factors were:

- (1) Overall increases in costs that affected other Chicago-area hospitals;
- (2) Changes in regulation;
- (3) Increases in demand;
- (4) Increases in quality at EHC above that of other Chicago area hospitals;
- (5) Changes in the complexity of patient cases;
- (6) Changes in payment mix;
- (7) Increases in teaching intensity;

²⁰² *In the Matter of Telebrands Corp., TV Sav., LLC, and Ajit Khubani*, 140 F.T.C. 278, 346 n.32 (2005).

²⁰³ *See Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146, 153 (1997) (J. Stevens concurring in part and dissenting in part) (where expert testimony that relied on the same methodology that the Environmental Protection Agency used was inadmissible).

²⁰⁴ *See, e.g., In re: Hydrogen Peroxide Antitrust Litig.*, 552 F.3d 305, 307 (3rd Cir. 2008) (noting that a "court's obligation to consider all relevant evidence and arguments extends to expert testimony, whether offered by a party seeking class certification or by a party opposing it").

²⁰⁵ *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 812 (7th Cir. 2012), *reh'g denied* (Feb. 28, 2012).

²⁰⁶ *See Evanston Northwestern Healthcare Commission Decision*, *supra* note 6, at 22 (relying on a DID analysis to control for other causes of price increases).

²⁰⁷ *Id.*

- (8) Decreases in prices charged for outpatient services to managed care organizations;
- (9) EHC learning about demand for services from Highland Park Hospital's pricing data;
- (10) Increases in market power resulting from the merger.²⁰⁸

The FTC's expert concluded that the first three causes for price increases were benign, and the expert then created three control groups based on these benign factors for her DID analyses.²⁰⁹ With these control groups, the expert quantified the impact of the benign factors on prices.²¹⁰ The expert then performed another DID analysis to determine whether patient mix, customer mix, and teaching intensity, factors five through seven, could have caused the price increases at EHC.²¹¹ The expert concluded that these factors differed significantly between the control group and EHC, meaning that the control group could not be used to quantify these factors' effects.²¹² The expert then performed a linear regression analysis that compared factors five through seven to Illinois payor data.²¹³ After quantifying the effect of factors five through seven via the regression analysis, the expert then concluded that any post-merger price increases that could not be explained by factors one through seven resulted from EHC's market power.²¹⁴

Given the power of DID analyses to control for benign variables that influence prices and its widespread use, a properly performed DID analysis can easily satisfy *Daubert's* reliability prong. Even if the Supreme Court decides that *Daubert* reviews are required at class certification, such a ruling will not deter hospital antitrust suits. But, despite the existence of a sound model for quantifying monopolistic

²⁰⁸ *Id.*

²⁰⁹ *Id.* at 24.

²¹⁰ *Id.*

²¹¹ *Id.* at 26.

²¹² *Id.*

²¹³ *Id.* at 26–7.

²¹⁴ *Id.* at 27.

practices, future anticompetitive conduct will only be deterred if cases are brought against those who engage in these illegal practices.

B. Trends in Class Action Litigation and the Role of the Private Payor in Vindicating Rights

Antitrust law provides a private right of action with harsh monetary penalties to incentivize private attorneys to litigate for the public good²¹⁵ and serve various other public policy purposes such as compensation, deterrence, and supplementation of the government action.²¹⁶ Private antitrust suits are also often litigated as class actions because individual consumers may suffer only a small amount of damages when a violator unlawfully abuses its market power.²¹⁷ Without the class action mechanism, consumers would abandon their claims because litigation would not be worth their while.²¹⁸ However, settlement, management turnover, and insurers' apathy toward monopoly pricing frustrate antitrust law's public policy goals.

1. Settlement: Thwarting Compensation and Deterrence

Private antitrust remedies compensate plaintiffs for both the injuries they suffer and the cost of litigation, and they deter anticompetitive conduct by making monopolistic practices less profitable.²¹⁹ Prevailing plaintiffs in antitrust suits receive attorneys' fees and treble damages, in the amount equal to three times damages.²²⁰ Treble damages compensate victims who must expend

²¹⁵ Meriwether, *supra* note 177, at 56.

²¹⁶ Crane, *supra* note 13, at 678.

²¹⁷ Christopher Leslie, *De Facto Detrebling: The Rush to Settlement in Antitrust Class Action Litigation*, 50 ARIZ. L. REV. 1009, 1010 (2008).

²¹⁸ *Id.*

²¹⁹ Leslie, *supra* note 217, at 1010.

²²⁰ 15 U.S.C.A. § 15 (West).

enormous resources to hire expert witnesses.²²¹ For instance, a DID analysis costs upwards of five hundred thousand dollars.²²² Yet it is impossible to fully comprehend the deterrent and compensatory impact of antitrust class actions without understanding the effect of settlement. One particularly important aspect of settlement is that despite treble damages being mandatory, federal judges generally refuse to treble antitrust settlements.²²³ The reason for this approach is that treble damages imply fault whereas settlement does not, and settlement negotiations exempt defendants from conceding guilt.²²⁴

Class actions' effectiveness as a means to enforce antitrust law becomes suspect if class counsel rushes to settle to ensure significant payouts for the attorneys while considerably under compensating the class.²²⁵ These collusive settlements undermine "the deterrent effect of private lawsuits and, consequently, of antitrust laws more broadly."²²⁶ In an effort to curb these practices, Congress required federal judicial approval of class action settlements.²²⁷ Nevertheless, even this safety net is inadequate because reviewing judges refuse to treble antitrust damages when suits are settled, and the settlement rate is high in antitrust class actions.²²⁸ Therefore, the threat of treble damages is minimized, and antitrust deterrence and compensation are less effective.²²⁹

While settlement alleviates some of the risk for plaintiffs given the complexity and drawn-out nature of antitrust litigation, the majority of settlements deny antitrust victims full recovery of the

²²¹ J. Douglas Richards, *What Makes an Antitrust Class Action Remedy Successful?: A Tale of Two Settlements*, 80 TUL. L. REV. 621, 633 (2005).

²²² Dranove Interview, *supra* note 173.

²²³ Leslie, *supra* note 217, at 1018.

²²⁴ *Id.* at 1024.

²²⁵ *Id.* at 1010.

²²⁶ *Id.*

²²⁷ *Id.*

²²⁸ *Id.* at 1010–11.

²²⁹ *Id.*

damages they suffered.²³⁰ Class actions suffer from classic agency problems because class counsel controls the settlement process and class members generally do not monitor their case.²³¹ The disconnect between counsel and the clients benefits the defendant, who aims to minimize expenditures and includes litigation costs in its payment to the class.²³² Defendants are also indifferent to the allocation of the payout between class and counsel.²³³ Therefore, settlement negotiations provide class counsel “an opportunity to entice defendants to reduce their total payments by providing counsel with generous fees but affording inadequate compensation to the class.”²³⁴ Hence, settlements deny class members their legal remedies, fail to disgorge the defendant’s ill-gotten gains, and potentially render antitrust class actions a mere cost of doing business.²³⁵

2. Hospital Management Passes the Buck

For private antitrust litigation to serve its deterrent purpose, the plaintiffs’ remedies also must directly impact the individuals within hospitals who engage in anticompetitive conduct.²³⁶ Unfortunately, the individuals who have the authority to approve a hospital merger are in upper-level management, and private antitrust litigation often outlasts the tenure of a hospital CEO.²³⁷ In short, turnover thwarts the deterrent objective because upper level management does not internalize the effects of an antitrust judgment.²³⁸

²³⁰ *Id.* at 1014.

²³¹ *Id.* at 1015.

²³² *Id.* at 1016.

²³³ *Id.*

²³⁴ *Id.* (internal quotation omitted).

²³⁵ *Id.* (internal quotations omitted).

²³⁶ Crane, *supra* note 13, at 690.

²³⁷ *See id.* (describing this phenomena in the private sector).

²³⁸ *Id.* at 694.

The average time to dispose of a civil case in federal court was 18.5 months in 1996, and it increased to 24.6 months in 2007.²³⁹ Because of the complexities of antitrust litigation, these cases are undoubtedly litigated for longer periods of time than others.²⁴⁰ For instance, in 2007, 378 federal antitrust cases had been pending for more than three years.²⁴¹ Based on these numbers, the estimated length of time from planning anticompetitive conduct to payment of a substantial settlement exceeds five years.²⁴² At the same time, the average tenure of a hospital CEO is 3.8 years.²⁴³

Compounding the problem is the fact that C-suite pay at a health system is approximately 40% more than at an independent hospital.²⁴⁴ Such a large difference in pay indicates that there are strong incentives for upper-level management to grow a hospital, and the easiest way to grow an organization is through consolidation. There is also little evidence to suggest that an antitrust judgment could harm a manager's reputation because the decision to engage in anticompetitive conduct is often a collective one.²⁴⁵ Therefore, it is difficult to pin the blame on one individual.²⁴⁶

On the other hand, upper level management is not completely unscathed by antitrust litigation. For one, these lawsuits are expensive and time consuming, and defendants disproportionately bear the

²³⁹ *Id.* at 691–2.

²⁴⁰ *Id.* at 692.

²⁴¹ *Id.*

²⁴² *Id.*

²⁴³ Joe Carlson, *Top executives staying put*, MODERNHEALTHCARE.COM (Mar. 14, 2011), <http://www.modernhealthcare.com/article/20110314/MAGAZINE/303149929>.

²⁴⁴ See Sabrina Rodak, *11 Hospital, Health System Executive Compensation Trends*, BECKER'S HOSPITAL REVIEW (May 8, 2012), <http://www.beckershospitalreview.com/compensation-issues/11-hospital-health-system-executive-compensation-trends.html> (percentage calculation based on data for 2011 C-suit hospital compensation).

²⁴⁵ Crane, *supra* note 13, at 694.

²⁴⁶ *Id.*

costs.²⁴⁷ CEOs and CFOs also care greatly about containing legal fees,²⁴⁸ and becoming embroiled in a lawsuit that could take years to resolve is not ideal from a cost perspective. Settlement can also accelerate payouts, but these settlements generally occur on the eve of trial unless the case is a government tag along.²⁴⁹

When management conduct brings increases in profits with only potential future liabilities, managers tend to choose immediate profits because they apply a discount to any future judgment.²⁵⁰ This is a financial concept known as the time value of money, where money today is worth more than money in the future. Additionally, the longer it takes to pay money out, the less its present value is worth. Given that the incentives to engage in anticompetitive behavior for short-term gains outweigh the remote probability of being held accountable, managers will discount the threat of litigation.²⁵¹ Hence, deterrence fails.

3. Private Insurers' Role in Supplementing Government Enforcement Actions

Private antitrust litigation supplements government action because the government lacks the resources to detect and prosecute all anticompetitive conduct.²⁵² Detecting hospitals' anticompetitive conduct is difficult, and only insurers are in a position to do so. Due to the complexities and lack of transparency associated with hospital billing, it is impossible for individual patients to know when they pay for monopoly-priced services.²⁵³ Because insurers negotiate service

²⁴⁷ *Id.* at 695.

²⁴⁸ *Id.* at 695–96.

²⁴⁹ *Id.*

²⁵⁰ *Id.* at 694.

²⁵¹ *Id.*

²⁵² Leslie, *supra* note 217, at 1010.

²⁵³ See Elisabeth Rosenthal, *Price for a New Hip? Many Hospitals Are Stumped*, N.Y. TIMES (Feb. 11, 2013), available at <http://well.blogs.nytimes.com/2013/02/11/price-for-a-new-hip-many-hospitals-are-stumped/?hp> (describing that it is practically impossible for a patient to call a

contracts with numerous hospitals, only they have the ability to compare price increases among providers within a market. By tracking price data, insurers can detect monopolistic activity even if there has been no government enforcement action. And indeed, insurers do monitor the cost of services closely. In the administrative hearing, insurers testified that EHC's newly formed hospital network had more bargaining power, and contracting managers testified that the hospital network commanded substantial price increases post-merger.²⁵⁴

However, there is no evidence to suggest that insurers are willing to sue providers,²⁵⁵ and they must be willing to do so to act as an effective market check. Because demand for health insurance is inelastic, meaning that an increase in price will not necessarily change demand,²⁵⁶ insurers are in a position to pass the cost of monopoly priced services to their customers. Therefore, insurers are not incentivized to bring antitrust suits. Increasing prices for consumers is much easier than becoming involved in expensive and time-consuming antitrust cases against hospitals. While insurers will express concern about a hospital's anticompetitive conduct to Regulators, they prefer to maintain productive relationships with providers.²⁵⁷

The history of the *Messner* case is a perfect example of insurers' unwillingness to participate in antitrust actions. In the administrative hearing, the FTC's expert found that EHC increased prices for Aetna,

hospital and get a quote for medial procedures). *See also* *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 821 (7th Cir. 2012), *reh'g denied* (Feb. 28, 2012) (noting that over time the service contracts that Dranove studied in his expert report changed pricing methodologies).

²⁵⁴ *Evanston Northwestern Healthcare Commission Decision*, *supra* note 6, at 13–19.

²⁵⁵ *See* Dranove Interview, *supra* note 173 (stating that insurers prefer to maintain good relationships with hospitals).

²⁵⁶ Su Liu & Deborah Chollet, *Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature*, MATHEMATICA POLICY RESEARCH, INC. (Mar. 24, 2006), *available at*, <http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf>.

²⁵⁷ Dranove Interview, *supra* note 173.

Humana, United, and Great West anywhere from 21.3% to 93.2%,²⁵⁸ and yet, none of these insurers participated in *Messner*.²⁵⁹ Given insurers' unwillingness to bring these cases, the ruling in *Messner* is unlikely to spur private antitrust suits absent a prior government enforcement action.

CONCLUSION

Ultimately, the Regulator's role in monitoring and prosecuting anticompetitive conduct will become increasingly important as the ACA continues to prompt an unprecedented number of mergers. Unless insurers are forced to change either their contracting processes or their models for charging premiums, they will continue to be an ineffective market check. With enhanced market power, management at these newly formed hospital networks and ACOs will be tempted to leverage their negotiating power to increase revenues. The temptation to charge monopolistic prices will be particularly strong if Medicare reimbursement rates continue to decline (a likely scenario), and management is forced to rely on service contracts with private payors to increase revenues.

However, if management does not temper its desire for higher profits, there will be consequences for hospitals. Should providers fail to produce better care coordination and lower healthcare costs, they will find themselves under immense political pressure and scrutiny to do so. Regulators, armed with a new approach to define hospital product markets, will conduct post-merger reviews and bring enforcement actions if necessary. At the very least, *Messner* provides a framework for future government tag along class actions. Though class actions cannot deter all of management's anticompetitive

²⁵⁸ *Evanston Northwestern Healthcare Commission Decision*, *supra* note 6, at 21.

²⁵⁹ See Complaint at 3, *Evanston Northwestern Healthcare Corporation Antitrust Litigation*, 2008 WL 4962356 (N.D. Ill. 2008) (No. 07-CV-4446) (plaintiffs listed in the most recent complaint include two individuals, a small Illinois corporation, and a union benefit plan).

conduct, *Messner* will have some deterrent effect given that it will prompt hospital management to reassess its litigation risks.²⁶⁰

²⁶⁰ Crane, *supra* note 13, at 697 n.103 (noting that deterrence is most effective among the targeted firm's competitors).