IN THE MATTER OF

ALVEY HOLDINGS, INC., ET AL.

CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATION OF SEC. 7 OF THE CLAYTON ACT AND SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT

Docket C-3488. Complaint, Mar. 30, 1994--Decision, Mar. 30, 1994

This consent order requires, among other things, a Missouri-based corporation and its wholly-owned subsidiary to divest, to a Commission-approved buyer, its own horizontal carousel business within six months of acquiring White Storage & Retrieval Systems, Inc., otherwise, a Commission-appointed trustee will complete the divestiture. In addition, the respondents are required to comply with all the terms of a Hold Separate Agreement, and are prohibited, for a period of ten years, from acquiring, without prior Commission approval, any interest in any entity engaged in the manufacture or sale of horizontal carousels in the United States within the previous two years.

Appearances

For the Commission: *M. Howard Morse, Allee A. Ramadhan* and *Morris A. Bloom.*

For the respondents: *James Clark* and *Kenneth Doran, Gibson, Dunn & Crutcher,* Los Angeles, CA.

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, and by virtue of the authority vested in it by said Act, the Federal Trade Commission ("Commission"), having reason to believe that respondents Alvey Holdings, Inc., and Alvey, Inc. (collectively Alvey), have entered into a Stock Purchase Agreement in which Alvey agreed to purchase from Donald J. Weiss 100% of the voting securities of White Storage & Retrieval Systems, Inc. ("White"), in violation of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. 45, and that such acquisition, if consummated, would violate Section 7 of the Clayton Act, as amended, 15 U.S.C. 18, and Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. 45, and it appearing to the Commission that a proceeding

in respect thereof would be in the public interest, hereby issues its complaint, stating its charges as follows:

I. RESPONDENTS

1. Respondent Alvey Holdings, Inc. is a corporation organized, existing and doing business under and by virtue of the laws of the State of Delaware.

2. Respondent Alvey, Inc. is a corporation which is a wholly-owned subsidiary of Alvey Holdings, Inc., and is organized, existing, and doing business under and by virtue of the laws of the State of Missouri. Both Alvey Holdings, Inc. and Alvey, Inc. have their principal places of business located at 9301 Olive Boulevard, St. Louis, Missouri.

3. The Buschman Company, a wholly-owned subsidiary of Alvey Inc., makes and sells horizontal carousels through its Diamond Machinery Division headquartered in Lewiston, Maine.

4. Respondents at all times relevant herein have been, engaged in commerce as "commerce" is defined in Section 1 of the Clayton Act, as amended, 15 U.S.C. 12, and are corporations whose businesses are in or affects commerce as "commerce" is defined in Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. 44.

II. THE ACQUISITION

5. Respondents have agreed to acquire the stock of White Storage & Retrieval Systems, Inc. (White), a New Jersey corporation, for approximately $17 million in cash. White makes and sells automated storage and retrieval systems used by manufacturers and distributors in warehouse and industrial settings. White is the United States' leading horizontal carousel producer.

III. THE RELEVANT MARKET

6. The relevant line of commerce within which to analyze the effects of Alvey's proposed acquisition is the manufacture and sale of horizontal carousels. Horizontal carousels are continuous loop, horizontally revolving devices for materials handling storage, generally consisting of drive mechanisms, power sources, controls,

and related software, and automatic load/unload devices. Horizontal carousels are used to store and retrieve medium to high-activity items for warehouse shipping or manufacture.

7. The relevant section of the country within which to analyze the effects of the proposed acquisition is the United States. No foreign made horizontal carousels are sold in the United States. Customers are unwilling to gamble on a manufacturer's ability to supply quick and reliable service when it is not supported by a U.S. based service network. No foreign makers of horizontal carousels have established a sales and service network in the U. S., and to do so would be both time consuming and expensive.

IV. MARKET STRUCTURE

8. There are only four competitors in the United States horizontal carousel market -- White, Alvey's Diamond Machinery Division, Raymond Corporation, and Richards-Wilcox, Inc. -- which collectively make approximately $20 million in sales annually.

9. White is the leading manufacturer and seller of horizontal carousels in the United States with approximately 55% of dollar sales. Alvey is a significant competitor to White in horizontal carousels with around 23% of dollar sales in the U.S. The other firms in the market, both of which have small market shares are perceived as weak competitors.

10. The U.S. horizontal carousel market is already highly concentrated, whether measured by the Herfindahl-Hirschmann Index or four-firm concentration ratios. Alvey's acquisition of White will substantially increase concentration in an already highly concentrated market.

V. ENTRY CONDITIONS

11. Entry into the U.S. horizontal carousel market sufficient to undermine an anticompetitive price increase would take well in excess of two years because of the need for competitors to have reference sites, software, an installed base of customers, and the need to develop an effective reputation for competency in developing system integration capabilities. The risk to customers of purchasing an inadequate system results in a strong emphasis on the reputation of the firms in the bidding process.

VI. EFFECTS OF THE ACQUISITION

12. The effects of the proposed acquisition, if consummated, may be substantially to lessen competition or to tend to create a monopoly in the relevant market in the following ways, among others:

(a) It will eliminate White as a substantial independent competitive force in the relevant market;

(b) It will eliminate actual, direct and substantial competition between Alvey and White;

(c) It will substantially increase the already high concentration in the relevant market;

(d) It will increase the opportunity for coordinated interaction in the relevant market; and

(e) It will allow a combined White/Alvey to unilaterally exercise market power, which will result in higher prices being paid by customers for horizontal carousels.

VII. VIOLATIONS CHARGED

13. The acquisition agreement described in paragraph five of this complaint constitutes a violation of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. 45.

14. The proposed acquisition of White by Alvey, if consummated, would constitute a violation of Section 7 of the Clayton Act, as amended, 15 U.S.C. 18, and Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. 45.

DECISION AND ORDER

The Federal Trade Commission, having initiated an investigation of the proposed acquisition by Alvey Holdings, Inc. and Alvey, Inc. (collectively "Alvey" or respondents) of White Storage and Retrieval Systems, Inc. ("White"), and the respondents having been furnished thereafter with a copy of a draft of complaint which the Bureau of Competition proposed to present to the Commission for its consideration and which, if issued by the Commission, would charge respondents with violation of the Clayton Act and the Federal Trade Commission Act; and

The respondents, their attorney, and counsel for the Commission having thereafter executed an agreement containing a consent order, an admission by the respondents of all the jurisdictional facts set forth in the aforesaid draft of the complaint, a statement that the signing of said agreement is for settlement purposes only and does not constitute an admission by respondents that the law has been violated as alleged in such complaint, and waivers and other provisions as required by the Commission's Rules; and

The Commission, having thereafter considered the matter and having determined that it had reason to believe that the respondents have violated the said Acts, and that the complaint should issue stating its charges in that respect, and having thereupon accepted the executed consent agreement and placed such agreement on the public record for a period of sixty (60) days, and having duly considered the comments filed thereafter by interested persons pursuant to Section 2.34 of its Rules, now in further conformity with the procedure prescribed in Section 2.34 of its Rules, the Commission hereby issues its complaint, makes the following jurisdictional findings and enters the following order:

1. Respondent Alvey Holdings, Inc. is a corporation organized, existing and doing business under and by virtue of the laws of the State of Delaware.

2. Respondent Alvey, Inc. is a corporation which is a wholly-owned subsidiary of Alvey Holdings, Inc., and is organized, existing, and doing business under and by virtue of the laws of the State of Missouri. Both Alvey Holdings, Inc. and Alvey, Inc. have their principal places of business located at 9301 Olive Boulevard, St. Louis, Missouri.

3. The Buschman Company, a wholly-owned subsidiary of Alvey Inc., makes and sells horizontal carousels through its Diamond Machinery Division headquartered in Lewiston, Maine.

4. The Federal Trade Commission has jurisdiction of the subject matter of this proceeding and of the respondents, and the proceeding is in the public interest.

ORDER

I.

It is ordered, That, as used in this order, the following definitions shall apply:

A. "*Alvey*" means collectively Alvey Holdings, Inc., a Delaware corporation, and Alvey, Inc., a Missouri corporation, their predecessors, successors and assigns, divisions, subsidiaries, affiliates, companies, groups, partnerships, and joint ventures that they control, directly or indirectly, and their directors, officers, employees, agents and representatives, and their respective successors and assigns.

B. "*Buschman*" means The Buschman Company, a Delaware corporation, and a wholly-owned subsidiary of Alvey, Inc., and Buschman's predecessors, successors and assigns, divisions, subsidiaries, affiliates, companies, groups, partnerships, and joint ventures that Buschman controls, directly or indirectly, and their directors, officers, employees, agents and representatives, and their respective successors and assigns.

C. "*Diamond*" means the Diamond Machinery Division of Buschman headquartered in Lewiston, Maine, and specifically includes all assets used in or relating to the business of horizontal carousels of Alvey, without regard to title ownership of such assets, including the manufacturing, production, marketing, warehousing, distribution, and research and development facilities, and all other assets, properties, interests, business and goodwill, rights and privileges, tangible and intangible, related thereto, including, without limitation, the following assets attributable to or used by Diamond:

(1) All machinery, fixtures, equipment, vehicles, furniture, tools and all other tangible personal property;

(2) All customer lists, vendor lists, catalogs, sales promotion literature, advertising materials, management information systems, and software;

(3) Technical information, intellectual property rights, trademarks and trade names other than any trademark or trade name which includes in any form the name "Buschman," patents, inventions, trade

secrets, technology, know-how, specifications, designs, drawings, processes and quality control data;

(4) Inventory;

(5) Accounts and notes receivable;

(6) All right, title and interest in and to owned or leased real property, together with appurtenances, licenses and permits;

(7) All right, title and interest in and to the contracts entered into in the ordinary course of business with customers (together with associated bid and performance bonds), suppliers, sales representatives, distributors, agents, personal property lessors, personal property lessees, licensors, licensees, consignors and consignees;

(8) All rights under warranties and guarantees, express or implied;

(9) All books, records and files;

(10) All items of prepaid expense;

(11) All known and unknown, liquidated or unliquidated, contingent or fixed, rights or causes of action which Diamond has or may have against any third party and all such rights which Diamond has or may have in or to any asset; and

(12) All customer (except Buschman Europe A/S) agreements or understandings, whether formal or informal, and all customer records and files.

D. "*White*" means White Storage & Retrieval Systems, Inc., a New Jersey corporation.

E. "*Acquisition*" means the stock acquisition of White by Alvey from Donald J. Weiss, as referenced in Commission Premerger Report Number 93-1624.

F. "*Commission*" means the Federal Trade Commission.

G. "*Horizontal Carousels*" means continuous loop, horizontally revolving devices for materials handling and storage, and generally consisting of drive mechanisms, power sources, controls, related software, and automatic load/unload devices.

II.

It is further ordered, That, Alvey shall comply with all the terms of the Hold Separate Agreement attached hereto as Appendix A and made a part of this order. The Hold Separate Agreement shall continue in effect until such time as Alvey or the trustee has

accomplished the divestiture required by paragraphs IV and V of this order or until such time as the Hold Separate Agreement provides.

III.

It is further ordered, That, pending divestiture of Diamond, Alvey shall take such action as is necessary to maintain the viability and marketability of Diamond, and shall not cause or permit the destruction, removal, wasting, deterioration or impairment of Diamond, except in the ordinary course of business that does not affect the viability and marketability of Diamond, ordinary wear and tear excepted.

IV.

It is further ordered, That, within six (6) months after the date that this order becomes final, Alvey shall divest, absolutely and in good faith, Diamond. The divestiture shall be made only in a manner that receives the prior approval of the Commission and only to an acquirer that receives the prior approval of the Commission. The purpose of the divestiture is to ensure the continuation of the assets as an ongoing viable business engaged in the manufacture and sale of horizontal carousels, to maintain Diamond as an independent competitor in the horizontal carousel business, and to remedy the lessening of competition resulting from the Acquisition as alleged in the Commission's complaint.

V.

It is further ordered, That:

A. If Alvey has not fully complied, absolutely and in good faith, with paragraph IV of this order within the time period provided in such paragraph, Alvey shall consent to the appointment by the Commission of a trustee to divest Diamond. In the event the Commission or the Attorney General brings an action pursuant to Section 5(1) of the Federal Trade Commission Act, 15 U.S.C. 45(1), or any other statute enforced by the Commission, Alvey shall similarly consent to the appointment of a trustee in such action. Neither the appointment of a trustee nor a decision not to appoint a

trustee under this paragraph shall preclude the Commission or the Attorney General from seeking civil penalties or any other relief available to it, including a court-appointed trustee, pursuant to Section 5(l) of the Federal Trade Commission Act, or any other statute enforced by the Commission, for any failure by Alvey to comply with this order.

B. If a trustee is appointed by the Commission or a court pursuant to paragraph V.A. or this order, Alvey shall consent to the following terms and conditions regarding the trustee's powers, duties, authorities, and responsibilities:

(1) The Commission shall select the trustee, subject to the consent of Alvey, which consent shall not be unreasonably withheld. The trustee shall be a person with experience and expertise in acquisitions and divestitures. If Alvey has not opposed the selection of a proposed trustee within fifteen (15) days after notice by the Commission's staff to Alvey of the identity of the proposed trustee, Alvey shall be deemed to have consented to the selection of the proposed trustee.

(2) Subject to the prior approval of the Commission, the trustee shall have the exclusive power and authority to divest Diamond, and to make any further arrangements that may be reasonably necessary to maintain the viability and competitiveness of Diamond's business.

(3) The trustee shall have twelve (12) months from the date the Commission approves the trust agreement described in paragraph V.B(8) to accomplish the divestiture. If, however, at the end of the twelve-month period, the trustee has submitted a plan of divestiture or believes that the divestiture can be accomplished within a reasonable time, the divestiture period may be extended by the Commission or, in the case of a court-appointed trustee, by the court, provided, however, the Commission may only extend the trustee's divestiture period two (2) times for such reasonable time as the trustee may request, not to exceed one (1) additional year.

(4) The trustee shall have full and complete access to the personnel, books, records, and facilities related to Diamond, or to any other relevant information, as the trustee may request. Alvey shall develop such financial or other information as such trustee may request and shall cooperate with any request of the trustee. Alvey shall take no action to interfere with or impede the trustee's accomplishment of the divestiture. Any delays in the divestiture

caused by Alvey shall extend the time for divestiture under paragraph V.B(3) in an amount equal to the delay, as determined by the Commission or, for a court-appointed trustee, by the court.

(5) Subject to Alvey's absolute and unconditional obligation to divest at no minimum price, and the purpose of the divestiture as stated in paragraph IV of this order, the trustee shall use his or her best efforts to negotiate the most favorable price and terms available for the divestiture. The divestiture shall be made in the manner set out in paragraph IV of this order, provided, however, that if the trustee receives bona fide offers from more than one acquiring entity, and if the Commission determines to approve more than one such acquiring entity, the trustee shall divest to the acquiring entity or entities selected by Alvey from among those approved by the Commission.

(6) The trustee shall serve, without bond or other security, at the cost and expense of Alvey, on such reasonable and customary terms and conditions as the Commission or, in the case of a court-appointed trustee, the court, may set. The trustee shall have authority to employ, at the cost and expense of Alvey, such consultants, accountants, attorneys, investment bankers, business brokers, appraisers, and other representatives and assistants as are reasonably necessary to harry out the trustee's duties and responsibilities. The trustee shall account to Alvey for all monies derived from the divestiture and all expenses incurred. After approval by the Commission and, in the case of a court-appointed trustee, by the court, of the account of the trustee, including fees for his or her services, all remaining monies shall be paid at the direction of Alvey and the trustee's power shall be terminated. The trustee's compensation shall be based in significant part on a Commission arrangement contingent on the trustee's divesting Diamond.

(7) Alvey shall indemnify the trustee and hold the trustee harmless against any losses, claims, damages, liabilities, or expenses arising out of, or in connection with, the performance of the trusteeship, including all reasonable fees of counsel and other expenses incurred in connection with the preparation for, or defense of any claim, whether or not resulting in any liability, except to the extent that such liabilities, losses, damages, claims, or expenses result from misfeasance, negligence, willful or wanton acts, or bad faith by the trustee.

(8) Within ten (10) days after appointment of the trustee, and subject to the prior approval of the Commission and, in the case of a court-appointed trustee, of the court, Alvey shall execute a trust agreement that transfers to the trustee all rights and powers necessary to permit the trustee to effect the divestiture required by this order.

(9) If the trustee ceases to act or fails to act diligently, a substitute trustee shall be appointed in the same manner as provided in paragraph V.A. of this order.

(10) The Commission or, in the case of a court-appointed trustee, the court may on its own initiative or at the request of the trustee issue such additional orders or directions as may be necessary or appropriate to accomplish the divestiture required by this order.

(11) The trustee shall have no obligation or authority to operate or maintain Diamond.

(12) The trustee shall report in writing to Alvey and to the Commission every sixty (60) days concerning the trustee's efforts to accomplish divestiture.

VI.

It is further ordered, That, within sixty (60) days after the date this order becomes final and every sixty (60) days thereafter until Alvey has fully complied with the provisions of paragraphs II, III, IV and V of this order, Alvey shall submit to the Commission a verified written report setting forth in detail the manner and form in which it intends to comply, is complying, or has complied with those provisions. Alvey shall include in its compliance reports, among other things that are required from time to time, a full description of all substantive contacts or negotiations for the divestiture, including the identity of all parties contacted. Alvey also shall include in its compliance reports copies of all written communications to and from such parties, all internal memoranda, and all reports and recommendations concerning divestiture.

VII.

It is further ordered, That for a period of ten (10) years from the date on which this order becomes final, Alvey shall not, without the prior approval of the Commission, directly or indirectly, through subsidiaries, partnerships, or otherwise:

A. Acquire any stock, share capital, equity or other interest in any concern, corporate or noncorporate, then engaged in, or within the two years prior to such acquisition engaged in, the manufacture or sale of horizontal carousels in the United States.

B. Except in the ordinary course of business, acquire any assets used for, or previously used for (and still suitable for use for) the manufacture of horizontal carousels from any concern, corporate or non-corporate, then engaged in, or within the two years prior to such acquisition engaged in, the manufacture or sale of horizontal carousels in the United States.

On the anniversary of the date on which this order becomes final, and on every anniversary thereafter for the following nine (9) years, Alvey shall file with the Commission a verified written report of its compliance with this paragraph of this order.

VIII.

It is further ordered, That, for the purposes of determining or securing compliance with this order, and subject to any legally recognized privilege, upon written request and on reasonable notice to Alvey, Alvey shall permit any duly authorized representatives of the Commission:

A. Access, during office hours and in the presence of counsel, to inspect and copy all books, ledgers, accounts, correspondence, memoranda and other records and documents in the possession or under the control of Alvey relating to any matters contained in this order; and

B. Upon five (5) days notice to Alvey, and without restraint or interference from Alvey, to interview officers or employees of Alvey, who may have counsel present, regarding such matters.

IX.

It is further ordered, That, Alvey shall notify the Commission at least thirty (30) days prior to any change in Alvey that may affect compliance obligations arising out of this order such as dissolution, assignment, or sale resulting in the emergence of a successor, the creation or dissolution of subsidiaries, or any other change.

APPENDIX A

AGREEMENT TO HOLD SEPARATE

This Agreement to Hold Separate (the "Agreement") is by and between Alvey Holdings, Inc., a corporation organized and existing under the laws of the State of Delaware, and Alvey, Inc., a corporation organized and existing under the laws of the State of Missouri (collectively "Alvey"), both with their principal offices and places of business located at 9301 Olive Boulevard, St. Louis, Missouri, and the Federal Trade Commission (the "Commission"), an independent agency of the United States Government, established under the Federal Trade Commission Act of 1914, 15 U.S.C. 41, *et seq.*, (collectively, the "Parties").

Premises

Whereas, on August 6, 1993, Alvey entered into a Stock Purchase Agreement in which Alvey agreed to purchase from Donald J. Weiss 100% of the voting securities of White Storage & Retrieval Systems, Inc. ("White"), a New Jersey corporation (hereinafter the "Acquisition"); and

Whereas, Alvey and White both own and operate facilities in the United States for the manufacture and sale of horizontal carousels; and

Whereas, the Commission is now investigating the Acquisition to determine if it would violate any of the statutes enforced by the Commission; and

Whereas, if the Commission accepts the attached Agreement Containing Consent Order ("consent order"), the Commission must place it on the public record for a period of at least sixty (60) days and may subsequently withdraw such acceptance pursuant to the provisions of Section 2.34 of the Commission's Rules; and

Whereas, the Commission is concerned that if an understanding is not reached, preserving the *status quo ante* with respect to the horizontal carousel manufacturing facilities owned by Alvey during the period prior to the final acceptance of the consent order by the Commission (after the 60-day public notice period), divestiture resulting from any proceeding challenging the legality of the

Acquisition might not be possible, or might be less than an effective remedy; and

Whereas, the Commission is concerned that if the Acquisition is consummated, it will be necessary to preserve the Commission's ability to require the divestiture of the Diamond Machinery Division ("Diamond") of Alvey's The Buschman Company ("Buschman") subsidiary as described in paragraph I of the consent order and the Commission's right to seek to restore Diamond as a viable competitor in the horizontal carousel business in the United States; and

Whereas, the purpose of this Agreement and the consent order is to:

(i) Preserve Diamond as an independent business pending its divestiture as an ongoing enterprise,

(ii) Remedy any anticompetitive effects of the Acquisition, and

(iii) Preserve Diamond as an ongoing entity engaged in the horizontal carousel business in the United States in the event that divestiture is not achieved; and

Whereas, Alvey's entering into this Agreement shall in no way be construed as an admission by Alvey that the Acquisition is illegal; and

Whereas, Alvey understands that no act or transaction contemplated by this Agreement shall be deemed immune or exempt from the provisions of the antitrust laws or the Federal Trade Commission Act by reason of anything contained in this Agreement;

Now, therefore, the Parties agree, upon understanding that the Commission has determined that it has reason to believe the acquisition may substantially lessen competition, and in consideration of the Commission's agreement that, unless the Commission determines to reject the consent order, it will not seek further relief from Alvey with respect to effects of the Acquisition on horizontal carousel manufacturing and sales in the United States, except that the Commission may exercise any and all rights to enforce this Agreement and the consent order to which it is annexed and made a part thereof, and, in the event the required divestiture is not accomplished, to seek divestiture of Diamond pursuant to the consent Agreement, and other relief, as follows:

1. Alvey agrees to execute and be bound by the attached consent order.

2. Alvey agrees that from the date this Agreement is accepted until the first of the dates listed in subparagraphs 2.a-2.c, hereof, it will comply with the provisions of paragraph 3 of this Agreement:

a. Three business days after the Commission withdraws its acceptance of the consent order pursuant to the provisions of Section 2.34 of the Commission's Rules;

b. 120 days after publication in the Federal Register of the consent order, unless by that date the Commission has finally accepted such order; or

c. The day after the divestiture required by the consent order have been completed.

3. Alvey will hold Diamond, as it is to be reconstituted in accordance with this Agreement, separate and apart on the following terms and conditions:

a. Prior to Alvey acquiring White and within thirty (30) days of the date that this Agreement is accepted by the Commission, Alvey shall cause Diamond to be incorporated as a corporation, separate and distinct from Alvey and/or Buschman, duly organized under and existing by virtue of the laws of the State of Maine, and will effect all formalities and legal requirements necessary to accomplish such incorporation.

b. Diamond shall be held separate and apart and shall be operated independently of Alvey (meaning here and hereinafter, Alvey excluding Diamond and excluding all personnel connected with Diamond as of the date this Agreement was signed) except to the extent that Alvey must exercise direction and control over Diamond to assure compliance with this Agreement or the consent order, or with respect to the services to be provided by Alvey and/or Buschman pursuant to contract, as provided in subparagraph 3.f hereof.

c. Alvey shall not exercise direction or control over, or influence directly or indirectly, Diamond; provided, however, that Alvey may exercise only such direction and control over Diamond as is necessary to assure compliance with this Agreement or the consent order.

d. Alvey shall maintain the viability and marketability of Diamond, and shall not sell, transfer, encumber (other than in the normal course of business), or otherwise impair its marketability or viability.

e. Except for the single Alvey director, officer, employee, or agent serving on the "Diamond Board" (as defined in subparagraph 3.j hereof), Alvey shall not permit any director, officer, employee, or agent of Alvey or White also to be a director, officer or employee of Diamond.

f. Except as required by law or except to the extent that necessary information is exchanged in the course of defending investigations or litigation, obtaining legal advice, acting to assure compliance with this Agreement or the consent order (including accomplishing the divestiture), and except to the extent that certain designated individuals on Alvey's accounting and order confirmation staff may provide accounting and order confirmation services to Diamond on the basis of a contractual arrangement between Alvey and Diamond, Alvey shall not receive or have access to, or the use of, any of Diamond's "material confidential information" not in the public domain. Any such information that is obtained pursuant to this subparagraph shall only be used for the purposes set out in this subparagraph. ("Material confidential information," as used herein, means competitively sensitive or proprietary information not independently known to Alvey, and includes, but is not limited to, customer lists, customers, price lists, prices, individual transactions, marketing methods, patents, technologies, processes, or other trade secrets.)

g. Alvey may retain an independent auditor to monitor the operation of Diamond. Said auditor may report to Alvey on all aspects of the operation of Diamond other than information on customer lists, customers, price lists, prices, individual transactions, marketing methods, patents, technologies, processes, or other trade secrets.

h. Alvey shall not change the composition of the management of Diamond except that: (1) the non-Alvey (as Alvey is defined in subparagraph 3.b hereof) directors or members serving on the Diamond Board (as defined in subparagraph 3.j hereof) shall have the power to remove employees; (2) within five (5) days of the incorporation referred to in paragraph 3.a hereof, Alvey shall be permitted to name and appoint Diamond's corporate officers; and (3)

Richard Anderson, currently Operations Manager for Diamond, and a long-time Buschman employee, may be permitted to transfer back to Cincinnati as had been previously agreed upon.

i. All material transactions out of the ordinary course of business and not precluded by subparagraphs 3.a - 3.h hereof, shall be subject to a majority vote of the Diamond Board (as defined in subparagraph 3.j hereof). The Diamond management shall prepare capital and operating budgets each six (6) months, which shall be subject to approval of a majority of the Diamond Board (as defined in subparagraph 3.j hereof).

j. Alvey shall elect a new three-person board of directors of Diamond ("Diamond Board") once the incorporation referred to in subparagraph 3.a hereof has occurred. The Diamond Board shall have the exclusive authority for managing Diamond. Alvey may elect the directors to the Diamond Board provided, however, that no director of the Diamond Board shall have had prior responsibility for, or knowledge of confidential information regarding Alvey's or White's horizontal carousel business, and no more than one Alvey director, officer, employee, or agent shall be a director of the Diamond Board ("Alvey Director"). Except as permitted by this Agreement, no Alvey Director, so long as he or she serves as a director, shall receive, in his or her capacity as a director of the Diamond Board, material confidential information and shall not disclose any such information received under this Agreement to Alvey or use it to obtain any advantage for Alvey. Such Alvey Director shall participate in matters which come before the Diamond Board only for the limited purpose of considering a capital investment, the hiring of outside services, or lease transactions in amounts exceeding $10,000, and carrying out Alvey's responsibilities under this Agreement or the consent order. Except as permitted by this Agreement, such Alvey Director shall not participate in any matter, or attempt to influence the votes of the other directors with respect to matters, that would involve a conflict of interest if Alvey and Diamond were separate and independent entities. Meetings of the Diamond Board during the term of this Agreement shall be stenographically transcribed and the transcripts retained for two (2) years after the termination of this Agreement.

k. Any Alvey employee who obtains or may obtain confidential information under this Agreement shall enter a confidentiality agreement prohibiting disclosure of confidential information until the

day after the divestiture required by the consent order has been completed.

l. All earnings and profits of Diamond shall be retained separately in or on behalf of Diamond. If necessary, Alvey shall provide Diamond with sufficient working capital to operate at its historic rate of operation.

m. Should the Federal Trade Commission seek in any proceeding to compel Alvey (meaning here and hereinafter Alvey including Diamond) to divest itself of Diamond or to compel Alvey to divest any assets or businesses of Diamond that it may hold, or to seek any other injunctive or equitable relief, Alvey shall not raise any objection based upon the expiration of the applicable Hart-Scott-Rodino Antitrust Improvements Act waiting period or the fact that the Commission has permitted the Acquisition. Alvey waives all rights to contest the validity of this Agreement.

4. For the purpose of determining or securing compliance with this Agreement, subject to any legally recognized privilege, and upon written request with reasonable notice to Alvey made to its principal office, Alvey shall permit any duly authorized representative or representatives of the Commission:

a. Access during the office hours of Alvey and in the presence of counsel to inspect and copy all books, ledgers, accounts, correspondence, memoranda, and other records and documents in the possession or under the control of Alvey relating to compliance with this Agreement;

b. Upon five (5) days notice to Alvey, and without restraint or interference from it, to interview officers or employees of Alvey, who may have counsel present, regarding any such matters.

5. This agreement shall not be binding until approved by the Commission.

IN THE MATTER OF

ADVENTIST HEALTH SYSTEM/WEST, ET AL.

FINAL ORDER, OPINION, ETC., IN REGARD TO ALLEGED VIOLATION OF SEC. 7 OF THE CLAYTON ACT

Docket 9234. Complaint, Nov. 7, 1989--Final Order, April 1, 1994

This final order dismisses a lawsuit challenging the acquisition of Ukiah General Hospital by Adventist Health System/West in Ukiah, California. According to the Commission decision, the evidence did not support the relevant geographic markets alleged in the complaint, which were limited to specific areas of California.

Appearances

For the Commission: *David M. Newman, Erika R. Wodinsky* and *Jeffrey Klurfeld.*

For the respondents: *Thomas Campbell, Gardner, Carton & Douglas,* Chicago, IL. and *Lawrence Dempsey, McDermott & Trayner*, Pasadena, CA.

COMPLAINT

The Federal Trade Commission, having reason to believe that Adventist Health System/West and Ukiah Adventist Hospital have acquired Ukiah General Hospital in violation of Section 7 of the Clayton Act, as amended, 15 U.S.C. 18, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint, pursuant to the provisions of Section 11 of the Clayton Act, as amended, 15 U.S.C. 21, stating its charges as follows:

I. DEFINITIONS

1. For the purposes of this complaint, the following definitions shall apply:

(a) "*Acute care hospital*" or "*hospital*" means a health facility, other than a federally owned facility, having a duly organized

governing body with overall administrative and professional responsibility, and an organized professional staff, that provides 24-hour inpatient care, as well as outpatient services, and which has as a primary function the provision of inpatient services for medical diagnosis, treatment, and care of physically injured or sick persons with short-term or episodic health problems or infirmities.

(b) To "*operate a hospital*" means to own, lease, manage, or otherwise control or direct the operations of a hospital, directly or indirectly.

(c) The "*southeastern Mendocino/western Lake County area*" means the area of central, southern, and eastern Mendocino County, and western Lake County, California, bounded generally on the south by Sonoma County, on the west by the Pacific Coast Mountain Range, on the north by the town of Laytonsville, and on the east by Clear Lake. This area does not include coastal Mendocino County or the eastern portions of Lake County.

II. THE RESPONDENTS

2. Respondent Adventist Health System/West ("AHS/West") a non-profit religious corporation organized, existing and doing business under and by virtue of the laws of the State of California, with its office and principal place of business in Roseville, California, and its mailing address at P.O. Box 619002, Roseville, California. AHS/West is a person subject to the jurisdiction of the Commission pursuant to Section 11 of the Clayton Act, as amended, 15 U.S.C. 21.

3. AHS/West is primarily engaged in the establishment, management, and maintenance of acute care hospitals in the western United States. It owns and operates nineteen hospitals in California, Oregon, Washington, Hawaii, and Utah.

4. Respondent Ukiah Adventist Hospital ("Ukiah Adventist") is a non-profit religious corporation organized, existing and doing business under and by virtue of the laws of the State of California, with its office, principal place of business and mailing address at 275 Hospital Drive, Ukiah, California. Ukiah Adventist operates a hospital facility also called Ukiah Adventist Hospital ("UAH"). Ukiah Adventist is a person subject to the jurisdiction of the Commission pursuant to Section 11 of the Clayton Act, as amended, 15 U.S.C. 21.

5. Ukiah Adventist's members consist exclusively of the members of the Board of Directors of AHS/West. Ukiah Adventist's members elect the majority of the members of the Board of Directors of Ukiah Adventist. Through this affiliation, AHS/West controls Ukiah Adventist.

6. At all times relevant herein, respondents have been and are now engaging in or affecting commerce within the meaning of Section 1 of the Clayton Act, as amended, 15 U.S.C. 12. AHS/West does business in a number of States. AHS/West and Ukiah Adventist, through their hospitals, among other things, have:

(a) Purchased substantial amounts of supplies, equipment and medicines from sources outside of the State of California;

(b) Received substantial revenues from private and governmental insurers located outside of the State of California; and

(c) Treated some patients who travel from or reside outside of the State of California.

7. Until the acquisition described in Section III below, AHS/West owned or operated two acute care hospitals, UAH and Frank R. Howard Memorial Hospital in Willits, California, in the southeastern Mendocino County area.

III. THE ACQUISITION

8. Ukiah Hospital Corporation is a wholly-owned subsidiary of HealthTrust, Inc. - The Hospital Company ("HealthTrust"), a corporation organized and existing under and by virtue of the laws of the State of Delaware, with its executive offices in Nashville, Tennessee. The sole shareholder of Ukiah Hospital corporation is HealthTrust. At the time of the acquisition, HealthTrust owned and operated over 90 acute care hospitals in 21 states, including Ukiah General Hospital ("UGH") in Ukiah, California.

9. At all times relevant herein, HealthTrust and Ukiah Hospital Corporation have been engaging in or affecting commerce within the meaning of Section 1 of the Clayton Act, as amended, 15 U.S.C. 12. HealthTrust does business in a number of States. HealthTrust and Ukiah Hospital Corporation, through their hospitals, among other things, have:

(a) Purchased substantial amounts of supplies, equipment and medicines from sources outside of the State of California;

(b) Received substantial revenues from private and governmental insurers located outside of the State of California; and

(c) Treated some patients who travel from or reside outside of the State of California.

10. On or about July 29, 1988, Ukiah Adventist entered into an agreement with Ukiah Hospital Corporation for Ukiah Adventist to purchase substantially all of the assets of Ukiah Hospital Corporation, including UGH and associated real property, inventories, tangible personal property, and all transferable licenses, as well as the name "Ukiah General Hospital." In consideration thereof, the agreement provided that Ukiah Adventist would pay Ukiah Hospital Corporation approximately $5.9 million. In addition, the agreement provided that Ukiah Hospital Corporation would retain accounts receivable, amounting to approximately $2.4 million.

11. AHS/West negotiated the agreement referred to in paragraph 10, above, on behalf of Ukiah Adventist, served as guarantor of Ukiah Adventist's obligations under that agreement, and ratified the agreement by vote of its Board of Directors.

12. On or about August 8, 1988, Ukiah Adventist and AHS/West, through its control of, and affiliation with, Ukiah Adventist, acquired UGH pursuant to the July 29, 1988 agreement described in paragraph ten, above.

IV. TRADE AND COMMERCE

13. For purposes of this complaint, the relevant line of commerce is acute care hospital services.

14. For purposes of this complaint, the relevant section or sections of the country are the southeastern Mendocino/western Lake County area, the southeastern Mendocino County area, and/or portions of these areas.

15. Prior to the acquisition described above, the relevant markets were highly concentrated, with no more than four firms doing business in the markets. The only hospitals in the southeastern Mendocino/western Lake County area, other than the AHS/West hospitals and UGH, were Mendocino Community Hospital in southeastern Mendocino County, and Lakeside Community Hospital

in western Lake County. In 1987, in the relevant geographic and product markets, AHS/West had a market share of 38% or more; UGH had a market share of 33% or more.

16. Entry into the relevant markets is difficult, due to the following factors, among others:

(a) Substantial lead times required to establish a new hospital, including but not limited to lead times for obtaining regulatory clearance for construction of hospital facilities; and

(b) Sunk costs that are large relative to the total cost for *de novo* entry.

V. THE EFFECTS OF THE ACQUISITION

17. The acquisition of UGH by AHS/West and Ukiah Adventist increased the market share of AHS/West, the largest provider of acute care hospital services in the southeastern Mendocino/western Lake County area from approximately 38% to approximately 71%, and increased the two-firm concentration ratio from approximately 71% to approximately 94%. As a result of the acquisition, the Herfindahl-Hirschmann Index increased by over 2500 points, from approximately 3100 points to approximately 5600 points. In the southeastern Mendocino area, the acquisition of UGH by AHS/West and Ukiah Adventist increased the market share of AHS/West from approximately 49% to approximately 92%, and increased the two-firm concentration ratio from approximately 92% to 100%. As a result of the acquisition, the Herfindahl-Hirschmann Index increased by over 4200 points, from approximately 4340 points to approximately 8580 points.

18. Through their acquisition of UGH, AHS/West and Ukiah Adventist acquired a direct and actual competitor in the relevant markets.

19. The effect of the acquisition of UGH by AHS/West and Ukiah Adventist may be substantially to lessen competition or tend to create a monopoly in the relevant markets in the following ways, among others:

(a) Actual and potential competition in the relevant markets has been substantially reduced;

(b) AHS/West and Ukiah Adventist have obtained a dominant position in the relevant markets;

(c) The likelihood of collusion in the relevant markets has been substantially increased; and

(d) Patients, physicians, and purchasers of health care coverage may be denied the benefits of free and open competition based on price, quality and service.

VI. VIOLATION CHARGED

20. The acquisition of UGH and other assets from Ukiah Hospital Corporation by AHS/West and Ukiah Adventist violates Section 7 of the Clayton Act, as amended, 15 U.S.C. 18, as an acquisition of the whole or any part of the assets of another person, and as an acquisition tantamount in its effects to a merger.

INITIAL DECISION

BY LEWIS F. PARKER, ADMINISTRATIVE LAW JUDGE
AUGUST 2, 1990

I. INTRODUCTION

The Commission issued its complaint in this case on November 7, 1989 charging that Adventist Health System/West ("AHS/West") and Ukiah Adventist Hospital ("Ukiah Adventist") had acquired substantially all of the assets of Ukiah Hospital Corporation ("UHC"), including Ukiah General Hospital ("Ukiah General") in violation of Section 7 of the Clayton Act, as amended, 15 U.S.C. 18.

Respondents filed their answer, denying that AHS/West and Ukiah Adventist are subject to the jurisdiction of the Commission pursuant to Section 11 of the Clayton Act, as amended, 15 U.S.C. 21 (Answer, paragraphs 2, 4).

On February 8, 1990, I issued an order deciding that the Commission did not have Section 7 jurisdiction over respondents under its assets acquisition clause and I granted respondents' motion to dismiss the complaint insofar as it challenged the transaction as a "pure" assets acquisition.

I did not dismiss the complaint *in toto* since it also claims jurisdiction over respondents because the challenged transaction was "tantamount in its effects to a merger" (Complaint, paragraph 20). I deferred ruling on this issue until the factual record was complete.

The parties have now filed stipulations of fact and have moved for summary decision on this issue. The following findings of fact adopt those stipulations and take into account the legal arguments made in the parties' motions.

II. FINDINGS OF FACT

A. *The Respondents*

1. Respondent AHS/West is a non-profit religious corporation organized, existing and doing business under and by virtue of the laws of the State of California, with its office and principal place of business in Roseville, California (Answer, paragraph 2).[1]

2. AHS/west is recognized as exempt from federal income taxation pursuant to Section 501(a) of the Internal Revenue Code of 1986, as amended ("Code"), as an organization described in Code Section 501(c)(3).

3. Respondent Ukiah Adventist doing business as Ukiah Valley Medical Center ("Ukiah Valley") since August, 1989, is a non-profit religious corporation organized, existing and doing business under and by virtue of the laws of the State of California, with its office, principal place of business and mailing address at 275 Hospital Drive, Ukiah, California (Answer, paragraph 4).

4. Ukiah Adventist is recognized as exempt from federal income taxation pursuant to Section 501(a) of the Internal Revenue Code of 1986, as amended ("Code") as an organization described in Code Section 501(c)(3).

5. The members of Ukiah Adventist, for purposes of California non-profit religious corporation law, consist of those individuals serving as the Board of Directors of respondent AHS/West. Ukiah Adventist's members elect the majority of the Board of Directors of Ukiah Adventist. Through this affiliation, the individuals serving as the Board Directors of AHS/West have certain controls over Ukiah Adventist, which include their rights as members in accordance with Ukiah Adventist's articles of incorporation and by-laws and California non-profit religious corporation law (Answer, paragraph 5).

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[1] The parties disagree on the identity of the acquiring person or persons. Respondents believe that the sole acquiring person was Ukiah Adventist, and that AHS/West served only as the guarantor for the acquisition. Complaint counsel believe that AHS/west was also an acquiring person through its control of Ukiah Adventist. Accordingly, the term "the buyer" will be used herein to refer to the acquiring person(s), and nothing in these findings should be construed as waiving any party's position with regard to the identity of the acquiring person(s).

B. *The Acquisition*

6. By an agreement dated July 29, 1988, entitled "Asset Purchase Agreement-Ukiah Hospital Corporation" ("asset purchase agreement"), the buyer acquired substantially all of the assets of UHC that consisted of and were used in the operation of Ukiah General in exchange for $5.6 million in cash, $326,079 for inventories and prepaids accepted by the buyer, and the assumption of certain specific liabilities of UHC (Answer, paragraph 10).

7. Pursuant to Section 1.1 of the asset purchase agreement, the buyer acquired the following assets of UHC:

(a) Real Estate. The land owned by UHC situated in Mendocino County, California, more particularly described at Exhibit 1.1(1) to the asset purchase agreement;

(b) Real Estate Improvements. All buildings, structures, fixtures and improvements then or thereafter erected or located on the real estate;

(c) Appurtenances. All tenements, hereditaments, rights, privileges, interests, easements and appurtenances then or thereafter belonging to or in any way benefitting the real estate or real estate improvements;

(d) Inventories. All inventories of every kind and nature whatsoever of a quality and quantity usable in the ordinary course of business of Ukiah General (specifically including, but not limited to, all pharmacy supplies, medical supplies, office supplies, equipment and maintenance supplies, other supplies and foodstuffs and specifically excluding all supplies, promotional materials, billing forms, stationery and other paper products which identify UHC as the owner or operator of Ukiah General) owned by UHC or in UHC's possession on the date of the asset purchase agreement or thereafter acquired, and relating to Ukiah General;

(e) Tangible Personal Property. All machinery, building materials, appliances, apparatus, motor vehicles, furniture, furnishings, fixtures, tools, instruments, parts and other tangible personal property of every kind and nature whatsoever owned by UHC on the date of the asset purchase agreement, other than the inventories, and all rights, titles and interests of UHC in any tangible personal property being purchased on contract or being leased by UHC on the date of the asset purchase agreement or thereafter

including but not limited to all those items specifically listed in Exhibit 1.1(5);

(f) Intangible Personal Property. All chattel paper, options to lease or purchase realty and/or personalty, contracts rights, documents, instruments, general intangibles, medical records, administrative records, other books and records relating to Ukiah General, all rights of UHC and any affiliate of UHC to the name "Ukiah General Hospital," plans and specifications for all real estate improvements (including but not limited to "as builts"), lien waivers, surety agreements, surety and performance bonds, warranties, guaranties, prepaid expenses, deposits, conditions, covenants, commitments, purchase orders, judgments, causes of action and choses in action relating to the design, development, construction or condition of the assets, contracts and agreements at Exhibit 1.1(6) to be assumed by the buyer, all other intangible personal property of every kind or nature whatsoever owned by UHC on the date of the asset purchase agreement or thereafter acquired and relating to Ukiah General, excepting the excluded assets in Section 1.2 of the asset purchase agreement, contracts and agreements not assumed by the buyer and other assets expressly excluded in the asset purchase agreement; and

(g) Authorizations. All transferable licenses, permits, certificates and franchises necessary to operate and conduct the business of Ukiah General and, to the extent transferable, all waivers of any requirements pertaining to such licenses, permits, certificates and franchises, all as described in Exhibit 1.1(7).

8. Pursuant to Section 1.2 of the asset purchase agreement, the following assets were excluded from the transaction: any cash, cash equivalents, service marks, corporate names (including but not limited to "Hospital Corporation of America," "HealthTrust," and "HealthTrust, Inc. - The Hospital Company" or any variation or combination thereof), patient accounts receivable, notes receivable, any and all claims of UHC against the United States Government under the Medicare program or the State of California under the MediCal (Medicaid) program or of any fiscal intermediary payable to UHC arising out of hospital operations through the closing date, including any claims generated by the sale of the assets, other receivables, intercompany accounts and computer software systems and programs of UHC or Hospital Corporation of America.

9. Through the transaction accomplished pursuant to the asset purchase agreement, the buyer acquired substantially all of the assets of UHC.

10. Pursuant to Section 4.16 of the asset purchase agreement, UHC certified that, except as set forth in Exhibit 4.16 thereto, as of the date on which it executed the asset purchase agreement, neither it nor HealthTrust, nor any subsidiary or affiliate of either, nor, to the best of UHC's knowledge, Hospital Corporation of America, had any direct or indirect interest in any health care related facility, program, franchise, contract or business of any kind or nature whatsoever located in or doing any business in Mendocino County or Lake County, California.

11. Pursuant to Section 5.4 of the asset purchase agreement, the buyer warranted and represented that it had made applications to the appropriate governmental authorities for the transfer of all authorizations and the grant of all other requisite governmental and regulatory approvals necessary to own and operate the acquired assets as part of a general acute care hospital.

12. The buyer did not acquire any stock or share capital of UHC or of any entity in connection with the purchase of substantially all of the assets of UHC.

13. Pursuant to Section 2.2(1) of the asset purchase agreement, the buyer assumed only certain specifically identified liabilities.

14. Pursuant to Section 2.2(2) of the asset purchase agreement, the expressly disclaimed assumption of the following liabilities and obligations of UHC:

(a) Any and all obligations of UHC accruing through the closing date under the assumed agreements;

(b) Any and all claims of the United States Government under the Medicare program or of the State of California under the MediCal (Medicaid) program or of any fiscal intermediary payable by UHC arising out of hospital operations through the closing date, including any claims for recapture of depreciation generated by the sale of the assets;

(c) Federal and state income taxes, if any, payable by UHC with respect to Ukiah General through the closing;

(d) Franchise taxes payable by UHC through the closing;

(e) Sales and other taxes (including, without limitation, use taxes) payable by UHC with respect to the business operations of Ukiah General through the closing;

(f) Any and all liabilities of UHC relating to Ukiah General for acts or omissions, including medical malpractice, arising prior to or on the closing date;

(g) Any and all obligations, and responsibilities under all laws (as defined in Section 4.12 of the asset purchase agreement) and agreements due or owed to or concerning any of the UHC's hospital employees;

(h) Any other debt, obligation, or liability not specifically and expressly included in the assumed liabilities, whether or not such debt, obligation, or liability is disclosed in any financial statement (and notes thereto) or any other document which was or may have been delivered by or on behalf of UHC to the buyer.

15. The acquisition of assets described in the asset purchase agreement involved no change in the corporate structure of either Ukiah Adventist or UHC. According to the Office of the Secretary of State for the State of California, UHC is currently an existing corporation in good standing under California law.

16. The asset purchase agreement does not contain any language requiring that UHC be dissolved or that it refrain from completing in the relevant market.

17. Pursuant to the asset purchase agreement, the buyer did not acquire the management personnel of UHC.

18. Pursuant to the asset purchase agreement, UHC did not acquire any voice in the decisions of the buyer, and the buyer did not acquire any voice in the decisions of UHC.

19. The asset purchase agreement did not provide for the assumption by the buyer of any employment contracts between UHC and UHC's employees. Pursuant to Section 9.11 of the asset purchase agreement, UHC terminated the non-management employees of Ukiah General prior to closing. After the closing, Ukiah Adventist hired a majority of individuals that were formerly non-management employees of Ukiah General. The former Ukiah General employees that were hired by Ukiah Adventist were required to formally apply and interview for positions with Ukiah Adventist. These hirings were not a condition in the asset purchase agreement.

20. The buyer assumed or otherwise acquired only those contracts and agreements of UHC which it specifically agreed to assume or acquire, which contracts and agreements are described in Exhibit 1.1(6) to the asset purchase agreement. With the exception of those specifically identified contracts and agreements, the buyer either had its own contracts or renegotiated new contracts.

21. UHC's shareholders or affiliated entities obtained no interest in the buyer and retained no interest in the acquired assets.

22. The buyer did not acquire all of the rights, powers, liabilities, fiduciary rights and obligations of UHC.

23. California corporate law requires that non-profit corporation involved in a merger file appropriate documentation with the State of California. Calif. Corp. Code §§6010-6014 (Deering 1990). The buyer did not file documentation with the State of California that would have reported a merger.

III. CONCLUSIONS OF LAW

Assuming the necessary adverse competitive effects, Section 7 of the Clayton Act outlaws both stock and assets acquisitions. However, the coverage of the assets acquisition clause of Section 7 is limited to persons subject to the jurisdiction of the Federal Trade Commission.[2]

In a prior order in this case (Order Ruling on Respondents' Motion to Dismiss, (Feb. 8, 1990)), I agreed with respondents that one must look to Section 5 of the FTC Act to determine the Commission's Clayton Act jurisdiction rather than to Section 11 of the Clayton Act as complaint counsel argue. Because the Commission does not have FTC Act jurisdiction over not-for-profit entities like respondents,[3] I held that it did not have Clayton Act jurisdiction over the challenged assets acquisition.

Since the challenged transaction was not a stock acquisition (Finding (F.) 12) -- the only other explicit Section 7 jurisdictional alternative -- my decision would have required dismissal of this case except for the allegation in paragraph 20 of the complaint that the assets acquisition was "tantamount in its effects to a merger,"

[2] "[N]o person subject to the jurisdiction of the Federal Trade Commission shall acquire the whole or any part of the assets of another person. . . ."

[3] *See Community Blood Bank of the Kansas City Area*, 405 F.2d 1011, 1020-22 (8th Cir.).

language which is taken from the Supreme Court's decision in *Philadelphia National Bank*, 374 U.S. 321 (1963), where it held:

[I]f such an exchange [of stock for assets] (or other clearly evasive transaction) were tantamount in its effects to a merger, the exchange would not be an 'assets' acquisition within the meaning of §7 but would be treated as a transaction subject to that section.

Id. At 344, n.22

The Supreme Court recognized that Section 7 jurisdiction did not attach to assets acquisitions by persons not subject to FTC jurisdiction, but it held that this exception:

excludes from the coverage of §7 only assets acquisitions by such corporations when not accomplished by merger.

374 U.S. at 342.

Two district court decisions have followed the Supreme Court's approach to assets acquisitions accomplished by merger.

In *United States v. Chelsea Savings Bank*, 300 F. Supp. 721 (D. Conn. 1965), the court held that the consolidation of non-stock corporations which combined the economic power of two banks, Chelsea and Dime, was tantamount in its effects to a merger because it resulted in the formation of a new bank (The Chelsea-Dime Savings Bank) whose affairs would be managed by a single board of directors. *Id.* at 723-24.

In *United States v. Rockford Memorial Corp.*, 717 f. Supp. 1251 (N.D. Ill. 1989), the district court decided that the government had Section 7 jurisdiction over a non-stock consolidation of not-for-profit hospitals.

The court recognized that "Section 7 does not reach non-merger assets acquisitions accomplished by persons not under the FTC's jurisdiction," *Id.* at 1254, but found that the transaction challenged by the government was "clearly a merger, not a pure assets acquisition" because:

The two existing corporations are subsumed into a new resulting entity. The resulting corporation inherits the program, services, management, rights, liabilities, obligations and abilities of Swedish American Corporation and Rockford Memorial Corporation. There will be continuity in management and personnel after the

consolidation, since representation [sic] of both corporations will oversee the new resulting corporation.

Id. at 1258.

The court referred to the following language in *Philadelphia National Bank*, 374 U.S. at 336 n.13, as the test for distinguishing between a sale of assets and a typical merger:

> A merger necessarily involves the complete disappearance of one of the merging corporations. A sale of assets, on the other hand, may involve no more than a substitution of cash for some part of the selling company's properties, with no change in corporate structure and no change in stockholder interests.[4]

It is apparent that the present assets acquisition differs from those in Chelsea and Rockford Memorial. In those cases, the acquisitions resulted in the disappearance of the acquired entities through consolidation whereas here, although substantially all of the assets of UHC were acquired (F. 9), there is no dispute that it still exists (F. 15), that the buyer did not file documents with the State of California reporting a merger (F. 23), that the buyer did not acquire UHC's management personnel (F. 17) or its employment contracts (F. 19), that the buyer did not acquire all of UHC's assets, rights, powers, liabilities, or obligations (F. 8, 14, 20, 22), and that neither party obtained any voice in decisions made by the other (F. 18).

The district court's decision in Rockford was overturned by the Seventh Circuit, *United States v. Rockford Memorial Corporation*, 898 F.2d 1278 (7th Cir. 1990), and the opinion by Judge Posner in that case suggests that the Supreme Court's decision in Philadelphia National Bank should be narrowly construed:

> The approach to statutory interpretation that informs Philadelphia National Bank is controversial, but it is neither indefensible nor irrelevant to the interpretive question in the present case. The approach, premised on recognition that legislative draftsmanship is often a rushed and clumsy process, deficient in foresight, tries to carry out the purposes of the statute insofar as these can be inferred, even if the result is a wide departure from literal meaning. But whatever its merits, it is not an approach in vogue in the Supreme Court at the moment and we hesitate to push it further than it was pushed in Philadelphia National Bank.

Id. At 1281

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[4] While this language is a quotation from the government's brief, I believe that the Court considered it persuasive. *See also* 15 Fletcher Cyclopedia Corporations § 7041 (Perm. ed. 1983).

In Rockford, the main reason for rejection of the lower court's decision was the fact that the acquired company had no stock or share capital. UHC is a for-profit stock corporation, but the issue before me is whether the Commission has jurisdiction over the acquisition by the respondents, AHS/West and Ukiah Adventist, which are not-for-profit corporations. In deciding that issue, I consider Judge Posner's reluctance to push the rationale of Philadelphia National Bank to extremes a persuasive approach to the question before me.

Complaint counsel's jurisdictional argument is an extreme one, in my view. There is no doubt, as complaint counsel argue, that assets acquisitions can have the same competitive effects as stock acquisitions -- indeed, that is why Congress amended the Clayton Act, *Philadelphia National Bank*, 374 U.S. at 340-41 -- but the statute has different jurisdictional tests for stock and assets acquisitions, a distinction which complaint counsel ignore by asserting that the "nominal form" of any assets acquisition can be ignored (Complaint Counsel's Motion for Partial Summary Decision, p. 7). I agree with respondents that this theory "proposes a standard whereby all transactions can be reached by the stock clause of Section 7" (Respondents' Motion for Summary Decision, p. 13).

That is not what Philadelphia National Bank held; rather, it looked to the form of the assets acquisition in question and found jurisdiction only because it was "accomplished by merger," 374 U.S. at 342, as did the district courts in Chelsea Savings and Rockford Memorial, and I find that in this case the assets acquisition challenged by the Commission was not accomplished by merger.

IV. ORDER

Therefore, since the Commission does not have Section 7 Clayton Act jurisdiction over respondents,

It is ordered that the complaint be, and it hereby is, dismissed.

INITIAL DECISION

BY LEWIS F. PARKER, ADMINISTRATIVE LAW JUDGE
DECEMBER 9, 1992

I. HISTORY OF THE PROCEEDING

On November 7, 1989, the Commission issued a complaint charging that Adventist Health System/West ("AHS/West") and Ukiah Adventist Hospital ("Ukiah Adventist") had acquired Ukiah General Hospital ("UGH") in violation of Section 7 of the Clayton Act, as amended, 15 U.S.C. 18.

The complaint alleges that AHS/West, a nonprofit religious corporation which establishes, manages, and maintains acute care hospitals in the western United States, controls Ukiah Adventist, the operator of a hospital facility called Ukiah Adventist Hospital ("UAH"), which is located in Ukiah, California.

The complaint further alleges that on or about July 29, 1988, Ukiah Adventist agreed with Ukiah Hospital Corporation ("UHC"), a wholly owned subsidiary of HealthTrust, Inc. ("HealthTrust"), to purchase substantially all of the assets of UHC, including UGH, an acute care hospital also located in Ukiah, California. The transaction was consummated on August 8, 1988.

According to the complaint, the acquisition of UGH by AHS/West and Ukiah Adventist increased the market share of AHS/West in the southeastern Mendocino/Lake County area from approximately 38 percent to 71 percent, and the HHI from approximately 3100 points to 5600 points. In the southeastern Mendocino county area, the HHI allegedly increased from approximately 4340 points to 8580 points.

The complaint concludes that the effect of the acquisition of UGH by AHS/West and Ukiah Adventist may be substantially to lessen competition or tend to create a monopoly in the relevant markets.

Shortly before trial began, complaint counsel moved for partial summary decision, and I ruled in their favor on several issues. Specifically, I found in my July 6, 1992, order that:

1. The interstate commerce requirements of Section 7 of the Clayton Act are satisfied.
2. Respondent AHS/West is properly named as a respondent.
3. The market share of Frank R. Howard Memorial Hospital in Willits, California, is attributable to respondents.
4. Respondents cannot sustain their burden of establishing a "failing firm" defense.

Trial began on July 13, 1992, in San Francisco, California. It ended on July 24, 1992. On September 4, 1992, respondents filed an offer of proof with respect to their rejected failing firm defense. After complaint counsel filed their reply to the offer of proof, I closed the record on September 25, 1992. The parties filed their proposed findings of fact and conclusions of law on September 25, 1992. Answers were filed on October 30, 1992.

This decision is based on the transcript of testimony, the exhibits which I received in evidence, and the proposed findings of fact and answers thereto filed by the parties. I have adopted several proposed findings verbatim. Others have been adopted in substance. All other findings are rejected either because they are not supported by the facts or because they are irrelevant.

II. FINDINGS OF FACT

A. *The Respondents*

1. AHS/West

1. AHS/West is a nonprofit religious corporation organized, existing and doing business under and by virtue of the laws of the State of California, with its office and principal place of business in Roseville, California (Ans. paragraph 2; Tr. 337, 342, 346).[1] AHS/West manages and controls 18 nonprofit hospitals, including respondent UAH, in California, Hawaii, Oregon, Utah, and Washington (CX-13-A-3, A-4, A-10 to A-19). The combined patient revenues of the AHS/West hospital system were more than $600 million in 1990 (*Id.*, A-5). AHS/West is affiliated with the Seventh-Day Adventist Church which has been involved in health care since approximately 1863 (Tr. 344).

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[1] Abbreviations used in this decision are:

Ans. : Answer
CPF : Complaint Counsel's proposed findings
RPF : Respondents' proposed findings
CX : Commission Exhibit
RX : Respondents' Exhiibt
Tr.: Transcript of the proceeding
F: Finding of fact
SD: Partial Summary Decision of July 6, 1992

2. Ukiah Adventist

2. Ukiah Adventist is a nonprofit corporation organized, existing, and doing business under and by virtue of the laws of the State of California, with its office and principal place of business in Ukiah, California (Ans. paragraph 4). Prior to the acquisition, it operated UAH, a 43-bed general acute care hospital (CX-4-A, paragraph 25; Cal. Health & Safety Code Section 1250(a), (Deering 1990)) at 275 Hospital Drive, Ukiah, California.

B. *The Acquisition*

3. HealthTrust is a Delaware corporation with its executive offices located in Nashville, Tennessee (CX-4-B, paragraph 30; CX-64-C). Prior to the acquisition, HealthTrust was the sole shareholder of UHC, a California corporation which operated UGH, a 51-bed general acute care hospital in Ukiah, California.

4. In 1988 HealthTrust and its subsidiaries owned and operated 95 general acute care hospitals with 13,232 licensed beds in 21 states (CX-4-B, paragraph 32; CX-64-B). HealthTrust had $1,666,102,000 in net operating revenues for the year ending August 31, 1988 (CX-64-J).

5. On July 29, 1988, UAH entered into an agreement with UHC for UAH to purchase substantially all of the assets of UGH, excepting only accounts receivable, for approximately $5.9 million (Ans. paragraph 10; CX-6-G). AHS/West initially proposed the acquisition to HealthTrust in October 1987 (SD paragraph 13) and it negotiated the July 29, 1988, agreement on behalf of UAH, served as guarantor of UAH's obligations under this agreement, and ratified the agreement by vote of its Board of Directors (SD pp. 9-11; Ans. paragraph 11; CX-6-Z-4; CX-9). On August 8, 1988, respondents acquired UGH pursuant to the July 29, 1988, agreement (CX-7; CX-8; Tr. 1049).

6. Respondents' purchase of UGH from UHC was part of a three-party transaction. This transaction involved (a) AHS/West purchasing UGH from HealthTrust for $5.9 million; (b) HealthTrust purchasing Scott Memorial Hospital, a 64-bed hospital in Lawrenceburg, Tennessee, from Adventist Health System/Sunbelt ("AHS/Sunbelt") for $1.2 million; and (c) AHS/West agreeing to pay AHS/Sunbelt $400,000 plus a share of UAH's profits for the

following ten years (CX-19-A; CX-20-C; Tr. 380-82, 409-11; *see also* RX-306-I-L; RX-311-F-G). In 1991, respondents paid AHS/Sunbelt $1.675 million to resolve the remaining obligations under their agreement with AHS/Sunbelt (CX-29-B; Tr. 382, 421).

7. The total cost to respondents of acquiring UGH was $7.975 million, including $5.9 million paid to HealthTrust, $400,000 paid by respondents to AHS/Sunbelt at the time of the transaction, and $1.675 million paid by respondents to AHS/Sunbelt in 1991 (CX-20-C; CX-29-B; Tr. 382, 421).

8. UAH, now known as Ukiah Valley Medical Center ("Ukiah Valley"), has, since August 1988, operated as a 94-bed acute care general hospital in Ukiah (Tr. 338, 1050; CX-32-D).

C. *Hospitals In Ukiah Prior To The Acquisition*

9. Prior to August 1988, there were three acute care general hospitals in Ukiah: Ukiah Valley (43 beds), then known as UAH, UGH (51 beds) and Mendocino Community Hospital ("Mendocino Hospital") (56 beds) (Tr. 182, 1050, 1203; RX-30-W). These hospitals were quite small compared to others in the hospital industry (Tr. 1050).

10. Prior to the acquisition, UAH and UGH had a 50-60 percent occupancy rate (Tr. 1052; RX-353-O); Mendocino Hospital's occupancy rate for the 1987-88 fiscal year was 15.7 percent (RX-110-A).

11. When Ann Mahoney assumed her duties as administrator of Mendocino Hospital in 1987, it was in poor financial condition; it had a deficit of approximately $325,000 to $350,000 a year (Tr. 180). Mendocino Hospital no longer operates (Tr. 204, 206-07).

12. From 1985 to 1988, the Ukiah hospitals experienced a significant drop in total occupancy. In 1985, they had a total average occupancy of 51.4 percent; by 1988 the rate had dropped to 40.9 percent (RX-362-R). One reason for the decline was the increased use of outpatient facilities by patients (Tr. 358, 1053).

13. Along with decreasing admissions, these three hospitals were also experiencing decreasing lengths of stay (Tr. 357-60). Utilization review was an important factor in decreasing length of stay (Tr. 357-58).

14. Approximately 45 percent of Ukiah Valley's patients are Medicare patients and approximately 20 percent are Medi-Cal

patients (Tr. 1058, 1062; RX-302). Medi-Cal is a program administered in the State of California to provide health care for indigents or low-income families (Tr. 1062). This adverse patient mix hurts the hospital financially (Tr. 560-62) and makes it difficult to recruit physicians to the Ukiah area (Tr. 1054; RX-13) because of the low Medicare and Medi-Cal reimbursement (Tr. 466-67, 1054-55). Because of the chronic nursing shortage, it is difficult for small, rural hospitals to attract nurses (Tr. 933-34).

15. In September 1987, when HealthTrust, Inc., first acquired UGH, its pre-tax, pre-management fee earnings were a loss of $190,000 (RX-314-O). UGH's net income for September 1987 was a loss of $199,514 (RX-314-O).

16. In December 1987, after four months under HealthTrust's ownership, UGH had a negative year to date cash flow of $7,921,772 (RX-286-F; RX-314-T). UGH had a negative year to date net income of $268,308 (RX-314-U). For just the month of December 1987, UGH had a negative cash flow of $150,901 (RX-314-T). UGH laid off several employees in 1988 (Tr. 1202, 1208-09).

17. While the monthly figures demonstrate heavy losses, HealthTrust officials testified that the yearly figures are the best indication of UGH's financial position (RX-311-Z-2, Z-3; RX-311-Q, R). By August 7, 1988, UGH had a year to date operating income loss of $562,467 and a loss of net income of $669,281 (RX-127-D; Tr. 1221). Mr. Robert Hornichek of HealthTrust referred to UGH's losses as "out of sight," with $6 million in long term debt and negative stockholder equity (RX-314-Z-5-6).

18.UGH lost significant amounts of money on Medicare and Medi-Cal patients (Tr. 1216-17).

19. UGH also needed major renovations. Mr. ValGene Devitt, President of Ukiah Valley testified that immediately after the acquisition he made an inspection of UGH (Tr. 1068). He discovered that its carpet was in extremely bad condition (Tr. 1068; *see also* Tr. 1207). Other problems included a malfunctioning main air-conditioning unit (Tr. 1068) and standby generator (Tr. 1068-69). Mr. Devitt also discovered that a $50,000 to $100,000 sprinkler system would have to be added to the UGH facility (Tr. 1069).

20. According to Mr. Leon W. Hooper, a vice-president of HealthTrust:

UGH and HealthTrust determined that, given UGH's financial decline and UGH and HealthTrust's unwillingness to invest additional significant capital, sale or other disposition of UGH was the only viable alternative to respond to the Hospital's continuing financial decline.

(RX-131-B).

21. Ms. Jamie Hopping, who was the administrator of UGH for six months in 1988 (Tr. 1202), was optimistic about its future while she was there (Tr. 1207-08) but she was not aware of Mr. Hooper's opinion with regard to UGH's financial condition (Tr. 1227).

22. Several Ukiah physicians and health care professionals testified that Ukiah could support only one hospital (RX-308-H; RX-312-D; RX-314-Z-12; RX-373-Z-4; Tr. 631-32, 1345-46, 1670, 1699), and that UAH and UGH unnecessarily duplicated services and equipment (Tr. 1431-32, 1450-51). Dr. Guthrie, a surgeon and a member of UAH's governing board, described the results of what has been called a medical arms race:

Q. Doctor, prior to the August 1, 1988 in favor of Ukiah Valley purchasing the assets of Ukiah General Hospital, were you in favor of that purchase?

A. Yes.

Q. What was the basis of your opinion?

A. Well, that's a --

Q. That's a big question.

A. It's a big step to take, you know, to take the risk of, financial risk, of buying a business when you've got one going. But I've seen, in my years here, I've seen so much waste of effort and money and duplication of services. And, at the risk of prolonging this, it seems back beyond these two hospitals, to when we had three. There was even more duplication, then. Every time one would get a CT scanner, or something like that, in order to stay in the market and be a full-service hospital, one would have to catch up with the other. It just went back like that, see-saw back and forth. And it just -- it was apparent -- it is apparent to me that, in a town of this size, that one hospital is plenty. If you have two or three hospitals of 40 beds, having to duplicate services, then, there is a lot of waste.

(RX-312-C-D).

Dr. Jepson, another Ukiah physician, stated:

Q. Prior to the acquisition now, did you have an opinion that Ukiah only needed or could only support one viable, acute care general hospital?

A. I've thought for 17 years that that's a town that needs one hospital.

Q. And why?

A. Small hospitals is crazy, and two hospitals is not smart, and one is the way to go. I've always thought that.

Q. Why do you have that opinion? What's the basis for that opinion, if you can be a little more specific?

A. Well, if you have two 40-bed hospitals, they're not efficient. If you have specialty groups trying to practice in both hospitals, they're competing with one another, trying to duplicate services. This hospital gets a CAT scan, that hospital has to have a CAT scanner. This hospital gets orthopedic equipment, that hospital has to have orthopedic equipment.

And there are inefficiencies in small size. There are inefficiencies in the delivery of care from a physician's standpoint. It's hard to take care of sick patients in two places. It's just a matter of efficiency.

(Tr. 1431).

D. *The Relevant Product Market*

23. Dr. Glenn Melnick, complaint counsel's economic expert, testified that the appropriate product market in which the effect of this acquisition should be measured consists of a product or service, or a group of products or services, for which a monopolist could profitably sustain a small but significant and nontransitory price increase (Tr. 708).

24. Whether a price increase can be profitably sustained depends upon the degree to which consumers may, in response to that increase, switch to alternative products or services (Tr. 707-08). Substitutability of an alternative product or service is determined, by finding to what extent a change in the price of one good or service might impact the demand for another good or service (Tr. 707-08).

25. Dr. Melnick determined substitutability by analyzing patient origin data compiled by the California Statewide Office of Health Planning and Development ("OSHPD"), planning documents from hospitals in the market (Tr. 875), the range of services California law permits under inpatient and outpatient status (Tr. 707-08, 815), and opinions in previously litigated hospital merger cases (Tr. 708-09).

26. After considering this evidence, Dr. Melnick concluded that the relevant product market in this proceeding is acute care inpatient hospital services (Tr. 709-10).

27. The types and intensity of services required by a patient distinguish inpatient and outpatient care. Inpatients need 24-hour nursing care, laboratory services, intensive monitoring, and the services provided by intensive care or coronary care units. Inpatients are often treated with procedures that involve the risk of bleeding or

infection, and may require complicated surgical or orthopedic procedures, blood bank or x-ray services and specialized nursing care (Tr. 100-01, 260-61, 468-69, 550, 630-31, 709, 921-22, 956, 970-71, 1018, 1026-27, 1258-59, 1266-67, 1321, 1471; Cal. Health & Safety Code Section 1259(a) (Deering 1990)).

28. Dr. Melnick recognized that there is some substitutability between inpatient and outpatient services but he concluded that they were nevertheless distinct product markets (Tr. 705).

29. Dr. Lynk, respondents' expert, agreed that most economists who study the hospital industry consider inpatient acute care services as the product definition most relevant for analysis of hospital competition (Tr. 1584-85; Lynk, *Antitrust Analysis and Hospital Certificate-of-Need Policy*, Antitrust Bulletin 61, 74-75 (Spring 1987)) and he adopted acute care inpatient hospital services as the product market in his analysis of the acquisition because "it makes some analytical sense only to look at that part of the hospital's activity" although limiting one's analysis to inpatient care facilities ignores some "linkage" between inpatient and outpatient care (Tr. 1474-75).

30. Other record facts confirm the experts' opinion. California law does not permit outpatient surgical facilities to treat patients who require overnight hospitalization, except for 13 postsurgical demonstration projects (Cal. Health & Safety Code Sections 1240(b)(1), 1250.9 (Deering 1990); CX-100-F).

31. Third-party payors are unwilling to pay for inpatient care if outpatient care would have been sufficient, forcing hospitals to develop review programs to determine whether inpatient care is necessary (Tr. 550-51). This type of program recognizes the essential difference between inpatient and outpatient care.

32. A UAH document, its 1989 strategic plan, states that its increased volume in outpatient services came "at the expense of other outpatient programs in the area." Inpatient programs were not mentioned (CX-175).

33. Dr. Melnick conceded that changes in technology allow physicians to perform what were inpatient procedures on an outpatient basis (Tr. 818) and physicians testifying in this proceeding listed several procedures which can be performed in an outpatient setting (Tr. 111, 292, 567, 919-21, 956, 1004, 1026-27, 1231). Also, Mr. Devitt testified that outpatient providers compete for Ukiah Valley's patients (Tr. 1108, 1114; *see also* Tr. 1011-12).

Nevertheless, there is no doubt that there are many procedures which can only be performed in an inpatient setting in acute care hospitals and only hospitals offering these procedures compete for patients needing those procedures.

E. *The Relevant Geographic Markets*

1. Ukiah And Surrounding Towns

34. Ukiah, California, is located in the southeastern part of Mendocino County, and is its county seat and largest city; it has a population of approximately 13,000 (Tr. 1050; CX-16-B; CX-65-Z-1; RX-30-Z-140; RX-335; RX-392). The nearest town with an acute care hospital is Willits, approximately 23 miles north of Ukiah on Highway 101 (CX-16-B; RX-30-Z-140). Ukiah, Willits, and other communities in eastern Mendocino County are separated from the coastal regions of Mendocino County by the mountains of the Coast Range, which inhibit travel between those areas (RX-112-G). Lakeport, in western Lake County, is approximately 34 miles southeast of Ukiah over a two-lane highway through the inner ranges of the Coast Range (RX-30-Z-140; RX-392). The town of Clearlake is separated from the western part of Lake County by Clear Lake (RX-392).

35. The nearest urban area to Ukiah is Santa Rosa, in Sonoma County, approximately 60 miles south on Highway 101, a combination two-lane and four-lane highway (CX-16-B; RX-30-Z-140; RX-335; RX-392; Tr. 1136-37). San Francisco is approximately 52 miles farther south from Santa Rosa, and 120 miles from Ukiah over Highway 101 (CX-13-A-18; RX-392).

2. Hospitals In Complaint Counsel's Proposed Relevant Geographic Markets

36. Prior to the acquisition, UAH was a 43-bed general acute care hospital, located at 275 Hospital Drive, Ukiah, California. It provided primary-level pediatric care, medical/surgical care, an emergency room, and ancillary services such as radiology and a laboratory (Tr. 1050; CX-15-Z-14; *see also* CX-13-A-18). Prior to the acquisition, UAH did not have an obstetrical unit (Tr. 360, 1204; RX-309-I; CX-16-H), nor did it offer complex medical care such as

neurosurgery, open-heart surgery, or organ transplants (Tr. 332, 916-17, 988-89, 1029, 1183, 1688-89). The gross patient service revenue for UAH in 1987, the year prior to the acquisition, was more than $15 million (RX-30-Z-128).

37. Prior to the acquisition, UGH was a 51-bed general acute care hospital, located at 1120 South Dora Street, Ukiah, California, which provided primary-level obstetrical, pediatric, medical/surgical care, an emergency room, and ancillary services such as radiology and a laboratory (Tr. 1050, 1235; RX-316-M). UGH did not offer complex medical care such as neurosurgery, open-heart surgery, and organ transplants (RX-316-I; Tr. 916-17, 988-89, 1029). UGH had the only obstetrical unit and the only level II neonatal intensive care nursery in Ukiah and thus had approximately 93 percent of the Ukiah obstetrical market (Tr. 105-07, 360, 1204; CX-15-Z-14; CX-16-B; CX-65-Z-46; CX-66-C; RX-126-B). The gross patient service revenue for UGH in 1987, the year prior to the acquisition, was more than $12.9 million (RX-30-Z-122).

38. Following the acquisition, respondents have continued to operate a 94-bed hospital on the UGH and UAH campuses under the name Ukiah Valley Medical Center (CX-13-A-18; RX-4-C; Tr. 359). The former UAH facility is referred to as the Hospital Drive campus, while the former UGH facility is referred to as the Dora Street campus (RX-393; Tr. 116).

39. Frank R. Howard Memorial Hospital ("Howard Hospital"), a 38-bed hospital located in Willits, is owned by the Frank R. Howard Memorial Foundation, which leases it to Willits Hospital, Inc., a wholly-owned subsidiary of Western Health Resources, an affiliate of respondent AHS/West (SD paragraph 20). Howard Hospital is approximately 23 miles north of Ukiah (RX-30-Z-140). AHS/West has the ability to, and does, direct and control the policies and operations of Howard Hospital (SD paragraph 21). The market share of Howard Hospital is attributable to respondents (SD p. 19).

40. Prior to the acquisition, Mendocino County owned and operated Mendocino Hospital, a 56-bed hospital located in Ukiah (Tr. 182; RX-30-Z-24, Z-140). In 1990, Mendocino Hospital ceased offering inpatient hospital services and, in 1992, it closed its outpatient operations as well (Tr. 203-04, 206-07, 359; RX-119). Mendocino County has recently announced plans to convert the hospital into a county administrative and health services office complex (Tr. 204-06).

41. Lakeside Community Hospital ("Lakeside") is a 63-bed hospital located in Lakeport, Lake County (CX-48-A-B, D), approximately 34 miles southeast from Ukiah and approximately 60 miles from Santa Rosa (RX-30-Z-140; RX-392). It provides primary level surgical and medical care (CX-48-D). It does not provide complex medical care, such as neurosurgery, open-heart surgery and organ transplants (CX-48-D).

42. The nearest hospitals that provide complex inpatient services not offered by UGH, UAH, Howard Hospital and Lakeside are Santa Rosa Memorial Hospital ("SRMH") and Santa Rosa Community Hospital ("SRCH").

3. Hospitals In Areas Surrounding The Proposed Relevant Geographic Markets

43. SRMH is a 225-bed hospital located in Santa Rosa, approximately 68 miles from Ukiah (CX-58-A-B; RX-30-Z-140; RX-335). It offers specialized procedures not available in Ukiah, including open-heart surgery, neurosurgery, thoracic surgery, renal surgery, and cancer treatment (Tr. 988-89, 1029; CX-58-C-J).

44. SRCH is a 145-bed hospital located in Santa Rosa, approximately 68 miles from Ukiah (CX-54-C; RX-30-Z-140; RX-335). It offers specialized procedures not available in Ukiah, including neurosurgery, thoracic surgery, and cancer treatment (CX-57-K, T, Z-3, Z-5; Tr. 553, 558).

45. Mendocino Coast District Hospital ("MCDH") is a 54-bed hospital located in Fort Bragg, Mendocino County (CX-51-A-B), 58 miles across the Coast Range from Ukiah (RX-30-Z-140; RX-335). Geographic distance and physical boundaries separate Fort Bragg from Ukiah and Willits (RX-111-G). Like the hospitals in complaint counsels proposed relevant geographic markets, MCDH provides only primary services, and does not provide complex services such as neurosurgery, open-heart surgery, or organ transplants (RX-112-G).

4. Elzinga-Hogarty Analysis Of Patient Discharge Data

46. Dr. Melnick determined the boundaries of the relevant geographic markets -- the areas in which a monopolist could profitably sustain a small but significant and nontransitory price

increase (Tr. 718) -- for acute care inpatient hospital services by analyzing 1987 patient discharge data (the last full year before the challenged acquisition) for hospitals located in several potential geographic markets (CX-86) according to the so-called Elzinga-Hogarty test.

47. The Elzinga-Hogarty test produces two numerical measures of the strength of a tested area as an appropriate geographic market. The first measure is LOFI or "little out from inside," which in this case measures the movement -- or "leakage" -- of residents from outside the proposed market to hospitals inside the proposed market. A LOFI of 100 would indicate that all patients at the hospitals in the proposed market resided in that market. The second measure is LIFO or "little in from outside," which in this case measures the "leakage" of residents from inside the proposed market to hospitals outside the proposed market. A LIFO of 100 would indicate that all patients who resided in the proposed market sought hospitalization in that market (Tr. 738-39, 1498-99; Elzinga & Hogarty, *The Problem of Geographic Market Delineation Revisited: the Case of Coal*, 23 Antitrust Bull. 1 (1978); Elzinga & Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 Antitrust Bull. 45 (1973)).

48. Under the Elzinga-Hogarty test, a recognizable, but weak, market is attained when both LOFI and LIFO statistics reach 75 percent. A market is characterized as strong if both LOFI and LIFO reach 90 percent (Tr. 742-44; Elzinga & Hogarty, *The Problem of Geographic Market Delineation Revisited: the Case of Coal*, 23 Antitrust Bull. 1 (1978); Elzinga & Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 Antitrust Bull. 45 (1973)). In evaluating Elzinga-Hogarty data, smaller markets are preferred to larger markets with similar LOFI and LIFO figures (Tr. 746-47). Dr. Melnick used ZIP codes to analyze patient discharge data because they are the smallest unit by which California collects patient origin data (Tr. 724, 782-83, 1501-02). He began his analysis by determining the ZIP codes from which UAH and UGH drew their patients prior to the acquisition.

49. Dr. Melnick's Elzinga-Hogarty analysis of patient discharges by various ZIP code groupings (CX-86) for several Markets including those proposed by him (Tr. 714-15) and by complaint counsel (Ukiah-Willits and Ukiah-Willits-Lakeport) produced the following LOFI and LIFO results (from CX-87):

CALCULATION OF LOFI AND LIFO MEASURES
FOR ALTERNATIVE MARKETS

Geographic Area	LOFI	LIFO	Average
Ukiah	71%	82%	76%
Ukiah + Willits	85%	81%	83%
Ukiah + Willits + Lakeport	91%	75%	83%
All Mendocino Co. + all Lake Co. + Santa Rosa	83%	78%	81%
All Mendocino Co. + all Lake Co. + Santa Rosa + Healdsburg + Sebastopol + St. Helena	89%	83%	86%

50. The Ukiah-Willits area consists of 15 ZIP codes surrounding Ukiah and Willits in southeastern Mendocino County; the Ukiah-Willits-Lakeport area includes these ZIP codes plus an additional seven ZIP codes in western Lake County (CX-86; CX-18-C).

51. The area that includes all of Mendocino and Lake Counties plus Santa Rosa, Healdsburg, Sebastopol and St. Helena corresponds to respondents' proposed alternative geographic market, which includes all of Mendocino, Lake, Sonoma and Napa Counties, but omits Queen of the Valley Hospital in Napa, Sonoma Valley Hospital in Sonoma and Petaluma Valley Hospital in Petaluma (Tr. 1496, 1614, 1619; RX-387). Dr. Melnick rejected this market, which has the highest LIFO-LOFI average, because there were other smaller markets with similar statistics (Tr. 746-47).

52. The Ukiah-Willits area is the smallest market that meets the Elzinga-Hogarty standard; with a LOFI of 85 and a LIFO of 81, it falls between its weak and strong thresholds (CX-87). The Ukiah-Willits-Lakeport market, with a LOFI of 91 and a LIFO of 75, is the smallest geographic market that satisfies the strong standard for one prong of the Elzinga-Hogarty test and satisfies the weak standard for the other prong (CX-87). Neither of the markets proposed by Dr. Melnick satisfy the Elzinga-Hogarty 90/90 strong market test (Tr. 825), a standard which Elzinga and Hogarty in later articles

expressed a preference for (Tr. 742-43, 824-25). While either one is a relevant market, if forced to choose, Dr. Melnick would pick Ukiah-Willits-Lakeport as the "most defensible" (Tr. 742).

53. The data compiled by Dr. Melnick reveals that many patients from the Ukiah-Willits-Lakeport area needing inpatient hospital services seek it elsewhere (2,711 in 1987 (CX-88)). The question is whether they do so because Ukiah hospitals do not provide the services needed by them, or whether they leave the Ukiah area even though hospitals in that area provide the services they need. If the former is the case, these patients could not be harmed by the acquisition and their number is irrelevant in analyzing the appropriate geographic market. If the latter is true, the proposed market does not accurately describe the competitive interactions of hospitals in the area.

54. Dr. Melnick tried to answer this question by adjusting the LIFO figure for the Ukiah-Willits-Lakeport proposed market to account for those patients who left that area for services that were not available there (Tr. 755-56). Dr. Melnick's adjustment used "Diagnosis Related Groups" or "DRG" data to calculate this number.

55. California regulations require hospitals to file DRG reports with OSHPD that classify each patient according to cause of hospitalization (Tr. 730-32). Each DRG is assigned a weight that indicates the relative resource requirements for treating the typical patient with that particular DRG and Dr. Melnick testified that a higher DRG-weight implies a more complex case (Tr. 731).

56. By Dr. Melnick's calculation, the residents of the Ukiah-Willits-Lakeport area who were hospitalized outside that area in 1987 were classified in DRGs that have a 38 percent greater severity weight than those residents seeking hospital services at facilities within the geographic market, and this suggested to him that patients leaving the area are different from those staying in the area since the intensity of services delivered to them by hospitals outside the area is much higher (Tr. 747-48, 841).

57. The reports that hospitals file with OSHPD also list procedure and diagnosis codes for each patient which identify the medical problems for which each patient was treated and the medical procedures and techniques employed to address the patient's diagnosis (Tr. 749-50).

58. Of the 2711 patients who left the Ukiah-Willits-Lakeport area for inpatient care in 1987, 1045 (or 39 percent) had a specific

diagnosis or received a specific procedure that complaint counsel allege was not delivered at any hospital in the area (CX- 88). Dr. Melnick conceded that some of these 1045 patients could have been treated at hospitals in the area (Tr. 851); however, some procedures such as neurosurgery, cardiac surgery and organ transplants are not available in the area and would have to be provided by tertiary care hospitals (Tr. 332, 916-17, 988-89, 1029, 1688-89).

59. Dr. Melnick calculated an adjusted LIFO for the Ukiah-Willits-Lakeport area by omitting all patients with unique diagnosis or procedure codes. The adjusted LIFO for this area was approximately 84 percent and the adjusted LOFI-LIFO average was approximately 88 percent (Tr. 756-57; CX-89).

60. Adjusting market data by omitting patients with unique needs not provided by hospitals in the market is theoretically sound, as UAH recognized in its 1989 strategic plan:

> Outmigration . . . demands . . . further detailed analysis. This analysis needs to identify specific Specialty Line outmigration, and may need to get as specific as looking at DRG's and principal procedures for outmigrating patients.

(RX-5-Z-129; *see also* CX-17-F-G). However, Dr. Melnick's analysis is flawed and one cannot, therefore, rely on his estimate as to how many of the 2711 outmigrating patients sought tertiary care.

5. Criticism Of Dr. Melnick's Analysis

61. Dr. Lynk rejected Dr. Melnick's attempt to refine his LIFO calculations to determine how much of the outmigration of patients from the Ukiah-Willits-Lakeport area was competitively insignificant in 1987.

62. Dr. Lynk criticized Dr. Melnick's unique diagnosis and DRG weight analyses for patients seeking treatment inside and outside his proposed relevant geographic market, arguing that Dr. Melnick's claim that average DRG weight differed between the two groups of patients ignored the significant DRG overlap between groups (Tr. 1504-10).

63. Dr. Lynk examined all DRGs for patients treated at UAH and UGH from 1984 through 1987, and then determined the extent to which those DRGs also appeared for patients treated in hospitals outside the service area. He concluded that when patients sought

treatment at SRMH, four out of five times it was for a DRG that was also performed in Ukiah. As to SRCH, patients there were treated 97 percent of the time for a DRG which had also been performed in Ukiah hospitals (Tr. 1526-27; RX-160; RX-162). He concluded, contrary to Dr. Melnick, that of the 25 percent of patients seeking treatment outside of the hospital area, a majority sought treatment available within the service area (Tr. 1528).

64. Dr. Lynk also concluded that Dr. Melnick's analysis of unique diagnoses and procedures was not a valid measure of treatment procedures inside and outside his proposed market (Tr. 1521-22) because classifications at this level did not necessarily reflect distinct medical procedures.

65. As an example, Dr. Lynk referred to diagnosis 140.0 in ICD-9-CM (the International Classification of Disease coding manual) which is malignant neoplasm of the upper left vermillion border and to diagnosis 140.1 -- malignant neoplasm of the lower left vermillion border (Tr. 1513).

66. The flaw in Dr. Melnick's diagnosis and procedure analysis is that:

> if a patient left the area, went down to Santa Rosa for treatment of a malignant neoplasm in his upper left, and his next-door neighbor stayed put and was treated for a malignant neoplasm of the lower left at Ukiah Valley, the Melnick Uniqueness Analysis would say there's no competitive overlap here. . . .

(Tr. 1513-14).

67. Thus, the failure to find that a Ukiah hospital performed a certain procedure in a given period of time while a Santa Rosa hospital did does not prove that the procedure could only be performed in Santa Rosa (Tr. 1515).

68. Dr. Lynk's criticism of Dr. Melnick's DRG weight and "unique diagnosis and procedure" analyses is convincing, and I conclude that they do not accurately measure the competitively insignificant outmigration from the Ukiah-Willits-Lakeport area. Complaint counsel conceded as much in oral argument:

> Q: What about quantitatively, though? How many, of the 25 percent, do you know precisely how many went outside the area for tertiary care?
>
> A: No.
>
> Q: Does this record show that?
>
> A: No. The record simply shows that it is a substantial number, Your Honor.

Q: Well, how substantial?

A: Well, let me suggest that.

Q: Okay.

A: Thank you.

Dr. Melnick suggested that one indicator of the extent to which patients were leaving the Ukiah area for care that was not available in Ukiah was to look at whether the outmigrating patients had left for procedures that are not available in Ukiah, or for treatment for diagnoses not normally treated in Ukiah. He found that, for 1987, 1,045 of the 2,700, or so, patients who left Ukiah had what he determined to be a unique diagnosis or procedure. Assuming that everyone of those people were not truly competitive, competitively significant, the LIFO for the proposed Ukiah-Willits-Lakeport market rises to about 84.

Now we know that's a soft number. We know it, respondents know it, everybody knows it. And rather than apologize for the softness of the number, I want to suggest that it is soft in both directions, and that the analysis is clearly correct that there should be a substantial upward adjustment --

Dr. Lynk's DRG analysis (F 63) -- unchallenged by complaint counsel -- refutes their argument that a substantial upward adjustment is warranted.

69. In an attempt to determine how much of the 25 percent leakage from the Ukiah-Willits area was by inpatients seeking tertiary care, complaint counsel turn to documents authored by respondents' employees.

70. According to complaint counsel, the LIFO figure for the Ukiah-Willits area -- 81 percent -- actually overstates the competitively significant outmigration from that area by 13 percent -- that is, it is not 19 percent (100 percent minus 81 percent) but close to six percent of total admissions. This calculation is derived from a planning document which states that 44 percent of outmigration from respondents' core area was to hospitals in immediately adjacent counties while 56 percent was to hospitals in San Francisco and the Bay Area or to hospitals scattered around California (CX-17-H). Using this estimate, complaint counsel calculate that 10.6 percent of all admissions from the core area are unrecoverable (calculated by multiplying the 19 percent of Ukiah-Willits patients who left this market for inpatient care by the 56 percent unrecoverable figure).

71. Complaint counsel also compute the percentage of admissions to Santa Rosa hospitals which is "competitively irrelevant" (CPF 61b) (*see* CX-18-R) (3%) and, adding this amount to the prior 10.6% calculation, estimate that 13 percent of the

admissions from UAH's core area have no competitive significance (CPF 62).

72. Discounting the 6608 hospital admissions from Ukiah-Willits area in 1987 (CX-87) by 13 percent, complaint counsel calculate that there were 5800 remaining admissions from that area. Five thousand three hundred ninety-five of these patients were hospitalized in Ukiah or Willits. Dividing this figure by 5800, complaint counsel calculate the adjusted LIFO for the Ukiah-Willits market as 93 percent.

73. Complaint counsel's adjusted figures for their proposed relevant geographic markets, using Dr. Melnick's adjustments for the Ukiah-Willits-Lakeport market and their adjustments for the Ukiah-Willits market, are:

Geographic Area	LOFI	LIFO	Average
Ukiah + Willits	85%	81%	83%
Ukiah + Willits (excluding outmigration for services unavailable in the market)	85%	93%	89%
Ukiah + Willits + Lakeport	91%	75%	83%
Ukiah + Willits + Lakeport (excluding outmigration for services unavailable in the market)	91%	84% (approx.)	88% (approx.)

I reject complaint counsel's adjustment to the LIFO figure for the Ukiah-Willits area because it is based on planning documents whose accuracy is unverifiable and because it was not calculated or referred to by Dr. Melnick in his testimony with respect to the geographic market and competitive injury. Since I have also rejected Dr. Melnick's adjustment to the Ukiah-Willits-Lakeport LIFO figure, I conclude that both Ukiah-Willits and Ukiah-Willits-Lakeport are such weak geographic markets that they do not describe the competitive interaction between hospitals in the Ukiah-Santa Rosa area.

74. The Elzinga-Hogarty test offers an easily-applied numerical standard for geographic market analysis, but its use in any particular case requires the exercise of judgment. Other evidence must, therefore, be considered to evaluate the soundness of any conclusion suggested by that test.

6. Other Evidence Relating To The Relevant Geographic Markets

75. In a 1986 analysis of the need to add a birthing center (RX-29), UAH posited a market that is almost identical to counsel's proposed Ukiah-Willits-Lakeport market (compare CX-80 and RX-29-Z-2). UAH used the vital statistics for Lake and Mendocino Counties, not counting the areas served by Redbud Community Hospital in Clearlake and MCDH (RX-29-Z-2).

76. An analysis of the proposed acquisition of UGH performed for AHS/West by John Nuveen & Co., respondents' consulting firm, identified "Ukiah General Hospital's primary and secondary service areas" as "Ukiah and a twenty-mile radius surrounding the Hospital" (CX-14, at p. 25). This is a smaller area than the Ukiah-Willits proposed market (RX-392).

77. In May 1987, AHS/West's departments of strategic planning and budgeting described the geographic market within which the two Ukiah hospitals operate:

> Ukiah is a town of about 13,000 . . . . The service area around Ukiah accounts for about 40,000 people with an additional 10,000 situated around the town of Lakeport, about an hour from Ukiah, but served by another hospital. To complete the picture there is Howard Memorial Hospital in Willits, about 25 miles north. This 32-bed hospital is now managed by AHS/West and is an integral part of our strategy regarding Mendocino County.

(CX-16-B). This describes, almost exactly, complaint counsel's proposed Ukiah-Willits-Lakeport market (*cf.* CX-80).

78. Other hospitals in the area view their service areas as local in nature. For example, MCDH's 1989 market assessment described its service area as coastal Mendocino County, stated that inpatients from outside that area (Fort Bragg) were primarily tourists, and concluded that most patients from its service area who sought hospitalization elsewhere were seeking more specialized levels of care than MCDH provided (RX-112-B-C, G). This document also stated that MCDH physicians believe that patients have a "clear preference to remain in

the service area when services are available because of the difficulty of traveling to other areas" (RX-112-G).

79. The authors of a UAH document discussing a new birthing center agreed with MCDH's assessment of its service area:

> [MCDH] serves the coastal area which is a distinctly separate market from the rest of Mendocino County and has very little impact on the obstetric market in the Ukiah area.

(RX-29-Z-7). The possibility that MCDH might reopen the birthing center which it had closed was of little concern; the "effect of this change will be negligible on the OB market in Ukiah" (RX-29-Z-10).

80. UGH's 1986 hospital management plan and budget noted the large number of specialty physicians represented on its medical staff and observed that "[p]atients previously leaving the area for care, are now staying due to the increase in specialties represented by the physician population" (RX-124-Z). The plan also states that "UAH continues to be a major competitor of UGH," but does not mention hospitals in Santa Rosa (RX - 124-Z-6).

81. Jamie Hopping, the administrator of UGH from February 1988 until August 1988, testified that she viewed UGH's competition to be primarily UAH and, to a much lesser degree, MCH (Tr. 1202-03). Kelly Morgan, Ms. Hopping's predecessor, described UGH as a provider of "acute care or primary care"; patients needing complex or specialized care usually went to Santa Rosa and San Francisco (RX-316-C-D, I). He stated that UGH competed with UAH and Mendocino Hospital in Ukiah, viewed Mendocino County as UGH's "priority service area" and therefore marketed UGH's services only in Mendocino and Lake Counties (RX-316-J-Z-2-3).

82. [ ]

83. Nicki Poor, the associate administrator of SRCH, testified that most of its patients come from Sonoma County, with only about 1.5 percent coming from Mendocino County and about 2.5 percent from Lake County (Tr. 547-48, 556). Some patients from Mendocino and Lake Counties come to SRCH for services not available in those counties, such as neurosurgery (Tr. 553). She views SRMH and Kaiser Hospital in Santa Rosa as its competitors; SRCH does not compete with hospitals outside of Sonoma County (Tr. 549-50). Although SRCH advertises in the Santa Rosa Press-Democrat and on a Santa Rosa radio station which may reach into Mendocino County,

SRCH is not attempting to reach patients residing there (Tr. 555, 565).

7. Medical Staff/Overlap And Patient Referrals

84. If physicians do not have privileges at a hospital, they are not permitted to admit patients (CX-33-I). Therefore, Ukiah area patients who regularly seek treatment at outlying hospitals and whose physicians do not have staff privileges at those hospitals would have to seek treatment from other physicians who do have privileges (Tr. 444-45; RX-318-Z-10-11).

85. The By-Laws of the Ukiah Valley's medical staff create four categories of staff membership: active, courtesy, consulting and provisional. Members of the active staff must have offices close enough to the hospital to provide appropriate continuity of quality care and they must regularly care for patients in the hospital. Their prerogatives include the right to admit patients and exercise clinical privileges and the right to participate in and vote on medical staff matters and to serve as staff officers and on staff committees (CX-33-L-Q).

86. Members of the provisional staff also have the right to admit patients without restrictions. Their status is essentially probationary, and they are subject to being proctored by active staff members for a minimum of a year until a determination is made that they are qualified to be admitted to active status (CX-33-N-P).

87. Members of the consulting staff and of the courtesy staff do not have the unrestricted right to admit patients. Courtesy staff physicians are those physicians who do not regularly care for patients in the hospital, but who have admitting privileges at some other hospital. They may admit patients to the hospital, but only consistent with the requirement that they not admit regularly. They do not have the right to vote on staff decisions or to participate on medical staff committees (CX-33-M).

88. Members of the consulting staff are those physicians who have indicated that they are willing to be available for consultation, but they are not allowed to admit patients to the hospital (CX-33-N). Frequently, members of the consulting staff at Ukiah Valley are physicians from Santa Rosa or San Francisco who can be called upon to consult with local physicians in difficult cases (CX-46-E-F).

89. Other hospitals have similar privilege categories (CX-47-A-F; CX-48-A-E; CX-49-A-D; CX-50-A-C; CX-52-A-F; CX-53-A-G; CX-56-A-Z-9; CX-57-A-Z-11; CX-59-A-O; CX-60-B-Z-4; CX-61-G-K).

90. The 1991 medical staff rosters of Ukiah Valley and surrounding hospitals show the following overlaps of physicians with active or provisional privileges or their equivalent:

a. Of the 88 physicians with active or provisional privileges at Ukiah Valley in 1991, seven had comparable privileges at Lakeside (compare CX-46-E-F and CX-50-A-C).

b. Of the 88 physicians with active or provisional privileges at Ukiah Valley in 1991, one had comparable privileges at MCDH (compare CX-46-E-F and CX-53-A-G).

c. Of the 88 physicians with active or provisional privileges at Ukiah Valley in 1991, one had comparable privileges at SRCH (compare CX-46-E-F and CX-57-A-Z-11). That physician, Dr. Charles Evans, is a specialist in emergency room medicine (CX-46-E; CX-57-K) and, therefore, has no discretion about where to admit patients.

d. Of the 88 physicians with active or provisional privileges at Ukiah Valley in 1991, none had comparable privileges at SRMH (compare CX-46-E-F and CX-59-A-O).

91. Physicians can serve patients from a greater distance on an outpatient basis than an inpatient basis (Tr. 819). Consequently, it may be feasible for a Ukiah physician to treat outpatients in Santa Rosa, which is about an hour's drive (Tr. 99, 235-36, 1110, 1295-96), but it is generally impractical for a physician who practices in Ukiah to treat inpatients in Santa Rosa (Tr. 99-100, 173-74).

92. Some Ukiah physicians testified that they d[o] not refer patients to Santa Rosa hospitals unless they need services that are not available in Ukiah (Tr. 477-80, 912-18, 919, 928-29, 944-45, 970-72, 1024-25, 1027-29, 1441). However, Dr. Valente testified that some patients are willing to travel to Santa Rosa for obstetrical procedures (Tr. 166; *see also* 858-59) while others have been referred by Ukiah physicians for treatment which is available in Ukiah:

I have admitted patients to physicians in, say, Santa Rosa for laparoscopies, for pelvic tumors and so forth, pelvic surgeries, hysterectomies for persistent

dysfunctional bleeding. These are not rare conditions. The services, frankly, are available in Ukiah.

(Tr. 291).

93. Dr. Pena testified that patients are able to go to Santa Rosa for hospital services if they want to (Tr. 281-82), and he has referred patients to Santa Rosa hospitals for procedures that were available in Ukiah (Tr. 289-92).

94. Although they were disgruntled, Dr. Falk treated several patients from Lake and Mendocino Counties at the Kaiser facility in Santa Rosa who were required by Kaiser to be treated there (Tr. 928-29), and Dr. Gester is aware of Ukiah area residents who go to Santa Rosa for primary or secondary care (Tr. 1710), as is Dr. Jepson (Tr. 1439-40). Once, Dr. Valente used the threat of sending patients to a Santa Rosa surgery center to pressure UAH into buying a laparoscope (Tr. 110-113).

95. Mr. King, the executive director of Travelers Insurance Company, testified that his insured, the employees of Mendocino County:

do use Santa Rosa Memorial Hospital to a considerable extent. Not to as great an extent as they use the hospital in Ukiah. But I do know that there is, for example, not a majority of the hospital expense dollars in the customers' claims experience going to Ukiah hospitals. They are distributed around quite a wide array. So there seems to be some basis for the members selecting hospitals outside of Ukiah, voluntarily at the present time; and I'm not sure why this is. Whether it's because of the geography or preference for their services, or just what.

(Tr. 1242). Mr. Harold Strunk of Blue Shield of California testified:

Q. If hypothetically the Ukiah Valley Medical Center opposed rates that Blue Shield deemed were unreasonable, would it be feasible for Blue Shield to insure people who lived in Ukiah and direct them to a Preferred hospital in Santa Rosa, or would that harm your ability to market the Blue Shield Preferred product in Ukiah?

[objection to the form of the question omitted]

A. I would think that people would gravitate toward Santa Rosa, a bigger center, than they would to go anywhere else that would be even more rural. It's not that far away. It's, what, a half hour, 45 minutes perhaps at most, depending on how you drive.

96. Dr. Stein of the Kaiser hospital in Santa Rosa testified that Kaiser expects its patients to use its facilities (RX-372-T) and that quite a number of patients from Mendocino and Lake Counties do so for primary, secondary and tertiary care (RX-372-T-Y-Z-Z-1). Under Medi-Cal guidelines, Ukiah patients could be required to use Santa Rosa hospitals (Tr. 582, 1109).

97. The evidence cited above indicates that while some of the outmigration from the Ukiah area is for services not available in the proposed market, Santa Rosa hospitals are used regularly by a considerable number of Ukiah area residents for routine medical care. This suggests that more patients, either by choice or by force of circumstances, could do so.

98. Taking into consideration Dr. Melnick's Elzinga-Hogarty analysis and other record evidence relating to patient outmigration, *e.g.* (F 63), I conclude that the relevant geographic market is Ukiah-Willits-Lakeport-Santa Rosa.

8. Respondents' Proposed Relevant Geographic Market

99. Dr. Lynk calculated the relevant geographic market by determining where 90 percent of the consumers who live in the service area go for hospital care (Tr. 1478), or, to put it another way, what hospitals accounted for 90 percent of hospital admissions of the service area residents (Tr. 1485).

100. Based on this analysis, Dr. Lynk concluded that the geographic market must include an area that accounts for the following hospitals located in southern Mendocino County, parts of Lake County and Napa County and probably all of Sonoma County (Tr. 1487): UGH, UAH, Mendocino Coast, Howard Memorial, Mendocino Community (all in Mendocino County), Lakeside Community, Redbud Community (both in Lake County), Santa Rosa Memorial, Santa Rosa Community, Warrack Medical Center, Healdsburg General, Palm Drive, Petaluma Valley, Sonoma Valley (all in Sonoma) and St. Helena and Queen of the Valley (in Napa) (RX-257; RX-258; Tr. 1503).

101. I reject Dr. Lynk's proposed market because his methodology incorporates some hospitals which are located so far from Ukiah that it is inconceivable that they would impose any competitive constraint on the activities of Ukiah Valley. This is not a conclusion without a foundation for respondents suggest an

alternative market definition which "would exclude Sonoma Valley, Petaluma Valley and Queen of the Valley in light of their greater distance from Ukiah" (RPF 241). I do, however, conclude that the extensive admission by Santa Rosa hospitals of Ukiah area residents for routine inpatient care (F 63) indicates that they should be included in the relevant geographic market.

F. *The Competitive Effects Of The Acquisition*

1. Concentration

102. The HHIs for acute care inpatient hospital services in the Ukiah-Willits area are:

Measure	Pre-Merger HHI	Post-Merger HHI	Increase
Patient Discharges	4402	8757	4355
Inpatient Days	4646	8892	4246

(CX-83). The market shares of the competitors in the Ukiah-Willits area before and after the UGH purchase are:

Competitor	Patient Discharges Pre-purchase	Patient Discharges Post-purchase	Inpatient Days Pre-purchase	Inpatient Days Post-purchase
UAH and Howard Hospital	46%	93%	57%	94%
UGH	47%	--	38%	--
MCH*	7%	7%	6%	6%

(CX-83). (*Mendocino Hospital).

103. The HHIs for acute care inpatient hospital services in the Ukiah-Willits-Lakeport area are:

Measure	Pre-Merger HHI	Post-Merger HHI	Increase
Patient Discharges	3196	5933	2737
Inpatient Days	3346	6009	2663

(CX-83). The market shares of the competitors in the Ukiah-Willits-Lakeport area before and after the UGH purchase are:

Competitor	Patient Discharges Pre-purchase	Patient Discharges Post-purchase	Inpatient Days Pre-purchase	Inpatient Days Post-purchase
UAH and Howard Hospital	36%	74%	45%	75%
UGH	38%	--	30%	--
MCH	5%	5%	5%	5%
Lakeside	21%	21%	21%	21%

(CX-83).

104. Prior to the acquisition there were three competitors in the Ukiah-Willits area and four in the Ukiah-Willits-Lakeport area. Immediately after the acquisition, there were two competitors in the Ukiah-Willits area and three in the Ukiah-Willits-Lakeport area. At the present time, there is one competitor -- respondents -- in the Ukiah-Willits area, and there are two competitors in the Ukiah-Willits-Lakeport area.

105. The post-acquisition HHIs understate the concentration of the market, because they include the market shares of Mendocino Hospital, which left the market.

106. In either of these areas, the post acquisition HHI is above 1800 and the areas are highly concentrated (Tr. 765).

2. Market Power

107. After reviewing the post-acquisition HHIs, Dr. Melnick concluded that the acquisition confers market power on respondents,

and that there is a "great possibility" that residents in the Ukiah-Willits-Lakeport area, and insurance companies serving those residents, would, because of the increased likelihood of successful collusion, have to pay higher prices (Tr. 766). He also expressed concern that Ukiah Valley would be able to set prices above marginal cost because of its dominant firm position (Tr. 767-68).

108. Dr. Melnick did not believe that hospitals outside this market, like those in Santa Rosa, provided a sufficient check on the exercise of market power because they were more than 60 miles from Ukiah and were not, therefore, a viable alternative for an HMO or PPO seeking to build a provider network.

109. His conclusion regarding market power was based, in part, on an analysis of the proposed acquisition by Nuveen & Co. (CX-14) which stated:

> The acquisition is sound because it increases AHS/W's market presence, and, consequently, its third-party contracting power in the Ukiah area. . . .
>
> By acquiring [UGH], the link between the AHS/W's Willits and St. Helena facilities will be fortified and the Adventist System will be vying for a dominant position on the Route 101 corridor between Eureka and Santa Rosa.

(CX-14-F). A second Nuveen study analyzing the benefits of the UGH purchase concluded:

> The potential economies of scale and large marginal revenue increases are not as readily available in the Ukiah market as in Lawrenceburg, because two facilities would continue to be operated. . . . The real benefit to consolidation in this market is the sole provider status. A sole community provider should entail reduced competition for medical staff members and nursing personnel. . . .

(CX-15-G).

110. Dr. Melnick also referred to an AHS/West analysis, dated May 1987, listing as arguments in favor of acquiring UGH (1) the "opportunity . . . for AHS/West to dominate the 101 corridor, from Santa Rosa north to Eureka"; and (2) that "whoever dominates Ukiah will, inevitably, dominate Mendocino and northern Lake County" (CX-16-H).

111. Respondents insist that these statements are not as damning as Dr. Melnick claims, but they do suggest that the proposed acquisition was favored because it would eliminate a competitor and enhance AHS/West's "presence" in the Ukiah area.

112. However, AHS/West's "presence" in Ukiah is significant only if it can exercise market power, a conclusion which I cannot accept because the relevant markets proposed by complaint counsel are "weak" according to Elzinga-Hogarty standards and inpatient outmigration from these alleged markets for routine medical care to Santa Rosa hospitals would be a likely response to the attempted exercise of such power. This would seem to be the reason why third-party payors expressed no concern that the acquisition would leave the Ukiah area with only one hospital (RX-371-I-4; RX-373-N). Significantly, Dr. Melnick's analysis of probable competitive injury did not include any consideration of the effect of adding the Santa Rosa area as part of the relevant geographic market (Tr. 880).

3. Entry Conditions

113. Andrew Door, an architect employed as project director for the San Francisco architectural firm of Anshen & Allen Architects, has direct experience in the construction of California hospitals (Tr. 597-99). He testified that it requires approximately six to eight months for the architectural firm and medical planners to define the size of a proposed hospital and its budget parameters, and to select a suitable site (Tr. 599). It takes an additional fifteen to eighteen months for the architectural team to produce a set of production documents for approval by OSHPD (Tr. 600-02) which takes from eight to twelve months to review them (Tr. 600-02). After OSHPD approval is obtained, it takes from twenty to twenty-four months to construct the hospital (Tr. 602). After construction is completed, the hospital must then be approved by OSHPD to ensure that it meets safety codes, and earthquake and other regulatory standards (Tr. 602). Once approved, the hospital must be licensed and supplied for occupancy (Tr. 602-03). The entire process typically takes four to five years (Tr. 601).

114. Melvin N. Hardman is principal architect for OSHPD and is intimately familiar with the process for constructing hospital facilities in California (Tr. 480-81, 490). OSHPD must review and approve hospital plans before construction of a hospital facility can begin (Tr. 482-87).

115. The process of constructing a hospital begins with the owner developing feasibility studies to determine the size and nature of the hospital (Tr. 481). The owner must then secure property that

is geologically and seismically suitable and obtain the necessary permits (Tr. 481-82). This preplanning stage takes from one to two years (Tr. 482). Once permits are obtained, the owner will normally hire an architect and/or engineer to begin preparing production documents which are then presented to OSHPD for initial review which can take from six to eight months (Tr. 482-85). It takes an additional one to two months to obtain OSHPD approval of the production documents and to obtain a building permit (Tr. 486). Actual construction takes about one and one-half years (Tr. 487). After construction is completed, the hospital must be inspected by OSHPD, licensed by the California Department of Health Services, and outfitted before occupancy. After construction is completed, OSHPD conducts the final inspection of the project (Tr. 487-89). Mr. Hardman estimated that it takes from three to five years to construct a fifty-bed hospital in California (Tr. 489).

116. Respondents argue that a potential competitor could enter the Ukiah market by purchasing and reopening the former Mendocino Hospital facility which was closed in 1990 (RPF 506-15). I disagree, for at the time it was closed, it was in poor condition: the roof needed repair; the hospital's equipment was antiquated; and the emergency room had been closed down (Tr. 202). Mendocino Hospital had only one surgical suite, so only limited surgery could be performed (Tr. 181). Moreover, the structure needed major seismic work (Tr. 181-82, 208). Ms. Mahoney, its former administrator, estimated that it would cost from $4 to $8 million to renovate Mendocino Hospital to make it an acute care facility and that the cost of the necessary seismic work alone would be from $400,000 to $550,000 (Tr. 206- 09). It would take at least two years to complete this work (Tr. 209). In any event, the facility is probably unavailable because Mendocino County has recently announced plans to convert it into a county administrative and health services office complex (Tr. 204-06).

4. Hospital Competition

117. Dr. Melnick testified that hospitals compete on price and service, and that this competition benefits consumers (Tr. 704-06). For example, a study of his shows that in hospital markets where there is competition, charges to third-party payors rise more slowly than in one hospital markets (Tr. 699-70; CX-90-C).

118. A 1988 paper written by Dr. Melnick and Jack Zwanziger stated that: "Previous studies of hospital competition have found that greater competition leads to higher costs." This paper concluded that programs in California intended to contain the rate of increase in hospital costs seemed to have worked (RX-365-A); however, it cautioned that: "It will be important to examine in future research whether these cost-reducing effects will persist in the long run. . . ." (RX-365-Q).

119. Furthermore, respondents' counsel reminded him that:

> Q. And your own research shows that one hospital markets have lower costs than two-hospital markets. So the expectation in Ukiah would actually be that the Ukiah Valley Medical Center would be a lower cost hospital?
>
> A. If the world stopped today and we left it like that, that would be the case. That's called the static.
>
> Q. All right.
>
> A. What we are looking at is a dynamic market, and by virtue of the use of competition and competitive pressure, we saw that costs started to decline. The gap between these are narrowing. And if we can keep that competitive pressure in markets in California, and in other places, we hope to see these lines cross.

(Tr. 871).

120. Hospitals compete for managed care contracts with third-party payors on the basis of both price and service. Representatives of Blue Shield of California and Blue Cross of California, the major third-party payors in Mendocino County, agreed that managed care contracts are sold on the basis of price and that hospital competition placed these third-party payors in a better negotiating position (RX-318-T; RX-371-Q; RX-373-Y-Z).

121. Third-party payors are price-sensitive when contracting for hospital services. Harold K. Strunk, Blue Shield's regional manager for hospital relations, stated:

> If there are . . . hospitals near or around your service area that meet your criteria for contracting, quality, and can work with you on price, then you can keep your rates down. [W]e're always aware of other hospitals, and we're always cognizant of ways that might reduce what our costs will be.

(RX-371-Q).

122. UAH and UGH competed for managed care contracts on both price and service. UAH's strategic plan for 1989 noted that "Ukiah General Hospital seems to have been very aggressive in

landing such [commercial insurance] contracts, whether or not they were always advantageous" (CX-17-N; *see also* RX-316-Z-4-5).

123. Prior to the acquisition, Blue Shield of California had a managed care contract with UGH because it was a full service hospital, *i.e.*, it had an obstetrical unit, whereas UAH did not (Tr. 360-61; RX-25-A; RX-371-Q). In August 1986, UAH applied to OSHPD for a permit to construct a birthing center so that it could better compete with UGH for managed care contracts (Tr. 360-61; RX-29-G). The proposed UAH facility would have been a 5,500 square foot "Birthing Center," which would have included four labor/delivery/recovery/postpartum ("LDRP") rooms and would have essentially duplicated UGH's obstetrical unit (RX-29-Z-41; RX-30-Z-7; Tr. 360-62; *see also* RX-29). UAH's explicit goals in building the birthing center were to become a full service hospital in order to attract a higher percentage of female patients of child-bearing age and thus be able to compete for managed care contracts (Tr. 360-61; RX-29-D, G-H). As of 1986, UGH had the only obstetric facility in Ukiah (Tr. 360; RX-29-D; RX-30-Z-7). Its facility was described as overcrowded and unresponsive (Tr. 102; RX-29-Z-7). Prior to the acquisition UGH had approximately 93 percent of the Ukiah obstetrical market (CX-15-Z-14).

124. UGH responded to UAH's proposed birthing center by expanding and improving its birthing center. A 1987 UGH planning document discussed the need to expand its birthing center to meet the challenge posed by UAH's proposed birthing center:

> [UAH] has signified its intent to enter the obstetric market with the construction of a 4-bed birthing unit. With the addition at the Ukiah General Hospital, we will maintain our strong competitive position for OB services and possibly deter the competing facility from proceeding with their plan.

(RX-125-A; Tr. 1204-05). The expanded UGH birthing center included eight LDRP rooms and a Level II neonatal nursery, which was described as being on the cutting edge of technology (CX-66-C; Tr. 106-07). The Level II nursery permitted UGH to treat newborns who would otherwise have been transferred to hospitals in Santa Rosa or San Francisco (Tr. 105-06). In addition, the presence of the Level II nursery permitted women with high-risk pregnancies to give birth at UGH, rather than at hospitals in Santa Rosa or San Francisco (Tr. 105-06).

125. The expanded UGH birthing center and Level II neonatal nursery was an improvement in the quality of care for Ukiah-area patients (Tr. 103-07).

126. Hospitals also compete for physicians, because physicians usually make the decision where to hospitalize patients. In its 10-K Annual Report (CX-64), HealthTrust described the role of physicians as the gatekeepers for hospital admissions:

> Since physicians control the majority of hospital admissions, a significant factor in a hospital's competitive position is the number and quality of physicians on its medical staff. A physician may at any time terminate his or her affiliation with a company owned hospital. Accordingly, the company seeks to retain physicians of varied specialties on its hospital staffs and to attract other qualified physicians by maintaining high quality facilities and equipment, dedicated employees and comprehensive support services for physicians and their patients, as well as high ethical and professional standards. The company believes that physicians refer patients to a hospital primarily on the basis of the quality of services it renders to physicians and patients, the quality of other physicians on the medical staff, the location of the hospital and the quality of its facilities, equipment and employees.

(CX-64-F).

127. UGH and UAH competed to influence physicians' decisions about where to admit patients by improving services and adding and updating equipment (Tr. 102-03, 109-10, 163-64, 630, 632-34, 899-900, 962). Ms. Mahoney testified that the loss of UGH and Mendocino Hospital as competitors resulted in loss of physician leverage and that when there were two or three hospitals in Ukiah, hospital administrations were more responsive to physicians' quality assurance concerns and equipment needs (Tr. 187-89, 199-201).

128. Despite the fact that hospitals do compete in terms of price, that competition is limited to only a portion of their patient census.

129. Approximately 45 percent of Ukiah Valley's patients are Medicare patients (Tr. 400-01, 1058). Medicare is a federally-funded program under which health care providers are reimbursed a set amount for a particular DRG (Tr. 399-401, 1058, 1214). Medicare dictates how much Ukiah Valley is reimbursed for treating Medicare patients (Tr. 399, 561). Usually, Medicare reimbursements are less than Ukiah Valley's cost of treatment (Tr. 1361-62).

130. Approximately 20 percent of Ukiah Valley's patients are Medi-Cal patients (California's Medicaid plan) (Tr. 1062). Medi-Cal reimburses a health care provider based upon its definition of the cost of providing certain services. Its reimbursement, which is usually

lower than Medicare's, is expected to decrease even further in the future (Tr. 401, 576, 588-89, 1062-63, 1366).

131. Medi-Cal reimburses Ukiah Valley under a non-negotiated cost-basis scheme (Tr. 577). Medi-Cal's reimbursement for patient treatment, which it dictates, is lower than Ukiah Valley's actual treatment cost (Tr. 561, 1361-62).

132. Seven to eight percent of Ukiah Valley's patients are no-pay patients (Tr. 1063); thus, about 75 percent of Ukiah Valley's customers (Medicare, Medi-Cal and no-pay) dictate how much it will be reimbursed for patient treatment (Tr. 1064). Dr. Melnick's analysis of competitive effects ignored payor mix (Tr. 797-98).

133. Mr. Harold Strunk, regional manager for hospital relations for Blue Shield of California, testified that if Ukiah Valley did not offer a reasonable rate, its subscribers probably would have to go to SRMH (RX-371-Z-3-4) and Mr. Devitt, Ukiah Valley's administrator, claimed that it could not dictate prices to third-party payors because they could send their subscribers to hospitals in Santa Rosa (Tr. 1066).

G. *Post-Acquisition Conduct*

134. Dr. Melnick ignored any post-acquisition effects in this case because an acquiring firm is aware of the possibility of an investigation and litigation and may be tempted to forego the exercise of any market power it possesses (Tr. 814).

135. Complaint counsel suggest, however, that an analysis of post-acquisition conduct reveals adverse effects on the price and quality of the hospital services offered by Ukiah Valley.

136. Prior to the acquisition, UAH and UGH offered complete on-site laboratory services (Tr. 115, 974); afterwards, laboratory services were consolidated at the UAH site at Hospital Drive, more than one mile from UGH's Dora Street facility (Tr. 116), and physicians with patients at the latter facility must now send specimens by courier to the Hospital Drive site for processing and evaluation (Tr. 620-21).

137. Some Ukiah physicians testifying at the hearing charged that they have experienced significant delays in obtaining laboratory results at the Dora Street site -- delays which might place a patient at risk if prompt test results were essential (Tr. 114-18, 620-22, 924-25, 974-76).

138. In its 1989 strategic plan, UAH acknowledged "ongoing consolidation problems, *i.e.*, clinical lab, as a result of partly developed and implemented consolidation plans" (RX-5-Z-130).

139. Some Ukiah physicians also complained that the closing of the Dora Street emergency room adversely affected the quality of services provided at that site (Tr. 202, 261-64, 274-75, 622-24, 900-07, 926, 938; CX-43-B-C).

140. Prior to the acquisition, the emergency room was staffed by a physician 24 hours a day, seven days a week, and emergency room physicians acted as backup for UGH's intensive care and neonatal intensive care units (Tr. 922-23, 1235, 1682). The committee coordinating the UAH/UGH consolidation expressed their concern, in memoranda dated August 31, and September 8, 1988, about problems which could be caused by closure of the UGH emergency room (RX-39-F-G, K-L).

141. Dr. Valente testified that hospital charges for a laparoscopic tubal ligation were about $1500 in 1988 and are now more than $3000 (Tr. 124); that charges for a tubal reanastomosis were $3500 in 1988 and are now between $8000 and $9000; and that charges for a hysterectomy were about $3500 before the acquisition and are now close to $6000 or more (Tr. 124-25). Dr. Baltins testified that charges for a simple arthroscopy of the knee were between $1400 and $1500 before the acquisition; they are now about $4700 (Tr. 1036-38).

142. Complaint counsel also claim that Ukiah Valley's charges for certain surgical procedures are substantially greater than at Santa Rosa hospitals (CPF 133).

143. Dr. Valente's and complaint counsel's claims are anecdotal and do not constitute reliable evidence that, because of the acquisition, Ukiah Valley has been able to charge more for comparable procedures than other hospitals.

144. A much more extensive pre- and post-acquisition analysis of prices charged by Ukiah Valley was conducted by Dr. Lynk. His study, using OSHPD data, compared Ukiah Valley's gross average charges for the top 20 DRGs performed there (Tr. 1530-31; RX-169; RX-319) with prices charged for the same DRGs at other hospitals used by patients in the 45 ZIP codes that regularly send patients to Ukiah Valley (Tr. 1530-31; RX-169; RX-319).

145. Dr. Lynk concluded, from this analysis, that Ukiah Valley did not charge prices above competitive levels either before or after

the acquisition; in fact, the gross charges at Ukiah Valley have been lower than the average of competing hospitals (Tr. 1532-34; RX-169).

146. Dr. Lynk reviewed prices charged by other hospitals affiliated with AHS/West and found that Ukiah Valley's pricing, relative to those hospitals, was neither inflated nor depressed (Tr. 1535-38; RX-319).

147. Dr. Lynk testified that third-party payors seek as large a discount as possible of gross charges by a hospital and that a hospital exercising monopoly power would be expected to resist discounts from its gross charges (Tr. 1538, 1541-42). However, his analysis of Ukiah Valley's contractual reductions and adjustments to its charges indicates that from 1988 to 1991, it increased the percentage discounts off its charges for all inpatients -- from 30.3 percent to 45.9 percent for Medicare inpatients, from 20.1 percent to 35.6 percent for PPOs, from 23.3 percent to 33.8 percent for Medi-Cal inpatients, and from 27 percent to 31.8 percent to HMO inpatients (Tr. 1539-41; RX-196-201; RX-275).

148. Respondents also deny that the consolidation of the laboratory and the emergency room have created significant quality of care problems. They point out that Dr. Valente, a Ukiah physician who was concerned about the acquisition (Tr. 131), conceded that quality of care with respect to surgical results can be hard to measure and that he would not judge a physician on the basis of the complaints of a few patients (Tr. 129-30).

149. In fact, it is not unusual for physicians to be dissatisfied with hospital administrations (Tr. 667). Dr. Carter, a staff emergency physician at Ukiah Valley, testified that "there is always an inherent distrust between medical staffs and administrator" (Tr. 1671).

150. While Ukiah physicians have complained about the post-acquisition consolidation of the UGH and UAH laboratories, there were complaints about the UGH laboratory prior to the acquisition (Tr. 1433, 1672) including the slow delivery of reports (Tr. 636-38).

151. Dr. Carter, a staff emergency room physician and chief of staff at Ukiah Valley (Tr. 1659-61), denied that consolidation of the emergency rooms at UGH and UAH reduced quality of care at Ukiah Valley; in fact, prior to the closing of the emergency room at UGH, he believed that the two emergency rooms should be consolidated because there were not enough patients to support them. In his

opinion, a single emergency room would increase the quality of emergency care (Tr. 1677).

152. Prior to the acquisition, UGH had one full-time emergency room physician and two part-time practitioners, who were pediatricians. Only Dr. Carter was board certified in emergency medicine (Tr. 1660, 1664). Being board certified is a recognition by the medical profession that a physician is a specialist or is proficient in his or her particular field (Tr. 268, 1693).

153. Prior to the acquisition, there were four full-time and a number of part-time emergency room physicians at UAH. Two of the four full-time physicians were board certified. It was difficult to attract more board-certified physicians to UAH because of the low volume of patients (Tr. 1695-96).

154. Dr. Gester, head of the emergency room at UAH, Dr. Carter and Mr. Devitt testified that the consolidated emergency room at Ukiah Valley has attracted more qualified physicians and nurses (Tr. 1078-79, 1675-76, 1697-98): All of its emergency room physicians are board certified, and six of the eight are certified in emergency medicine (Tr. 1705). Dr. Gester and Mr. Devitt also believe that the acquisition was a factor in improving the quality of nurses, particularly in the emergency room (Tr. 1078, 1707).

155. Dr. Gester also believes that the acquisition was beneficial because prior to the acquisition, despite the low volume at UGH and UAH, a physician had to be at each facility (Tr. 1703). Now, with the consolidation, Ukiah Valley has double coverage during busy times and realizes greater economy during slower hours (Tr. 1703). In his opinion, if divestiture were ordered in this case and two emergency rooms were established, the quality of emergency room care would suffer (Tr. 1711).

H. *Post-Acquisition Efficiencies*

156. During his testimony, Dr. Lynk noted the "remarkably small size of both of these hospitals [UAH and UGH] prior to the consolidation" and referred to economic literature which recognizes that hospitals of this size are not large enough to compete effectively and are much more likely to fail than larger hospitals (Tr. 1557-58, 1569-70).

157. After reviewing data concerning hospitals of various sizes compiled by the American Hospital Association, Dr. Lynk concluded

that smaller community hospitals in California have a lower occupancy rate (Tr. 1558-60; RX-213). He also testified that smaller hospitals are less able to offer the services provided by large hospitals and are at a disadvantage in terms of labor cost (Tr. 1561-64; RX-214; RX-217; RX-216-A-O).

158. Dr. Lynk's opinion is confirmed in "Economic Analysis In Health Care Antitrust," an article written by FTC economists:

> A recent review of the literature on hospital cost function estimation found that most analyses characterize production of hospital services as having constant returns to scale or constant unit cost with increasing output once a threshold of approximately 200 beds is reached. Thus, most of these studies indicate that hospitals below this size prior to the acquisition are not capable of producing hospital services with maximum efficiency. In particular, Grannemann found evidence of strong economies of scale in the production of emergency room services, and most studies which disaggregate hospital output find that average costs decrease at least up to some point with increases in unit output and bed utilization. This would imply that a consolidation of the overlapping departments of the two hospitals might produce significant efficiencies due to the presence of scale economies in production.

159. Dr. Richard C. Stein, physician-in-charge at Kaiser Permanente Medical Group in Santa Rosa, testified that Kaiser would not build a hospital smaller than 100 beds (RX-372-G-H), and, while not necessarily agreeing with him, Dr. Melnick conceded that "most authors" find that cost per patient admission is minimized beginning at around 70 or 80 beds (Tr. 861).

160. Ukiah Valley's goal is to consolidate on one campus (Tr. 415, 429, 434, 1077-78, 1381-82, 1420; RX-4-C; RX-5-Z; RX-41-A-B) and Mr. Ammon, the executive vice-president of AHS/West, testified that it will cost between two and three million dollars to consolidate the facilities (Tr. 425).

161. However, Ernst & Whinney, which was hired by respondents to study the efficiencies of the combined operation, estimated that it would result in a one-time savings of $2.5 million -- mostly because UAH would not have to build its proposed birthing center (Tr. 384-86, 422).

162. Mr. Brett Spenst, Ukiah Valley's chief financial officer, estimated that between August 8, 1988 (the date of the acquisition) and December 31, 1991, Ukiah Valley has saved over $11,000,000 in operating costs as a result of the acquisition (Tr. 1381; CX-95-A-I). Some of the savings claimed by Mr. Spenst are:

Elimination of a number of duplicative departments, resulting in reductions in full-time equivalents ("FTEs") (Tr. 1371) in the accounting department (saving three FTEs) (Tr. 1371, 1393), medical records and transcription department (four FTEs) (Tr. 1372, 1393) food preparation department (two FTEs) (Tr. 1372), patient business offices (five FTEs) (Tr. 387, 1372), warehouse (one FTE) (Tr. 1373) computer services (one-half FTE) (Tr. 1373) and personnel (Tr. 1371).

163. According to Mr. Spenst, Ukiah Valley has also achieved efficiencies by reducing its length of stay by half a day through increased case management (Tr. 1372-73, 1393).

164. Other cost savings which Mr. Spenst claims are a result of the acquisition include:

Efficiencies achieved by consolidating the managements of the two separate hospitals (Tr. 387, 1070-71, 1098-99).

Realization of continuing ongoing annual savings by consolidating service departments (Tr. 387-88, 1072) including approximately $700,000 on emergency room fees by not having to staff two fully equipped emergency rooms (Tr. 623, 1376, 1402; RX-24; RX-48-A).

Savings of approximately $95,000 by having only one lab contract, rather than two separate contracts for pathology services (Tr. 1173-75, 1376). Supply expense, maintenance contract costs, and lease and rental costs have also been reduced significantly (Tr. 1376-77, 1411).

Increased experience rating at Ukiah Valley resulting in reduced malpractice insurance costs (Tr. 1378, 1399-1401).

Supplying its own blood needs has reduced costs in that area (Tr. 1378).

Foregoing the purchase of equipment which would duplicate UGH's equipment (Tr. 1099). This savings allegedly totals some $2.7 million (Tr. 1378-79, 1414-16). By avoiding duplicative Birthing Center equipment, Ukiah Valley supposedly saved approximately $500,000 (Tr. 389-90, 1103, 1167, 1380). Mr. Devitt also testified that Ukiah Valley will also save money by selling existing duplicative equipment (Tr. 1170-71).

165. Complaint counsel challenge most of the claimed cost savings, arguing either that they are overstated or are offset by other costs, including the cost of consolidation.

166. The costs of full consolidation are not, as respondents argue, two to three million dollars. Acquisition costs alone were some $8 million (F7) and respondents' proposed master plan for consolidation estimates that Phase I construction (OB/GYN Unit, pharmacy, conference rooms, ICU/CCU, "shelled space on two upper floors" and central HVAC plant) would cost $8 million (RX-28-C, E-F).

167. The $16 million acquisition and renovation cost will be reduced when and if respondents sell the abandoned UGH facility but

there is no reliable estimate of the profit, if any, which respondents would realize if it were sold.

168. Furthermore, the cost savings realized by not building a birthing center is merely a cost deferral, for if the facilities are consolidated, a new birthing center will have to be constructed at the UAH site, probably at a cost of $4 million (RX-28-E).

169. Complaint counsel challenge respondents' estimate that they saved $1.89 million in salaries and benefits from August 1988 to December 1991 (CX-95-A), claiming that, when adjusted for inflation, respondents' salary and benefit costs per adjusted occupied bed are the same as the two hospitals' costs were before the acquisition (CPF 146-150).

170. Complaint counsel also argue that Mr. Spenst has overstated the savings realized from not operating a duplicate birthing center (CPF 153-54), property tax savings (CPF 152), savings from avoiding purchase of duplicate facilities (CPF 155) and staffing economies of scale (CPF 156).

171. Respondents' estimates of cost savings are not as precise as claimed, and they make some assumptions which may not be correct, but complaint counsel's criticisms do not take into account the effect of savings, no matter how modest at any particular moment, over a long period of time. For example, the construction of a new birthing center will be costly, but cost savings can probably defray the initial costs in three to five years. The benefits of the new center will be realized for many years to come (Tr. 389, 1194, 1380, 1420). As Mr. Devitt testified:

> Q. But those costs [of construction of the OB department] will have to be deducted from your savings. Isn't that fair to say that?
>
> A. On the one hand, I would say yes; but over the long-term operation, consolidation on the one campus will more than save the investment in the capital -- in the building. The building, as I said before, is a one-time capital expenditure. Once you have it built, you then gain the efficiencies of having everything on one campus. When we were going to have a $2 million investment in a second OB in town, it was going to be a $2 million investment and only, we hoped, half of the OB business in town, and splitting everything in that direction. We will have one facility and, with the efficiencies realized with one facility, we will realize a considerable savings in operations. It will pay for itself.

(Tr. 1168).

172. Thus, despite the uncertainties presented by respondents' estimates, I conclude that the full consolidation of UAH and UGH

would result, over time, in significant cost savings as compared with the cost which would be incurred by UGH and UAH if they were to operate as separate facilities.

III. CONCLUSIONS OF LAW

A. *Jurisdiction And Interstate Commerce*

In its August 2, 1991, decision in this case, the Commission decided that Section 7 of the Clayton Act reaches asset acquisitions by not-for-profit entities; furthermore, the interstate commerce requirements of Section 7 of the Clayton Act have been met in this proceeding (SD paragraphs 1-5).

B. *The Relevant Product Market*

Whether complaint counsel's proposed product market -- inpatient acute care hospital services -- is appropriate is determined by examining "the cross-elasticity of demand between the product itself and substitutes for it." *American-Medical Int'l* ("AMI"), 104 FTC 1, 191 (1984); *Brown Shoe, Co. v. United States*, 370 U.S. 294, 325 (1962); *Department of Justice and Federal Trade Commission 1992 Horizontal Merger Guidelines,* 4 CCH Trade Reg. Rep. paragraph 13,104 at Section 1.1 ("1992 Merger Guidelines").

The "cluster of products and services," *United States v. Philadelphia National Bank*, 374 U.S. 321, 356-57 (1963), offered by acute care hospitals to inpatients has been adjudged as the appropriate product market in several cases involving hospital mergers. *See FTC v. University Health Systems*, 938 F.2d 1206, 1210-11 (11th Cir. 1991); *Hospital Corp. of America* ("HCA"), 106 FTC 361.

Respondents ask me to consider the size of UGH and UAH and their greater reliance than larger hospitals on outpatient business, a business which is facing increasing competition from surgicenters and other providers who are offering outpatient treatment for conditions which were formerly treated on an inpatient basis.

The record supports respondents' claim that outpatient providers are offering increased competition to hospitals' outpatient facilities (F 33), but this trend has no effect on inpatient care, for which there is no outpatient substitute. *United States v. Rockford Memorial Hospital Corp.* ("Rockford"), 898 F.2d 1278 (7th Cir. 1990):

For many services provided by acute-care hospitals, there is no competition from other sorts of provider. If you need a kidney transplant, or a mastectomy, or if you have a stroke or a heart attack or a gunshot wound, you will go (or be taken) to an acute-care hospital for inpatient treatment. The fact that for other services you have a choice between inpatient care at such a hospital and outpatient care elsewhere places no check on the prices of the services we have listed, for their prices are not linked to the prices of services that are not substitutes or complements. If you need your hip replaced, you can't decide to have chemotherapy instead because it's available on an outpatient basis at a lower price. Nor are the prices of hip replacements and chemotherapy linked.

The court recognized that "a growing number of services provided by acute care hospitals are also available from nonhospital providers," but noted that "for many services provided by acute-care hospitals, there is no competition from other sorts of providers." *Id.* at 1284. *See also HCA*, 106 FTC at 464-66.

The evidence in this case justifies the same conclusion as in Rockford, University Health and HCA. UAH planning documents treat inpatient and outpatient care as separate businesses (F 32); physicians testified that the cluster of inpatient services offered by hospitals are not found at outpatient facilities (F 27); third-party payors will not pay for inpatient procedures if outpatient care would be adequate (F 31); and, most economists who study the hospital industry recognize that inpatient acute care hospital services are a relevant product market (F 29).

C. *The Relevant Geographic Markets*

A geographic market is the smallest area in which a hypothetical monopolist could impose a "small but significant and nontransitory" increase in price. 1992 Merger Guidelines Section 1.21. *AMI*, 104 FTC at 119. It is the area in which participants "effectively compete," and "to which the purchaser can practicably turn for supplies." *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320, 327, 332 (1961).

Past cases have viewed hospital markets as local in nature, *AMI*, 104 FTC at 197; *HCA*, 106 FTC at 471-72. In Rockford, the trial court stated: "[P]hysicians and patient preferences for nearby hospitals is the main reason for keeping the geographic area relatively small," 717 F. Supp. at 1277.

Respondents do not deny that hospital markets are local in nature but they point to the Santa Rosa hospitals, located only 60 miles away, as reliable, "local" alternatives for inpatients who up to now have used hospitals in the Ukiah-Willits and Ukiah-Willits-Lakeport area.

The Ukiah-Willits and Ukiah-Willits-Lakeport markets are the smallest ones which satisfy the Elzinga-Hogarty test, but they are weak and Dr. Melnick's and complaint counsel's attempts to refine the LIFO figures for Ukiah-Willits and Ukiah-Willits-Lakeport are unconvincing (F 68-73).

The reason for their weakness is apparent: there is substantial outmigration from these areas for routine medical care, particularly to Santa Rosa, for Dr. Lynch's DRG analysis reveals that a majority of the patients seeking care at Santa Rosa hospitals could have been treated at UAH and UGH (F 63), and some Ukiah physicians testified that Ukiah residents have sought medical care in Santa Rosa hospitals for conditions which could have been treated at Ukiah hospitals (F 92-93).

Health care providers also testified that their Ukiah subscribers do go or could go to Santa Rosa hospitals for routine medical care, and Medi-Cal guidelines suggest that requiring patients to do so would not be impractical (F 94-96).

Complaint counsel point to denials by other Ukiah physicians that they send their patients to Santa Rosa hospitals for routine care (F 92), to the lack of overlaps in the medical staff of Ukiah and Santa Rosa hospitals (F 90), to testimony by representatives of SRMH and SRCH (F 82-83), respondents' own analysis of UAH's and UGH's competitors (F 75-77, 79-81), and other hospitals' analyses of competition (F 78) as confirmation that the leakage from the Ukiah area to outside hospitals is competitively insignificant. All of these factors have been considered by the Commission and the courts in determining the boundaries of the relevant geographic market. *AMI*, 104 FTC at 122, 123; *HCA*, 106 FTC at 438; *Rockford*, 717 F. Supp. at 1277.

However, this evidence does not necessarily support complaint counsel's claim. Dr. Lynch's DRG analysis which shows significant outmigration for routine procedures suggests that Ukiah area patients are bypassing Ukiah physicians for physicians with hospital privileges in Santa Rosa -- and, in fact, [ ] of SRMH and SRCH's inpatients come from Mendocino and Lake counties. This is not an

insignificant amount, since most of them receive routine medical care (F 63). Compare Owens-Illinois, Inc., FTC Dkt. 9212 (Slip op. Feb. 26, 1992), in which the Commission found that the "presence of a substantial competitor . . . and a 4-5% market share [in metal cans] shows that metal cans compete with glass in this end-use segment." *Id.* at 16. Although this case involved product market definition, the same principle is applicable to the geographic market issue. Thus, the outmigration for routine care in this case is much more significant than in *AMI*, 104 FTC at 122.

Also, references to "service areas" in documents cited by complaint counsel (F 76, 77) do not establish that they are relevant geographic markets, for that phase refers to the area from which hospitals draw their patients, not the area to which Santa Rosa. Finally, the fact that Santa Rosa hospitals did not view UGH and UAH as competitors does not mean that the larger hospitals do not attract Ukiah residents for routine care -- as they, in fact, do (F 63).

Since Ukiah residents can practicably turn to Santa Rosa hospitals for routine medical care if necessary, Tampa Electric, *supra*, and complaint counsel's proposed relevant geographic markets do not include those hospitals, I reject those markets.

D. *Effects On Competition*

Dr. Melnick's conclusion that the acquisition is anticompetitive is based on the very high HHI's in the Ukiah-Willits and Ukiah-Willits-Lakeport markets (F 102-06). He expressed no opinion with respect to the effects of the acquisition in a market which would include the Santa Rosa hospitals (F 112).

Since I have found that the relevant geographic market includes these hospitals, I reject Dr. Melnick's claim that the acquisition confers market power on Ukiah Valley. Other record evidence supports my conclusion.

No matter which market is chosen, the acquisition can have no effect with respect to Medicare, Medi-Cal and no-pay patients, for Ukiah Valley cannot charge prices which exceed the amounts allowed by Medicare and Medi-Cal and receives nothing from no-pay patients. Thus, Ukiah Valley can affect the prices charged to only 25% of its patients (F 128-32), and would face considerable opposition from third-party payors if it attempted to gouge their subscribers, including threats to use Santa Rosa hospitals (F 133). In

fact, representatives of third-party payors expressed no concern about this acquisition (F 112). *See United States v. Archer-Daniels-Midland Co.*, 1991-2 CCH Trade Cas. paragraph 69,647 at 66,918, 66,922 (S.D. Iowa 1991).

E. *Post-Acquisition Conduct*

Some evidence regarding post-acquisition conduct may be considered when the potential impact of a challenged acquisition is assessed. *See United States v. General Dynamics Corp.*, 415 U.S. 486, 504-06 (1974); *United States v. Falstaff Brewing Co.*, 410 U.S. 526, 530 n. 11 (1973); *FTC v. Consolidated Foods Corp.*, 380 U.S. 592, 598 (1965).

However, since the possibility of post-acquisition price manipulation exists, I reject respondents' claim that Ukiah Valley has exercised pricing restraint (F 144-47). *See General Dynamics*, 415 U.S. at 504-05.

If a demonstration that no anticompetitive effects had occurred at the time of trial or if judgement constituted a permissible defense to a Section 7 divestiture suit, violators could stave off such actions merely by refraining from aggressive or anticompetitive behavior when such a suit was threatened or pending.

On the other hand, proof that respondents have been able to raise post-acquisition prices is relevant; however, the evidence presented by complaint counsel is anecdotal and does not support their claim (F 141-43). *See Simeon Management Corp. v. FTC*, 579 F.2d 1137, 1148 (9th Cir. 1978); *Wilk v. American Medical Ass'n*, 1987-2 CCH Trade Cas. paragraph 67,689 at 58,542; *Coca-Cola Bottling Co. of New York*, 93 FTC 110, 202 (1979).

F. *Efficiencies*

Since I have found that the challenged acquisition will not adversely affect competition, I need not resolve the parties' disagreement over possible efficiencies of the acquisition; nevertheless, some comment on this issue should be made.

There is no question that there were significant acquisition costs and that there will be significant consolidation costs, but, in the long run, the savings realized by operating a single facility in Ukiah will outweigh those costs (F 171-72).

Furthermore, the creation of a hospital which is larger and more efficient than UGH and UAH will provide better medical care than those hospitals could. *See Hospital Characteristics and Quality of Care*, J.A.M.A., Vol. 268, No. 13, p. 1709 (Oct. 7, 1992), reporting a study which concluded:

Quality varies from state to state, but teaching, larger, and more urban hospitals have better quality in general than nonteaching, small, and rural hospitals.

Complaint counsels analysis of this acquisition assumes that competition among health care providers will give consumers the same benefits as competition in other industries, *see Fishman v. Estate of Wirtz*, 807 F.2d 520, 537 (7th Cir. 1986), and they argue that competition between UAH and UGH before the acquisition was beneficial and that divestiture will reinstate those benefits to consumers residing in the Ukiah area.

The facts belie this claim. Competition did exist between those hospitals (F 122-27), but it appears to have increased the cost of hospital care in the Ukiah area through duplication of services (F 22). This is not surprising, for Dr. Melnick's 1988 analysis of hospital costs concluded that previous studies found that greater hospital competition led to higher costs. Dr. Melnick is optimistic that California programs now in place will contain costs (F 118), but at the present time one hospital markets in California have lower costs than two hospital markets (F 119).

Thus, I agree with respondents that -- assuming the acquisition is illegal -- the traditional remedy of divestiture would probably saddle Ukiah with two inefficient hospitals (F 9-22) in place of one which, despite the costs of acquisition, will, in the long run, provide better health care to Ukiah residents (F 156-59).

G. *Summary*

1. The Commission has §7 jurisdiction over respondents.
2. The acts and practices of respondents occurred in, and affected, interstate commerce.
3. The relevant product market is acute care inpatient hospital services.
4. The relevant geographic market encompasses the Ukiah-Willits-Lakeport-Santa Rosa area.

5. The challenged acquisition has not conferred market power on respondents and it is not likely to substantially lessen competition in the relevant geographic market.

ORDER

It is ordered, That the complaint be, and it hereby is, dismissed.

OPINION OF THE COMMISSION

BY AZCUENAGA, *Commissioner*:

This case presents the question whether the acquisition of Ukiah General Hospital by the Adventist Health System/West violates Section 7 of the Clayton Act. The dispositive issue is whether the town of Ukiah, California and its immediate environs is a relevant geographic market.

The Administrative Law Judge dismissed the complaint, which alleged that the acquisition substantially lessened competition in the market for acute care hospital services in the southeastern Mendocino/Western Lake County area. He determined that the relevant product market was inpatient acute care hospital services, but rejected complaint counsel's argument that the relevant geographic market was the area immediately surrounding the towns of Ukiah, Willits, and Lakeport, California (or alternatively, Ukiah and Willits). He found that if the Ukiah hospitals imposed an anticompetitive price increase, residents of that area could seek care at hospitals in Santa Rosa, California. Complaint counsel's showing of anticompetitive effects attributable to the merger was premised on adoption of a geographic market alleged in the complaint. Complaint counsel made no attempt to prove that the merger lessened competition in a broader market including the Santa Rosa hospitals. Oral Argument, Tr. 7.[1]

[1] The following abbreviations are used:

ID	Initial Decision
Tr.	Transcript of the hearing before the ALJ
Oral Argument, Tr.	Transcript of the Oral Argument before the Commission
CX	Complaint Counsel's Exhibit
RX	Respondents' Exhibit
CPF	Complaint Counsel's Proposed Finding
RPF	Respondents' Proposed Finding

Complaint counsel appeal the dismissal. The initial argument is that the ALJ erred in rejecting the proposed Ukiah-Willits-Lakeport or Ukiah-Willits geographic markets. Complaint counsel then argue that the acquisition substantially lessened competition in the alternative geographic markets.

We conclude that complaint counsel failed to carry the burden of proof that Ukiah-Willits-Lakeport or Ukiah-Willits is a relevant geographic market for the purposes of Section 7 of the Clayton Act.[2] The complaint does not permit a determination of the effects of the acquisition in any other relevant geographic market, and it is unnecessary to consider markets broader than the two supported by complaint counsel. Accordingly, we affirm the dismissal of the complaint.[3]

I. BACKGROUND

Ukiah, California is a community with a population of approximately 13,000 and is located in a valley separated by the Coastal Range from the Pacific Ocean. ID at 10. It is the county seat of Mendocino County. Because of the mountains, the main transportation corridor through Ukiah is Highway 101, which runs approximately north-south. The town of Willits is approximately 23 miles north of Ukiah on Highway 101, and the nearest urban center is Santa Rosa, which is approximately 60 miles south of Ukiah on Highway 101. San Francisco is approximately 120 miles away from Ukiah on Highway 101. ID at 10. Lakeport is approximately 34 miles to the southeast in Lake County.

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[2] Commissioner Starek concurs in the decision to dismiss the complaint but notes that even if one assumes *arguendo* that the relevant geographic market is either of the markets alleged in the complaint, the evidence demonstrates that the roster of relevant participants in each market includes firms other than those identified in the complaint. As described in the Commission's Opinion, the evidence in the record identifies two Santa Rosa hospitals as firms that participate in the assumed relevant markets. Because complaint counsel has not presented argument or evidence that the acquisition will have anticompetitive effects in any market in which the Santa Rosa hospitals are relevant participants, the complaint can be dismissed for failure to establish a *prima facie* case.

[3] On September 24, 1993, Respondents filed a "Motion For Leave to File Additional Supplemental Authority and for Summary Affirmance of the Initial Decision" urging that the Commission summarily affirm the Initial Decision on the basis of the Department of Justice and Federal Trade Commission "Statements of Antitrust Enforcement Policy in the Health Care Area." On October 5, 1993, complaint counsel filed an "Opposition to Motion for Leave to File Supplemental Authority and for Summary Affirmance." In light of the above disposition of the matter, the respondents' motion is dismissed as moot.

A. *The Parties and the Acquisition*

The Adventist Health System/West ("AHS/West") is a nonprofit California corporation that manages and controls eighteen hospitals in five western states, including Ukiah Adventist Hospital (UAH).[4] ID at 3. Ukiah Adventist is the name of the California corporation that operated the 43-bed UAH facility prior to the acquisition. ID at 3-4.

Healthtrust is a Delaware corporation that owned and operated 95 general acute care hospitals in 21 states. Before the acquisition in question, it owned Ukiah Hospital Corporation ("UHC"), which operated Ukiah General Hospital ("UGH"), a 51-bed general acute care hospital in Ukiah. ID at 4.

On July 29, 1988, Ukiah Adventist Hospital entered an agreement with UHC to purchase the assets of UGH, other than accounts receivable and certain business records. ID at 4. AHS/West had initially proposed the transaction and negotiated on behalf of UAH. The asset acquisition was completed an August 8, 1988, as one piece of a three-part transaction, the other parts of which are not relevant to the Commission's review.[5]

UAH was renamed Ukiah Valley Medical Center ("Ukiah Valley") after the merger. Since the acquisition, it has been operated as a 94-bed hospital at the two physically separated sites of the former UAH and UGH. ID at 11.

B. *Hospitals in the Area*

At the time of the acquisition in August 1988, three hospitals were doing business in Ukiah. In addition to UAH (43 beds) and UGH (51 beds), Mendocino Community Hospital had 56 beds in Ukiah. Mendocino Community Hospital, however, had only a 16 percent occupancy rate in the 1987-1988 fiscal year. ID at 5. In 1990, Mendocino Community Hospital stopped offering inpatient

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[4] AHS/West is affiliated with the Seventh-Day Adventist Church. Tr. 343-44.

[5] In connection with the UGH acquisition, HealthTrust purchased a hospital in Lawrenceburg, Tennessee from Adventist Health System/Sunbelt ("AHS/Sunbelt"), and AHS/West agreed to pay AHS/Sunbelt $400,000 plus a share of UAH's profits for ten years. ID at 4. AHS/West ultimately paid AHS/Sunbelt $1.675 million to settle the profit sharing obligation. *Id.* The total cost of the acquisition to AHS/West was $7.975 million, including a payment of $5.9 million to HealthTrust plus the payments of $400,000 and $1.675 million to AHS/Sunbelt. ID at 4.

hospital services, and in 1992, it closed its outpatient facility as well. ID at 11.

Prior to the transaction, UAH offered medical/surgical care, an emergency room, primary-level pediatric care, and ancillary services such as a laboratory and radiology. ID at 10. It did not have an obstetrical unit and did not offer advanced care such as neurosurgery, open-heart surgery or organ transplants. *Id.*

Like UAH, Ukiah General Hospital did not offer advanced medical services such as organ transplants, neurosurgery or open-heart surgery. ID at 10. It offered a range of services similar to UAH, except that it also had an obstetrical unit and neonatal intensive care nursery. *Id.*

Frank R. Howard Memorial Hospital is a 38-bed hospital located in Willits. An affiliate of AHS/West, which is under the control of AHS/West, leases and operates Howard Hospital. ID at 11.

Lakeside Community Hospital ("Lakeside") is a 63-bed hospital located in Lakeport, California. ID at 11. Like UAH and UGH, it provided primary level surgical and medical care and did not offer complex care such as neurosurgery, open-heart surgery, or organ transplants. *Id.*

The largest hospitals in the area are located in Santa Rosa. Santa Rosa Memorial Hospital ("SRMH") has 225 beds, and does offer more complex medical services that are not available in Ukiah, including open-heart surgery, neurosurgery, thoracic surgery, and cancer treatment. ID at 11-12. Santa Rosa Community Hospital has 145 beds, and also offers such specialized care as neurosurgery, thoracic surgery and cancer treatment. ID at 12. Kaiser recently opened a 106 bed hospital in Santa Rosa that offers primary and secondary care. Tr. 1003.[6]

II. THE RELEVANT PRODUCT AND GEOGRAPHIC MARKET

The Supreme Court has held that the "[d]etermination of the relevant product and geographic markets is 'a necessary predicate'" to a claim based on Section 7 of the Clayton Act. *United States v. Marine Bancorporation*, 418 U.S. 602, 618 (1974), quoting *United*

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[6] Mendocino Coast District Hospital has 54 beds and is located in Fort Bragg, about 58 miles from Ukiah on the distant side of the Coast Range. MCDH provides only primary services and does not provide services such as neurosurgery, open-heart surgery, or organ transplants. ID at 12.

There are a large number of hospitals in San Francisco, which is about 120 miles from Ukiah on Highway 101. ID at 10.

States v. E.I. DuPont de Nemours & Co., 353 U.S. 586, 593 (1957). This prerequisite follows from the requirement of Section 7 that the substantial lessening of competition be proven "in any line of commerce in any section of the country." *Brown Shoe Co. v. United States*, 370 U.S. 294, 324 (1962). The Court has held that the question whether a merger substantially lessens competition can only be answered in terms of a relevant antitrust market. *Du Pont*, 353 U.S. at 593.

A. *Product Market*

Administrative Law Judge Parker accepted complaint counsel's proposed product market definition, which is the provision of inpatient acute care hospital services. ID at 40-41. Respondents do not challenge this conclusion on appeal. Complaint counsel's expert, Dr. Melnick, opined that the appropriate product market is inpatient acute care hospital services. Tr. 708-10. Respondents' expert economist, Dr. Lynk, agreed that most economists who study the hospital industry consider this to be the appropriate market in which to analyze hospital competition. Tr. 1584-85. He, however, cautioned against overlooking the competitive significance of outpatient care. Tr. 1474-75.

Several courts and the Commission have employed this product market definition in analyzing mergers under Section 7 of the Clayton Act. *See, e.g., FTC v. University Health Systems*, 938 F.2d 1206, 1210-11 (11th Cir. 1991); *United States v. Rockford Memorial Hospital Corp.*, 898 F.2d 1278 (7th Cir. 1990); *Hospital Corporation of America*, 106 FTC 361, 464-66 (1985), *aff'd, Hospital Corporation of America v. FTC*, 807 F.2d 1381. (7th Cir. 1986). We adopt the ALJ's finding that the relevant product market is the provision of inpatient acute care hospital services.

B. *Geographic Market*

Section 7 of the Clayton Act prohibits certain acquisitions "where in any line of commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. 18. "Without exception the Court has treated 'section of the country' and 'relevant geographic market' as identical...." *United States v. Marine Bancorporation*, 418

U.S. 602, 620 (1974). The Supreme Court has stated that the relevant geographic market is "the 'area of effective competition . . . in which the seller operates, and to which the purchaser can practicably turn for supplies.'" *United States v. Philadelphia National Bank*, 374 U.S. 321, 359 (1963), quoting, *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961). It is fundamental that the Government has the burden of proving the relevant geographic market. *United States v. Connecticut National Bank*, 418 U.S. 656, 669 (1974).

The Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, (April 2, 1992) at Section 1.21, set forth the methodology employed in ascertaining the relevant geographic market for the purpose of exercising prosecutorial discretion in deciding whether to challenge a merger. Under that methodology, the agency starts with the location of each merging firm (here, Ukiah) and asks the question what would happen if a hypothetical monopolist imposed a small but significant and nontransitory price increase, assuming that the prices and terms remained constant at other locations. If the reduction in sales due to the price increase was sufficiently large to render the price increase unprofitable, then the agency adds the next best substitute location to the proposed market, and the test is repeated.

"All relevant evidence," is considered in evaluating how consumers would react to such a price increase. *Id.* Specifically, evidence that buyers have shifted purchases to another geographic location, or have considered doing so, evidence that sellers base business decisions on the prospect of buyer substitution, and evidence of the timing and cost of switching suppliers is relevant. *Id.*

The record contains little direct evidence regarding what purchasers of health care services would do in response to a small but nontransitory price increase in the proposed relevant markets in Mendocino County. Testimony by health insurance firms is equivocal, but definitely does not rule out the possibility that these consumers could shift their purchases of hospital services to providers other than those located in Ukiah, Willits, and Lakeside. A witness from Travelers, which insures the employees of Mendocino County, said that patients from Mendocino "do use Santa Rosa Memorial Hospital to a considerable extent. Not to as great an extent as they use the hospital in Ukiah." Tr. 1242. Although he suggested that Santa Rosa hospitals are a viable alternative for

Mendocino County residents, the weight of his opinion is undercut by his statement that "I don't live up there and I don't have that much knowledge of that area." *Id.*

In response to a question whether Blue Shield could direct Ukiah residents to Santa Rosa after an unreasonable price increase by the Ukiah hospitals, an official of Blue Shield testified that "I think that people would gravitate towards Santa Rosa, a bigger center, than they would to go anywhere else that would be even more rural. It's not that far away. . . ." RX-371-U. Nonetheless, he expressed concern that not having a plan hospital in Ukiah would make it more difficult to market Blue Shield plans to employers located there. *Id.* Discussing a similar hypothetical, a Blue Cross official said that although "some of the people [in Ukiah] are becoming used to going down to Santa Rosa to shop, to buy cars, and I think they're more receptive to traveling," the lack of an affiliation with a Ukiah hospital would be a competitive disadvantage. RX-373-Z-6. Kaiser has a hospital in Santa Rosa, and its patients from Mendocino and Lake Counties are expected to, and do, use the Kaiser hospital for all nonemergency care. RX-372-T.

The likely response of health insurance plans and their patients to a price increase is important in evaluating the bounds of the geographic market. As indicated above, the inquiry under the Merger Guidelines is to define the area in which a hypothetical monopolist could profitably impose a price increase. Normally, one would not distinguish among sales, but certain characteristics of the health care market may make certain patients especially critical to hospital profits. The ALJ found that the hospital can increase its prices to only 25 percent of its patients. ID at 32. He found that 45 percent of the patients were under Medicare and that their treatment was reimbursed at a rate determined by the Medicare program. ID at 32, paragraph 129. Approximately 20 percent of the patients were under Medi-Cal, which similarly had a government-determined reimbursement rate. ID at 32, paragrah 130, 131. Seven to eight percent of the patients do not pay at all. ID at 32, paragraph 132. At this point, the record does not contain sufficient information about how Medicare and Medi-Cal reimbursement rates are determined to support reliable conclusions regarding a hypothetical hospital monopolist's ability to increase prices to patients covered by those

plans.[7] Although we do not adopt the ALJ's findings, the evidence suggests that insured patients may be particularly significant to hospital profitability.

If hospital profits depend on attracting insured patients, the response of insurers and their patients likely will determine whether a hypothetical monopolist can raise prices. A shift of patients that represents a small share of a hospitals total patient load, but that accounts for a disproportionately large share of hospital profits, might well be sufficient to make a price increase unprofitable.

The record contains no evidence to indicate whether the insured patients are more price sensitive than those covered by Medicare and Medi-Cal. Oral Argument, Tr. 16. Regardless of the price sensitivity of the patients, it seems plausible that insurers are sensitive to hospital costs and might offer incentives to persuade patients to shift to lower cost, but more distant, providers. The record, however, does not permit a determination of the degree of price sensitivity that would undermine an anticompetitive price increase by the hospitals in the proposed markets.

Instead of attempting to establish how Ukiah consumers of hospital services would respond to a small but nontransitory price increase, complaint counsel relied on expert testimony regarding the Elzinga-Hogarty test.[8] They argue that this test is "[t]he most widely recognized quantitative analysis of geographic markets." App. Brief at 20. Complaint counsel cite *Hospital Corporation of America*, 106 FTC at 438, 468 n.7, and the district court opinion in *United States v. Rockford Memorial Corp.*, 717 F. Supp. 1251, 1266-78 (N. D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990), in support of their reliance on the Elzinga-Hogarty test. Appeal Brief at 20, 22.

Neither HCA nor Rockford provides a basis for definitive reliance on the Elzinga-Hogarty test as the appropriate method under the Clayton Act to establish a geographic market. In HCA, the footnote in the Commission opinion relied on by complaint counsel merely described, without endorsing, the ALJ's finding that the Chattanooga urban area was the smallest market that satisfied the

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[7] The ALJ found that the Medicare and Medi-Cal reimbursements were less than the cost of treatment. ID at 32, paragraph 129, 131. We do not adopt this finding, however, which was based on extremely limited and imprecise bits of testimony.

[8] *See* Elzinga & Hogarty, *The Problem of Geographic Market Delineation Revisited: the Case of Coal*, 23 Antitrust Bull. 1 (1978); Elzinga & Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 Antitrust Bull. 45 (1973).

Elzinga-Hogarty test. Indeed, the Commission stated that the ALJ's static Elzinga-Hogarty analysis was "incomplete."[9] 106 FTC at 472. After noting that it would be "difficult" to define an appropriate market, the opinion simply accepted arguendo the respondent's proposed market in finding liability. Similarly, in Rockford, although the district court employed Elzinga-Hogarty data extensively in its discussion, the Court of Appeals characterized the district court's market as "imperfect" and adopted it as the "less imperfect" alternative under a "clearly erroneous" standard of review. 898 F.2d at 1285.

That is not to say that patient flow analysis, employing the Elzinga-Hogarty methodology and other statistical techniques, has no place in geographic market definition. Indeed, historical or current patterns of patient flows are valuable sources of information in analyzing the question whether a hypothetical monopolist in a geographic area could exercise market power. The point is that other evidence is equally relevant.

Despite complaint counsel's heavy reliance on the Elzinga-Hogarty data, the results of the test do not provide clear support for the proposed Ukiah-Willits or Ukiah-Willits-Lakeport markets. The Elzinga-Hogarty test employs two measures of historical product or service flows into or out of a proposed geographic market. One measure is referred to as "little out from inside" or LOFI, which signifies the percentage of patients who reside in the area, and measures inmigration for services in the market.[10] The second measure is called "little in from outside" or LIFO, which signifies the percentage of patients from a particular area who remain in the area for hospital services rather than go outside the area for hospital services.[11] This statistic measures outmigration for services. *See* note 8 *supra*.

One obvious issue in using the Elzinga-Hogarty analysis is determining the cutoff percentages for patient in- and outmigration

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[9] On appeal to the Commission, complaint counsel urged adoption of a broader market defined as the Chattanooga Metropolitan Statistical Area. 106 FTC at 468. The Commission declined to accept the proposed MSA as a market because "[g]eopolitical designations such as 'MSA' may reflect a host of considerations that do not concern the issue of competition between hospitals." 106 FTC at 471.

[10] A LOFI figure of 100 percent would indicate that all the patients served by area hospitals resided within that area (that is, no patients came from outside into the market for treatment).

[11] A LIFO statistic of 100 percent would indicate that all the patients requiring hospital services within the geographic area sought treatment at a hospital in the area (that is, no patients from inside the area sought treatment outside).

at which a geographic market is established. Many argue that Elzinga-Hogarty analysis, as a static measure of historical patient flows, cannot by itself establish a relevant market, even at 100 percent levels.[12] Proponents of the test have suggested that 75 percent is a point at which a "weak" market might be recognized and that 90 percent is a point at which one might have confidence that the market is "strong." *See* note 8 *supra.* Although the proponents of this test initially suggested the 75 percent figure, in a subsequent article they apparently endorsed the 90 percent threshold. *Id.* As complaint counsel's expert acknowledged, there is no empirical evidence to support the use of either 75 or 90 percent (or any other level of historical migration) to define a market. Tr. 742-44. The Commission has not, and does not now, endorse either the "strong" or the "weak" test as the basis for establishing a relevant market.

Complaint counsel's expert, Dr. Melnick, used California state data on patient discharges from hospitals as the basis for his patient flow analysis. Tr. 719-20.[13] He identified the 22 zip codes from which UAH and UGH discharged the largest number of patients. Tr. 720; CX-80. Ten of the 22 zip codes were grouped around Ukiah; five were around Willits; and seven were around Lakeport. CX-86. The two hospitals drew patients from all three communities in significant numbers. Of the top five zip code areas from which UAH and UGH patients were drawn, two were Ukiah, two were Lakeport, and one was Willits. CX-80, 86. In absolute numbers, the two hospitals drew the most patients from the ten Ukiah zip codes, but they drew significant numbers from both Lakeport and Willits. CX-80, 86.

Dr. Melnick calculated Elzinga-Hogarty figures for an array of possible zip code groupings including areas far broader than the 22 zip codes around Ukiah, Willits, and Lakeport. Tr. 741, CX-85, 87. He concluded that the "most defensible" geographic market, based on this analysis, is Ukiah, Willits, and Lakeport, but said that Ukiah-Willits was an alternative possibility. Tr. 742.

Although complaint counsel refer to Ukiah-Willits and Ukiah-Willits-Lakeport as alternatives, the record does not provide a plausible basis for excluding Lakeport from the Ukiah-Willits

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[12] *See, e.g.*, James T. Halverson and Paul L. Yde, "Purpose, Practicability, and Profitability in Merger Market Definition," in Collaboration Among Competitors: Antitrust Policy & Economics (E. Fox & J. Halverson, eds. 1992).

[13] Dr. Melnick used data from 1987, which was the last year prior to the merger. Tr. 722.

geographic market. There is no testimony by customers or third-party payors that in the event of a small but nontransitory price increase by a hypothetical monopolist in Ukiah, patients could not readily turn to the hospital in Lakeport. Complaint counsel's expert did not advocate a Ukiah-Willits market, stating that the larger market including Lakeport was more "defensible." Tr. 742. Of course, since the only hospital in Willits is operated by an AHS/West affiliate, it is unlikely to provide a competitive alternative to patients confronted by an anticompetitive price increase in Ukiah. The Lakeside Hospital is the hospital nearest to Ukiah not operated by AHS/West.

The Elzinga-Hogarty statistics for the Ukiah-Willits-Lakeport area do not support finding a relevant geographic market limited to those communities. The hospitals in the area draw 91 percent of their patients from area residents, indicating a low level of inmigration of patients for services. The Elzinga-Hogarty measure of outmigration, however, is only 74.57 percent, which means that 25.43 percent of the area residents needing hospital services seek treatment outside the area. Tr. 833 (Dr. Melnick). Complaint counsel's expert was not aware of any economics literature defining a relevant geographic market on the basis of Elzinga-Hogarty figures below 75 percent. Tr. 833. Although the difference is fractional and could be ignored by rounding 74.57 up to 75, the fact is that neither the "weak" nor the "strong" Elzinga-Hogarty test is fully satisfied.

Recognizing this difficulty, complaint counsel argued that a large portion of the patient outmigration was attributable to patients seeking tertiary care, such as open heart surgery, not available in the Ukiah-Willits-Lakeport area. In effect, complaint counsel requests that the product market be redefined to exclude certain tertiary care services from the cluster of inpatient acute care hospital services. Hospital product markets represent a cluster of services, and in some cases it might be appropriate to ignore some services that are competitively irrelevant to evaluating the merger. Since neither UGH nor UAH provided such services as neurosurgery, cardiac surgery and organ transplants, the merger has no bearing on the provision of those services, and it seems plausible to exclude patient migration to seek those services in assessing the impact of the merger.

Although in principle we agree that services irrelevant to competition between the merging hospitals might be disregarded, complaint counsel failed to carry their burden to identify those

services and to demonstrate their impact on the patient flow statistics. Complaint counsel's expert attempted to adjust the LIFO statistic for the Ukiah-Willits-Lakeport market to exclude those patients who sought treatment outside the market for services not offered by a hospital in the market. Tr. 755. He calculated a LIFO figure of 84 percent for what his exhibit describes as an "alternative product market." CX-89. In 1987, 2711 patients left the Ukiah-Willits-Lakeport area for inpatient hospital care, and Dr. Melnick excluded 1045 of those from the LIFO calculation on the basis of his "unique" diagnosis analysis. Tr. 757. Dr. Melnick, however, expressed reservations about reliance on his recalculated LIFO of 84 percent, saying that "I would be very cautious in trying to press 84 for a LIFO." *Id.* He opined that the LIFO was probably between 75 and 84. Tr. 757, 851.

In order to exclude the 1045 patients from the analysis, Dr. Melnick examined the "Diagnosis Related Groups" (DRG) assigned to the outmigrating patients to identify the medical treatment. In California, a system of 473 DRGs is employed. Tr. 748. He identified 1045 patients with "unique" diagnoses or procedures, that is, a diagnosis or procedure for which no one else in the area was discharged in 1987. Tr. 749-55. Those patients were excluded from the Elzinga-Hogarty calculations.

Although a patient might have a "unique," diagnosis or procedure in the sense that a Ukiah hospital did not have an identical patient during a specific time period, that does not necessarily mean that a Ukiah hospital did not offer that service. Respondents' expert, Dr. Lynk, testified that the list of procedures and diagnoses used by Dr. Melnick to characterize a treatment as "unique" was too finely divided to provide meaningful results. Tr. 1515. The uniqueness occurred because the treatment was not done during the time period in question, not because the hospital did not offer that service.[14] *Id.*

Unchallenged evidence indicates that most patients went from Ukiah to Santa Rosa to seek treatment offered by the Ukiah hospitals. Dr. Lynk examined the DRGs for patients treated at UAH and UGH for the period from 1984 to 1987, and compared those DRGs with the DRGs at hospitals outside Ukiah. RX-160. This use of a longer time

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[14] Dr. Lynk illustrated his point by applying the same uniqueness methodology to compare the overlap between UGH and UAH, and he calculated that over half of the patients admitted to UGH were "unique" in the sense that they had a diagnosis or procedure not done in the same year at UAH. Tr. 1521; RX-389.

period reduced the likelihood of a spurious "uniqueness" finding. Dr. Lynk observed that 80 percent of the patients who went from the proposed geographic market to Santa Rosa Memorial Hospital were assigned a DRG for a treatment actually performed at a Ukiah hospital. Tr. 1527; RX-160. Ninety-seven percent of the patients who went from the proposed market to Santa Rosa Community Hospital were assigned a DRG for a treatment actually performed at a Ukiah hospital. *Id.* Complaint Counsel did not refute or even challenge this analysis. Oral Argument, Tr. 11-12.

Administrative Law Judge Parker concluded that Dr. Lynk's unchallenged analysis in RX-160 refuted complaint counsel's claim that the LIFO statistic should be revised substantially upward from 75 percent on the basis of Dr. Melnick's DRG analysis. ID at 16-17. We affirm that finding.

Finally, complaint counsel also developed a second adjusted LIFO statistic, not on the basis of Dr. Melnick's testimony. Complaint counsel found in the "Ukiah Adventist/General Hospital Strategic Plan 1989" a pie chart indicating that 56 percent of the patient outmigration from the so-called "service area" went to hospitals not in the immediately adjacent counties of Lake, Humboldt and Sonoma. CX-17-H. The document suggests that these patients are not "recoverable." *Id.* Based on this figure, complaint counsel would ignore 56 percent of the outmigration as competitively insignificant and adjust the LIFO upward on that basis. Appeal Brief at 39.

Complaint counsel in effect request that the Commission accept the conclusions of the analysts in the Ukiah Adventist/General Hospital and the AHS West Strategic Planning Department that outmigration to San Francisco and other hospitals outside Sonoma, Humboldt and Lake Counties is not "recoverable," that is, is competitively irrelevant. Assuming arguendo that the Strategic Plan is accurate, that assumption does not save the day for the geographic market alleged in the complaint because Santa Rosa is in Sonoma County, and, in the view of the AHS/West strategic planners, patients lost to Santa Rosa hospitals are "recoverable" or competitively relevant. CX-17-H. If we assume that UAH could recover patients from Santa Rosa by competition, it seems likely that it equally well could lose patients to Santa Rosa by virtue of anticompetitive price increases. Thus, acceptance of the market analysis in the Strategic

Plan would lead to inclusion of Santa Rosa hospitals in the geographic market.

Finally, complaint counsel point out that few Ukiah physicians have hospital privileges at Santa Rosa hospitals, and that a patient would need to be referred to a doctor with privileges at a Santa Rosa hospital in order to obtain treatment there. Complaint counsel correctly observe that this circumstance provides a disincentive to seeking treatment in Santa Rosa. Each element of the case must be established by a preponderance of the evidence, and the presence of this disincentive is not sufficient to justify ignoring the competitive significance of the Santa Rosa hospitals in light of the evidence of outmigration.

Complaint counsel have failed to carry their burden of proof to establish that Ukiah-Willits or Ukiah-Willits-Lakeport is a relevant geographic market. The present record is insufficient to support the relevant geographic markets alleged in the complaint.

The complaint is dismissed.

CONCURRING OPINION OF COMMISSIONERS DEBORAH K. OWEN AND DENNIS A. YAO

I. INTRODUCTION TO THE CASE

A. *Procedural History*

The complaint in this matter challenges the acquisition by respondent Adventist Health System/West ("AHS/West"), which operates Ukiah Adventist Hospital ("Ukiah Adventist"), of the assets of Ukiah General Hospital ("Ukiah General") from HealthTrust, Inc. ("HealthTrust"), and its wholly owned subsidiary Ukiah Hospital Corporation ("UHC").[1] The acquisition placed Ukiah General and Ukiah Adventist, the two remaining acute care general hospital facilities in Ukiah, California, under common ownership and control. The complaint alleges that the acquisition may substantially lessen competition in the provision of acute care hospital services in the southeastern Mendocino/western Lake County area in violation of Section 7 of the Clayton Act.

[1] The acquisition was part of a complex three-party transaction. The total cost to respondents was $7.975 million, including $5.9 million paid to HealthTrust for Ukiah General, and $2.075 million paid by respondents to Adventist Health Systems/Sunbelt for a hospital located in Lawrenceburg, Tennessee. The complaint challenged only the hospital overlap in Ukiah, California.

The administrative law judge ("ALJ") dismissed the complaint, finding that the challenged acquisition did not confer market power on respondents AHS/West and Ukiah Adventist and was, therefore, not likely to substantially lessen competition in the relevant geographic market.[2] The ALJ identified inpatient acute care hospital services as the relevant product market, concluding that the evidence in this case justified the same conclusion on product market definition as in previous hospital merger cases.[3] The ALJ rejected complaint counsel's proposed geographic markets, finding them to be weak due to substantial outmigration from the Ukiah area to nearby Santa Rosa for routine medical care. The initial decision identified a geographic market that encompasses the Ukiah-Willits-Lakeport-Santa Rosa area. The ALJ concluded that the challenged acquisition did not confer market power on respondents and was not likely to substantially lessen competition in the relevant geographic market.

Complaint counsel has appealed the initial decision, asserting that the evidence fails to support the broad geographic market identified by the ALJ and that the initial decision was based on the proposition that health care competition harms consumers. Complaint counsel argues that the relevant geographic market is Ukiah-Willits or Ukiah-Willits-Lakeport, and that the acquisition will substantially lessen competition in either of these markets. Complaint counsel further contends that respondents have failed to demonstrate sufficient efficiencies to justify the acquisition. We concur in the result contained in the Commission's opinion, but for slightly different reasoning, and we adopt its reasoning, except to the extent that it may be inconsistent with the analysis herein.

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[2] We concur in the findings of fact in the Initial Decision to the extent that they are not inconsistent with this opinion.

[3] Complaint counsel and respondents agree that the relevant product market is acute care inpatient hospital services. This market is supported by record evidence. Respondents' planning documents consider inpatient and outpatient care to be separate products. *See* CX 175. California law also supports the distinction between inpatient and outpatient care. *See* CX 100-F; CA Health & Safety Code Section 1240(b)(1). In addition, third-party payors recognize the distinction between inpatient and outpatient care. Tr. 550-51. This product market is consistent with other hospital merger cases. *See, e.g. FTC v. University Health, Inc.*, 938 F.2d 1206, 1210-11 (llth Cir. 1991); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284 (7th Cir.), cert. denied, 111 S.Ct. 295 (1990); *Hospital Corporation of America*, 106 FTC 361, 464-66 (1985). Accordingly, as neither party has challenged this issue on appeal, we concur in the administrative law judge's finding that acute care inpatient hospital services is the relevant product market.

B. *Hospitals in the Ukiah Area*

Ukiah is located in the southeastern part of Mendocino County and has a population of approximately 13,000. The nearest town with an acute care hospital is Willits, approximately 23 miles north of Ukiah. Ukiah, Willits and other communities in eastern Mendocino County are separated from the coastal regions of Mendocino County by the mountains of the Coast Range, which inhibit travel between those areas. I.D.F. 34.[4] Lakeport is located approximately 34 miles southeast of Ukiah and is situated in western Lake County. The nearest urban area to Ukiah is Santa Rosa, in Sonoma County, approximately 60 miles south.

Prior to August 8, 1988, there were three acute care general hospitals in Ukiah: Ukiah Adventist, Ukiah General, and Mendocino Community Hospital. I.D.F. 9. These three hospitals were quite small compared to others in the hospital industry. Tr. 1050. Ukiah Hospital Corporation, a wholly-owned subsidiary of HealthTrust, Inc., then operated Ukiah General, a 51-bed acute care hospital. Respondents AHS/West and Ukiah Adventist, both nonprofit corporations,[5] operated Ukiah Adventist Hospital, a 43-bed general acute care hospital, located approximately one and one half miles from Ukiah General. Prior to the acquisition, Ukiah General and Ukiah Adventist each provided primary-level pediatric, medical/surgical care, an emergency room, and ancillary services such as radiology and a laboratory. I.D.F. 36-37. Only Ukiah General

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[4] The following abbreviations appear in this opinion:

I.D.	Initial Decision
I.D.F.	Initial Decision Finding of Fact
C.P.F.	Complaint Counsel's Proposed Finding of Fact
R.P.F.	Respondents' Proposed Finding of Fact
C.A.B.	Complaint Counsel's Appeal Brief
C.R.B.	Complaint Counsel's Reply Brief
R.A.B.	Respondents' Answering Brief
CX	Complaint Counsel's Exhibit
RX	Respondents' Exhibit
Tr.	Transcript

[5] The complaint in this matter issued on November 7, 1989. In January, 1990, respondents moved to dismiss the complaint on jurisdictional grounds, arguing that Section 7 of the Clayton Act does not reach asset acquisitions by nonprofit corporations. The administrative law judge ruled that Section 7 did not apply to asset acquisitions by nonprofit corporations and dismissed the case in August 1990. Complaint counsel appealed that dismissal and the Commission reversed the administrative law judge's decision, holding that Section 7 of the Clayton Act does reach asset acquisitions by nonprofit corporations. *See also FTC v. University Health, Inc.*, 938 F.2d 1206, 1214-17 (llth Cir. 1991); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1280-81 (7th Cir.), *cert. denied*, 111 S.Ct. 295 (1990).

provided primary-level obstetrical care, including the only level II neonatal intensive care nursery in Ukiah. Neither hospital offered complex medical care such as neurosurgery, open-heart surgery, or organ transplants. *Id.* Since the acquisition, the two hospitals have continued to operate at the two separate locations under the name Ukiah Valley Medical Center ("Ukiah Valley").[6] Mendocino Community Hospital, a 56-bed acute care general hospital, was in poor financial condition prior to the acquisition. Mendocino Community ceased offering inpatient hospital services in 1990 and closed its outpatient operations in 1992. I.D.F. 40.

Respondent AHS/West controls the operations of Frank R. Howard Memorial Hospital, a 38-bed hospital located in Willits. Lakeside Community Hospital ("Lakeside") is a 63-bed hospital located in Lakeport. Lakeside provides primary level surgical and medical care, but does not offer complex medical care. I.D.F. 41. The nearest hospitals that provide complex inpatient services not offered by the hospitals in Ukiah, Willits, or Lakeport are located in Santa Rosa. Santa Rosa Memorial Hospital ("Santa Rosa Memorial") is a 225-bed hospital that offers specialized procedures, including cancer treatment, open-heart surgery, neurosurgery, thoracic surgery, and renal surgery. I.D.F. 43. Santa Rosa Community Hospital ("Santa Rosa Community") is a 145-bed hospital that offers the foregoing complex procedures. The two large Santa Rosa hospitals are located approximately 68 miles south of Ukiah.

II. ANALYTICAL FRAMEWORK

A. *Introduction*

Section 7 of the Clayton Act prohibits acquisitions[7] where the effect "in any line of commerce or in any activity affecting commerce . . . may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. 18. Such activity may also violate Section 5 of the FTC Act, if it constitutes an "unfair method of competition." 15 U.S.C. 45. The "unifying theme" of merger analysis is that

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[6] Ukiah Valley has continued to operate at two separate sites during the pendency of this litigation. The inherent risk of a divestiture order justifies the limited consolidation of the hospital operations to date.

[7] The terms acquisitions and mergers are used interchangeably in this opinion and refer to any transaction subject to Section 7 of the Clayton Act.

"mergers should not be permitted to create or enhance market power or to facilitate its exercise." *U.S. Department of Justice & Federal Trade Commission Horizontal Merger Guidelines* ("Merger Guidelines"), Section 0.1, *reprinted in* 4 Trade Reg. Rep. (CCH) paragraph 13,104.[8] Market power is "the ability profitably to maintain prices above competitive levels for a significant period of time," *id.*, or to "lessen competition on dimensions other than price, such as product quality, service, or innovation." *Id.* at n.6; *see also* Owens-Illinois, Inc., Dkt. No. 9212, 5 Trade Reg. Rptr. (CCH) paragraph 23,162 (FTC 1992) (quoting 1984 U.S. Department of Justice Merger Guidelines).

Evaluating whether a merger may result in market power necessitates determining, first, the relevant product and geographic market, the level of concentration in that market, and the change in concentration from the merger. However, that is only the starting point. Given that market structure, the Commission must determine also: (1) whether potential anticompetitive effects are demonstrable; (2) whether entry into the market would be timely, likely and sufficient to counteract the potential for anticompetitive effects; (3) whether there are any efficiency gains specific to the merger, and if so, their magnitude; and (4) whether, absent the merger, one of the firms will fail and exit from the market. *See generally* Merger Guidelines, Section 0.1 and *passim*; *Owens-Illinois*, *passim*.

Applying these principles, we must conclude that complaint counsel has failed to demonstrate that respondents' acquisition of Ukiah General may be substantially to lessen competition or that the transaction constitutes an unfair method of competition in violation of Section 7 of the Clayton Act. Although complaint counsel has not met its burden of proof on its alleged geographic market, the evidence in the record is also insufficient to meet the burden of proof as to alternate geographic markets advanced during the course of these proceedings. Despite the inconclusive evidence on this issue, even assuming, *arguendo*, the geographic market advanced by complaint counsel, the combination of other factors, such as the significant outmigration to Santa Rosa, the absence of any significant third-party payor objections to this acquisition, and the likelihood that these large buyers might resist price increases in the face of any

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[8] The Merger Guidelines "update the Merger Guidelines issued by the U.S. Department of Justice in 1984 and the Statement of the Federal Trade Commission Concerning Horizontal Mergers issued in 1982." Merger Guidelines, Section 0. n.4.

cost savings resulting from the consolidation, all lead to the conclusion that the evidence of anticompetitive effects is weak, if not nonexistent. Consequently, we concur in the ALJ's dismissal of the complaint.

B. *The Relevant Geographic Market*

Complaint counsel, respondents and the ALJ considered at length the Elzinga-Hogarty analysis in determining the relevant geographic market.[9] We agree with the reservations of the majority with respect to the Elzinga-Hogarty test, although we also agree that the test can be a useful starting point in the analysis of a geographic market, and we now turn to the various market definitions proposed by the parties and the ALJ.[10]

Respondents AHS/West and Ukiah Adventist advanced two alternate geographic markets during the administrative trial. Respondents' larger market encompasses southern Mendocino County, parts of Lake County and Napa County and probably all of Sonoma County.[11] RX 257; RX 258; Tr. 1503. This proposed market included 16 hospitals prior to the merger. Respondents' alternate market would omit from this geographic market three hospitals located in Sonoma and Napa Counties, because of their greater distance from Ukiah. RX 257; Tr. 1503; *see also* R.P.F. 241. Applying the Elzinga-Hogarty analysis, respondents' smaller

[9] The Elzinga-Hogarty test examines patient origin data, and produces two numerical measures of the strength of a tested area as an appropriate geographic market. The first measure is LOFI, or "little out from inside," which, in this case, measures the migration of residents from outside the proposed market to hospitals inside the proposed market. A LOFI of 100 would indicate that all patients at the hospitals in the proposed market resided in that market. The second measure is LIFO, or "little in from outside," which, in this case, measures the migration of residents from inside the proposed market to hospitals outside the proposed market. A LIFO of 100 would indicate that all patients who resided in the proposed market sought hospitalization in that market. Under the Elzinga-Hogarty test, a recognizable, but weak, market is attained when both the LOFI and LIFO statistics reach 75 percent. A market is characterized as strong if both LOFI and LIFO statistics reach 90 percent. Elzinga & Hogarty, *The Problem of Geographic Market Delineation Revisited: the Case of Coal*, 23 Antitrust Bull. 1 (1978); Elzinga & Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 Antitrust Bull. 45 (1973). I.D.F. 47.

[10] The best evidence about geographic markets is evidence of dynamic effects in the movement of supplies and demands in response to price or other changes in competition strategy. Analyses like the Elzinga-Hogarty test may sometimes capture some of these dynamic effects, although such tests are largely static. As a consequence, the Elzinga-Hogarty test is probably most reliable in determining whether a proposed market is not the relevant geographic market, because the test's numbers are too low.

[11] Napa County is directly south of Lake County and east of Santa Rosa.

alternate geographic market falls between the "weak" and "strong" thresholds, with a LOFI of 89% and a LIFO of 83%. The ALJ rejected this geographic market because it included some hospitals which are located so far from Ukiah that he found it "inconceivable that they would impose any competitive constraint on the activities of Ukiah Valley." I.D.F. 101. The judge noted that respondents' willingness to jettison three of the most distant hospitals from Ukiah attested to the reasonableness of his finding that such distant hospitals have no competitive constraint upon Ukiah hospitals.

The ALJ defined the relevant geographic market to include Ukiah, Willits, Lakeport, and Santa Rosa. I.D.F. 98. This market includes the following 7 hospitals, pre-merger: Ukiah General, Ukiah Adventist, Frank R. Howard Memorial (owned by AHS/West), Mendocino Community Hospital, Lakeside Community, Santa Rosa Memorial, and Santa Rosa Community. The Elzinga-Hogarty analysis results in a LOFI of 83% and a LIFO of 78%, figures that suggest an even weaker market than that proposed by respondents.

Complaint counsel proposed a geographic market encompassing 22 zip codes in Ukiah, Willits and Lakeport. C.A.B. 19-20.[12] This market includes 5 hospitals, pre-merger, three of which were controlled by respondent AHS/West after the acquisition. The Ukiah-Willits-Lakeport market is identical to the geographic market identified by the ALJ, without the two Santa Rosa hospitals. The acquisition resulted in three competitors in the Ukiah-Willits-Lakeside market: Ukiah Valley with approximately 75% market share, Mendocino Community with a 5% market share, and Lakeside with a 21% share. I.D.F. 103; CX 83.[13]

The patient origin data for this market indicates a LOFI of 91% and a LIFO of 75%. This geographic market is the smallest area that satisfies the "strong" standard for one prong of the Elzinga-Hogarty test and satisfies the "weak" prong for the other prong. I.D.F. 52.

During oral argument, complaint counsel argued that the LOFI figure is more significant than the LIFO figure, and that this supported the Ukiah-Willits-Lakeport market. Oral Argument Tr. 20.

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[12] Complaint counsel alleged two alternate markets in the complaint. The smaller alternate market, consisting of the 15 zip codes surrounding Ukiah and Willits, was viewed by complaint counsel's expert as less defensible. *See* Tr. 742.

[13] The initial decision and briefs submitted on appeal inexplicably omitted the HHI calculations for alternate geographic markets, other than the 15 and 22 zip code markets proposed by complaint counsel. One must assume that the concentration figures would decrease as additional competing hospitals are included in the markets.

complaint counsel concluded that this was a more appropriate market than the smaller Ukiah-Willits market, and that the LIFO of 75% understated the strength of the Ukiah-Willits-Lakeport market because it failed to account for migration from the Ukiah area seeking tertiary care. *Id.* We disagree with complaint counsel's assertion, and note that the patient flow data and other record evidence suggest that the LIFO figure is more important in this analysis.

Roughly 5% of Ukiah residents migrate to Santa Rosa for hospital services. CX 85. One reason for this leakage may be the perceived quality difference between Ukiah and Santa Rosa hospitals. *See* Tr. 163, 552-55. In contrast, only .2% of Santa Rosa residents migrate to hospitals in the Ukiah-Willits-Lakeport market. CX 85. The perception of quality of care differences may account for this minuscule leakage. This suggests that the LOFI, or the willingness of Santa Rosa residents to migrate to Ukiah area hospitals, is not as important in this case and that the LIFO figure should carry greater weight. This further suggests that there are a greater number of patients on the margin in Ukiah who would be willing to migrate to Santa Rosa in the event of a price increase. Thus, a small price change would be likely to affect a larger number of customers in Ukiah. This idea is further supported by evidence that many Lakeport residents, who had a choice of going to Ukiah or Santa Rosa hospitals, chose to go to Santa Rosa even though travel time to Ukiah appears to be shorter. CX 80; CX 85.

Furthermore, although the Elzinga-Hogarty numbers for complaint counsel's market appear to be high, the limitations associated with the Elzinga-Hogarty analysis, as noted above, necessitate considering other relevant evidence in order to determine the relevant geographic market.

In support of this geographic market, complaint counsel offered evidence that there are virtually no physician overlaps between hospitals in Ukiah and those in surrounding cities. In 1991, only one of the 88 physicians with active or provisional privileges[14] at Ukiah Valley also had comparable privileges at Santa Rosa Community.

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[14] Hospital bylaws often establish different categories of medical staff membership. Members with active or provisional staff privileges usually have the right to admit patients without restriction. Members of a hospital's consulting staff or courtesy staff do not have the unrestricted right to admit patients. I.D.F. 84-89.

Compare CX 46-E-F with CX 57-A-Z-11.[15] None of the 88 physicians with active or provisional privileges at Ukiah Valley had comparable privileges at Santa Rosa Memorial. Compare CX 46-E-F with CX 59-A-0. Seven of these 88 physicians had comparable privileges at Lakeside, and one had comparable privileges at Mendocino Community. Compare CX 46-E-F with CX 50-A-C and CX 53-A-G.

On the other hand, patient discharge data revealed that 25% of Ukiah area residents seek acute care inpatient hospital services outside the 22 zip code geographic market. The data compiled by complaint counsel's expert indicated that in 1987, 2,711 patients from the Ukiah-Willits-Lakeport area needing inpatient hospital services sought it elsewhere. CX 88. Respondents' expert examined all diagnosis related groups ("DRG")[16] for patients treated at Ukiah Adventist and Ukiah General from 1984 through 1987 and determined the extent to which those DRGs also appeared for patients treated in hospitals outside the service area. Evidence indicated that 80% of the time, patients sought treatment at Santa Rosa Memorial for a DRG that was also performed in Ukiah, and 97% of the time, patients at Santa Rosa Community were treated for a DRG which had also been performed in Ukiah hospitals. RX 160; RX 162; Tr. 1526-30.

Other anecdotal evidence indicated that some of the outmigration from the Ukiah area was for services available in the 22 zip code geographic area. Dr. Valente, a physician specializing in obstetrics and gynecology at Ukiah Valley, testified that some patients are willing to travel to Santa Rosa for obstetrical procedures. *See* Tr. 166; *see also* Tr. 363. Complaint counsel's expert corroborated this by noting that recent studies indicate that an increasing number of patients are travelling more than 50 miles for obstetrical procedures. Tr. 858-59. Dr. Peña, a general practitioner with emergency room experience at Ukiah Valley and the two predecessor hospitals, stated that patients are able to go to Santa Rosa for hospital services if they want to and he has referred patients to Santa Rosa hospitals for procedures that were available in Ukiah. *See* Tr. 281-82, 289-92. Dr.

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[15] That physician was a specialist in emergency room medicine and had no discretion about where to admit patients. *See* CX 46-E; CX 57-K; *see also* I.D.F. 90(d).

[16] State regulations require all California hospitals to submit reports to the office of Health Planning and Development, including classifications of each patient according to cause of hospitalization. Tr. 730-32. Each DRG is assigned a weight that indicates the relative resource requirements for treating a typical patient with a given DRG. I.D.F. 55.

Falk, a former chief of staff at Ukiah General, indicated that he had treated several patients from Lake and Mendocino Counties at the Kaiser facility in Santa Rosa who were required by Kaiser to be treated there. *See* Tr. 918, 928-29 (also noting that patients were disgruntled about having to travel to Santa Rosa). Drs. Gester and Jepson, the head of Ukiah Valley's emergency room and former chief of staff at Ukiah Adventist, respectively, knew of Ukiah area residents who travel to Santa Rosa for primary and secondary care. *See* Tr. 1710; 1439-40. Evidence also demonstrated that Dr. Valente threatened to take his patients to Santa Rosa if Ukiah Adventist failed to purchase diagnostic equipment. *See* Tr. 110-13.

The evidence as to geographic markets is most suggestive of the market found by the ALJ, but not wholly conclusive. For purposes of completing the analysis, we are prepared to assume, *arguendo*, the best case from complaint counsel's point of view that -- the 22 zip code geographic market is correct -- nonetheless, we would not find a violation here. To find an antitrust violation, we must conclude that the record evidence demonstrates that the effect of the acquisition within a proven market may be substantially to lessen competition. The combination of several factors, such as the significant outmigration to Santa Rosa, the absence of any significant third-party payor objections to this acquisition, and the likelihood that these large buyers might resist price increases in the face of any cost savings resulting from the consolidation, all lead to the conclusion that the evidence of anticompetitive effects is weak, if not nonexistent. Even as to the best case scenario from complaint counsel's perspective, the record evidence fails to demonstrate that the effect of the acquisition may be substantially to lessen competition. Consequently, we concur in the ALJ's dismissal of the complaint.

C. *Competitive Effects*

The Herfindahl-Hirschmann Index ("HHI") for complaint counsel's geographic market would result in a post-merger HHI of 5933 based on 1987 patient discharges and 6009 based on inpatient days for that year, with an increase due to the merger of 2737 and 2663, respectively. I.D.F. 103; CX 83. The Guidelines characterize as "highly concentrated" any market in which the post-merger HHI exceeds 1800 and presume that mergers producing an increase in the

HHI of more than 100 points are likely to create or enhance market power or facilitate its exercise. Merger Guidelines, Section 1.5, 1.51.[17]

The level of market concentration, however, is only the starting point to determine the likelihood of anticompetitive effects, and many other factors affect the likelihood of collusive or unilateral anticompetitive conduct. *See* Merger Guidelines, Section 2.0; *see also United States v. Baker Hughes, Inc.*, 908 F.2d 981, 984, 992 (D.C. Cir. 1990) ("The Herfindahl-Hirschmann Index cannot guarantee litigation victories."); *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1386 (7th Cir. 1986) (Posner, J.) (stating that market share figures are not always decisive in a Section 7 case and that the Commission was prudent in inquiring into the probability of harm to consumers), *cert. denied*, 481 U.S. 1038 (1987). This is especially the case where the evidence delimiting a geographic market is weak, as it is here, thus raising questions as to the true level of concentration resulting from the merger. The market for acute care inpatient hospital services in the Ukiah area has a number of characteristics that are relevant to the assessment of its likely future competitive performance and that reduce any concerns of possible future anticompetitive conduct raised by this acquisition.

1. Santa Rosa Hospitals Pose a Competitive Constraint

The evidence described in the previous section on geographic market provides considerable support for the ALJ's assessment that Santa Rosa hospitals are used regularly by a significant number of Ukiah residents for routine medical care, and therefore, that Santa Rosa hospitals pose a competitive constraint on Ukiah Valley. While the Santa Rosa hospitals' effect likely would be dispositive if they were included in the geographic market,[18] as previously indicated, the evidence on geographic market is inconclusive. Thus, we have

[17] As previously noted, the presumption may be overcome by a showing that factors such as competitive effects resulting from the merger, entry, efficiency gains specific to the merger, and the availability of the failing firm defense make it unlikely that the merger will create or enhance market power or facilitate its exercise, in light of concentration and market shares. Merger Guidelines, Section 1.51.

[18] For example, one would expect to see a phenomenal reduction in the concentration figures if the hospitals in and near Santa Rosa (such as those located in Clearlake, Healdsburg, St. Helena, and Sebastapol) were included in the analysis. As previously noted, two of the four Santa Rosa hospitals are relatively large, one with 225 beds and another with 145.

assumed complaint counsel's alleged market for purposes of completing the analysis. Accordingly, the Santa Rosa hospitals would not be part of the geographic market in this analysis, and would not, in and of themselves, resolve this case. Nevertheless, the fact that they have some impact cannot be ignored, and must be weighed alone with other factors affecting the competitive effects of the merger.[19]

2. Third-Party Payors Have Not Objected to the Merger

There is no record of complaints from buyers or customers about the acquisition. At oral argument, complaint counsel offered citations to record evidence purportedly indicating third-party payors' "expressions of concern" about the merger.[20] Although one third-party payor expressed concern that the marketability of its PPO health plan would be adversely affected if there were no participating hospital in Ukiah, none of the third-party payors expressly objected to the acquisition at issue on balance, we cannot conclude that these purchasers expressed opposition to this merger.

Evidence cited by complaint counsel does not indicate that insurers voiced any objection to the acquisition. Mr. Pimentel, the Blue Cross senior contract manager who was responsible for negotiating contracts with hospitals in Mendocino, Lake and Sonoma Counties from 1983 to 1986, testified that if Blue Cross were unable to negotiate a favorable Prudent Buyer Plan rate with Ukiah Adventist, Mendocino County residents would have to go outside the county to get medical services in order to take full advantage of the

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[19] *Cf. Owens-Illinois, Inc.*, Dkt. No. 9212, 5 Trade Reg. Rptr. (CCH) paragraph 23,162 (FTC 1992) at 22,822 (import sales included in calculation of market share even though geographic market limited to continental U.S.); *see also* Merger Guidelines, Sections 1.31, 1.41.

[20] During oral argument, complaint counsel responded to a specific question about customer complaints:

> Commissioner Owen: Did [third-party payors] complain about this merger?
>
> Mr. Newman: Not in so many words. They clearly were concerned, in general, about the possibility of monopoly hospitals, because it makes it more difficult for them to negotiate contracts that's consistent with the economic literature, which shows that for third-party payors, who are engaged in managed care and selective contracting, the prices rise more rapidly in areas where there's no competition than where there is competition.
>
> Commissioner Owen: Can you cite me to the record on those expressions of concern?
>
> Mr. Newman: Yes. Just a moment. That would be in Mr. Pimentel's testimony, which is RX 318, and in particular, I believe it's pages Z-5 and Z-6, and also Mr. Strunk's and Mr. Wendorf's testimony.

Oral Argument Tr. at 16-17.

Prudent Buyer Plan. He further noted that the subscriber is not precluded from going to a non-prudent buyer hospital. RX 318-Z5 through Z6. Nowhere is there any indication of concern about this fact. Pimentel also stated that Blue Cross will not consider the Prudent Buyer Plan particularly marketable in an area unless prospective insureds have access to participating providers in the area. *Id.* at 47. This does not rise to any expression of concern or complaint about the acquisition. Pimentel simply indicated that whether or not insureds have access to participating providers in the area affects the marketability of Blue Cross' prudent buyer plan. Respondents' exhibit 318 does not indicate that this witness was opposed to the acquisition.[21]

Complaint counsel also cited the deposition testimony of Mr. Strunk, the Blue Shield regional manager for hospital relations, as evidence that third-party payors expressed concern about the acquisition. This testimony does not indicate that Blue Cross had any concern about the acquisition. Strunk stated that if Ukiah Valley and Blue Shield were unable to agree on rates, then subscribers would gravitate toward Santa Rosa. Strunk Depo. Tr. 20. He viewed the negotiated rates between Blue Shield and Ukiah Valley as reasonable and favorable. *Id.* at 13, 28. Although it was Blue Shield's goal to have a preferred provider hospital in each county in California, *id.* at 22, if Blue Shield felt that Ukiah Valley was not offering the third-party payor a reasonable rate, then Blue Shield would send its subscribers to Santa Rosa Memorial, a preferred provider hospital. *Id.* at 28-29. Simply put, Blue Shield viewed the acquisition as a "nonevent." *Id.* at 27.[22]

Complaint counsel also cited the deposition testimony of Mr. Wendorf, the senior contract manager at Blue Cross with responsibility for negotiating contracts with hospitals in Mendocino

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[21] Elsewhere in his deposition, Pimentel testified that Blue Cross contracted with only one hospital in Ukiah, Ukiah Adventist, as part of the Prudent Buyer Plan. Ukiah General and Mendocino Community did not submit bids to participate in the plan, each indicating that it was not interested in participating. Ukiah Adventist offered no obstetrical services. Pimentel stated that this affected Blue Cross' ability to sell the Prudent Buyer Plan because it included a hospital that was not a full-service hospital. Nonetheless, Blue Cross required its subscribers to travel outside the Ukiah area in order to obtain obstetrics services under the plan. Insureds travelled to St. Helena, Santa Rosa Memorial, and Deer Park. Because these insureds would not have been entitled to the Blue Cross negotiated discount had they opted to stay in Ukiah and seek obstetrical services at Ukiah General, this evidence indicates that consumers were price sensitive and willing to travel to Santa Rosa in the event of an effective price increase (although the price differential was not specified in his testimony).

[22] Complaint counsel's expert was unaware of this testimony prior to trial. Tr. 807.

and Lake Counties, both before and after the acquisition. Wendorf stated that Prudent Buyer subscribers from Lake and Mendocino Counties may use any participating hospital in Sonoma County or San Francisco. Wendorf Depo. Tr. 39. Based on his experience in negotiating with the hospitals before the acquisition, and with Ukiah Valley after the acquisition, he indicated that he had not encountered any problems in negotiating favorable rates. *Id.* at 41.[23]

When asked if anything made him feel that he would experience problems in the future, Mr. Wendorf cited the fact that Ukiah Valley is now the only hospital provider in the Ukiah area. *Id.* at 42. He testified that he would not want to be put in the position of having to send his Prudent Buyer subscribers to Sonoma County in the event that Blue Cross was unable to negotiate a contract with Ukiah Valley. *Id.* at 44. In the next breath, however, Wendorf testified that the Prudent Buyer rate that Blue Cross negotiated with Ukiah Valley after the merger was "very favorable," since Blue Cross did not have a negotiated prudent buyer plan, which provided deeper discounts than the standard fee-for-service contracts, in other rural areas with only one provider. *Id.*[24]

Wendorf testified that he was in favor of the acquisition because there was not a need for the number of hospitals in that area, and he did not believe that Ukiah could support two full acute-care service hospitals. *Id.* at 45; *cf.* Tr. 804-05. He observed that Ukiah residents are becoming accustomed to travelling to Santa Rosa to shop and purchase automobiles. Despite this greater willingness to travel to Santa Rosa, Wendorf acknowledged that an inability to negotiate a prudent buyer plan with Ukiah Valley would harm his ability to market the Blue Cross prudent buyer plan to potential subscribers in the Mendocino County area. *Id.* at 47.

Though not cited by complaint counsel during oral argument, the testimony of the Travelers contract negotiator for this region bears on

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[23] Wendorf testified that he did not believe that Ukiah could support two acute-care service hospitals. Wendorf Depo. Tr. 45. He supported the closure of Mendocino Community Hospital for this reason. *Id.* He presumably held this view because the revenues received by the hospitals were insufficient to meet their costs. The record describes UGH's increasing net income losses. *See e.g.*, RX 286-F; RX 314-O, -T, -U; RX 127-D (UGH operated at a net income loss from September 1987, when it was purchased by HealthTrust, until it was sold in August 1988). This seems to imply an understanding that the merger would lead to lower costs in the long run as a result of efficiencies.

[24] Wendorf also testified that the prudent buyer contracts that Blue Cross had been able to negotiate with Ukiah Adventist, and then Ukiah Valley, from 1986 to present, contained favorable rates for the carrier. *Id.* at 27.

whether third-party payors expressed concern about having one hospital in Ukiah. Mr. King indicated his reluctance to offer a managed-care preferred provider network for his largest subscriber, Mendocino County employees, which accounted for 2500 lives, unless it included a Ukiah hospital. Tr. 1243. The import of his personal opinion is greatly minimized by the fact that the covered County employees used Santa Rosa Memorial Hospital to a considerable extent. Tr. 1242. King acknowledged that, contrary to what one might expect, the Ukiah hospitals did not account for a majority of the hospital expense dollars in the customers' claims experience. *Id.*

The record evidence, on balance, cannot be read to indicate that insurers expressed any significant complaints about the acquisition. Third-party payors are most knowledgeable about market conditions in the area and, nonetheless, raised no strong objections to the acquisition. Those third-party payor representatives who expressed concern that the acquisition had the potential to adversely affect the marketability of an insurer's plan also testified that the rates they had negotiated with Ukiah Adventist, and Ukiah Valley, were favorable to the respective carriers, both before and after the acquisition of Ukiah General by Ukiah Adventist. Accordingly, the absence of any third-party payor opposition to the acquisition weighs against any finding that this acquisition will result in any anticompetitive effect.

3. Price Increases Will Likely Be Resisted by Large Buyers in the Face of Resulting Efficiencies

Although respondents' efficiency arguments may not rise to the level of a defense, as might be raised to an otherwise anticompetitive merger and recognized under Section 4 of the Merger Guidelines, they cannot be ignored. Although not dispositive, efficiencies may be relevant, for a variety of reasons, in the competitive effects analysis.[25] Consideration of efficiencies is particularly appropriate

[25] Some commentators have proffered useful suggestions as to various alternatives. *See, e.g.*, Remarks of Kevin J. Arquit, Director Bureau of Competition, Before the State Bar of Texas, Apr. 24, 1992, at 9-10 (stating that when "[e]fficiencies are raised by the parties to suggest that [post-merger] higher expected returns will stem from lower costs, the argument really is that there is an 'efficiency' rather than an 'anticompetitive story,' that explains the underlying basis for the merger. In such circumstances, it is appropriate to have a thorough discussion of efficiencies even though they may be neither merger-specific nor necessarily passed on to consumers. On the other hand, where the efficiency banner is raised specifically as a defense to an otherwise competitively troubling merger, the standard

in this instance where large third-party payors will likely anticipate many of respondents' purported cost-saving efficiencies, and therefore, would likely protest any price increases in the face of such cost cuts.[26]

Consideration of large and sophisticated buyers generally focuses on the buyers' ability to exert countervailing power, even against a seller's oligopoly, by (1) shifting a large proportion of business to any firms that are willing to deviate from the coordinated behavior; (2) inducing new entry into the oligopolized market; or (3) through vertical integration.[27] Here, our consideration of large buyers focuses in part on their perception that the acquisition will result in efficiencies. As large and sophisticated purchasers of acute care inpatient hospital services, third-party payors would likely be able to constrain anticompetitive behavior by exerting countervailing power, as suggested above, in the event of any proposed price increases that might follow merger-generated, cost-cutting measures by Ukiah Valley.[28]

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is, and should be, much different.") (emphasis added); Remarks of Janus A. Ordover, Deputy Assistant Attorney General for Economics, Antitrust Division, and Margaret E. Guerin-Calvert, Assistant Chief, Economic Regulatory Section, Antitrust Division, Before the Federal Reserve Bank of Chicago, May 8, 1992, at 20-21 ("The Department also considers whether a merger will result in a net gain in efficiency and considers this both in the competitive effects analysis and in evaluating an efficiencies defense, as laid out in Section 4 of the Guidelines. . . . it must be emphasized that efficiencies do not enter our merger analysis solely in the form of a defense. They are also relevant to our understanding of a transaction's competitive effects. . . . [A] careful analysis of the productive efficiencies flowing from a transaction is essential to the proper analysis of its likely competitive effects.") (emphasis added).

[26] The Commission and federal courts have considered the sophistication of buyers in analyzing the competitive effects of a merger. *See generally United States v. Baker Hughes, Inc.*, 908 F.2d 981 (D.C. Cir. 1990); *United States v. Syufy Enterprises*, 903 F.2d 659 (9th Cir. 1990); *United States v. Archer-Daniels-Midland Co.*, 1991-2 Trade Cases (CCH) paragraph 69,647 (S.D. Iowa 1991); *United States v. Country Lake Foods*, 754 F. Supp. 669 (D. Minn. 1990); *FTC v. R.R. Donnelley & Sons Co.*, 1990-2 Trade Cas. (CCH) paragraph 69,239 (D.D.C. 1990); *Owens-Illinois, Inc.*, Dkt. No. 9212, 5 Trade Reg. Rptr. (CCH) paragraph 23,162 (FTC 1992); *Olin Corp.*, Dkt. No. 9196, 5 Trade Reg. Rptr. (CCH) paragraph 22,857 (FTC 1990).

[27] *See, e.g. Baker Hughes, Inc.*, 908 F.2d at 986-87 (noting that analysis of other factors, such as buyer sophistication, are relevant and can be dispositive in a Section 7 rebuttal analysis); *Country Lake Foods, Inc.*, 754 F. Supp. at 679; *Olin Corp.*, 5 Trade Reg. Rptr. (CCH) paragraph 22,857, at 22,553.

[28] The perceptions and actions of customers are always relevant in merger analysis as antitrust enforcers must identify conditions that will tend to lead to deviations from, or adherence to, coordinated interaction. Merger Guidelines, Section 2.1.

Critics might argue that large third-party payors, though knowledgeable purchasers of medical services, lack the ability to switch their business to hospitals outside of the geographic market. Record evidence belies that argument. *See* Section II.C.2., *supra* (discussing insurers' willingness to send preferred buyer subscribers outside of Ukiah for medical services). We cannot ignore the perceptions of these large buyers, one of which was described by complaint counsel's expert as one of the largest, if not the largest, preferred provider organization in the country. Tr. 761.[29]

Testimony of Ukiah Valley administrators indicated both the political and financial pressure on the hospital in negotiating contracts with third-party payors. Mr. Devitt, president of Ukiah Valley, stressed the importance of having a local hospital in managed-care plans, especially those covering large subscribers such as the school system or Mendocino County employees. Tr. 1066. He testified that if Ukiah Valley failed to negotiate with these third-party payors in good faith, the hospital would incur great pressure from the school system or the County. *Id.* Both Devitt and Mr. Spenst, the hospital's chief financial officer, emphasized the importance of managed-care contracts, which represent a significant portion of Ukiah Valley's patient base, in light of their financial impact on the hospital. Tr. 1067, 1369. Third-party payors routinely threaten to send their subscribers elsewhere. Tr. 1369.

Although complaint counsel disputed several of respondents' claimed efficiencies, others were not challenged.[30] For example, complaint counsel did not dispute on appeal that the acquisition has allowed Ukiah Valley to eliminate a number of duplicative departments, resulting in reductions of several full-time-equivalents

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[29] Although there is little record evidence on whether efficiencies would be passed on to other buyers, such as smaller ones, the absence of any significant concerns on the part of third-party payors suggests that this is not a likely problem.

[30] We must be somewhat circumspect in any reliance on the purported efficiencies advanced by respondents because they have been under antitrust scrutiny since the August 1988 acquisition.

("FTE").[31] Tr. 1371-73, 1393; CX 95-B.[32] In addition, respondents contend that Ukiah Valley's increased experience rating has resulted in a reduction in its malpractice insurance costs. *See* Tr. 1378, 1399; 1401; CX 95-A; CX 95-E.[33] Finally, the creation of a hospital which is larger and more efficient than either Ukiah General or Ukiah Adventist will provide better medical care than either of those hospitals could separately. Evidence indicates that several quality of care benefits may have already resulted from the acquisition. Ukiah Valley has been able to attract more highly qualified management, more qualified physicians and nurses, and more medical specialists in the fields of nephrology, pediatric gastroenterology, pediatric neurology, plastic surgery, rheumatology, and oral surgery. Tr. 1078-79, 1159, 1550-53; 1675-76, 1697-98, 1705; RX 59-A; RX 223; and RX 224. Ukiah Valley has also been able to direct its cost savings to the purchase of necessary equipment, which improves the quality of care it can provide to its patients.[34] Respondents eventually intend to consolidate the separate campuses into a single facility.[35] Consolidation will only increase the foregoing efficiencies. In light

[31] Hospitals often hire many part-time employees. An FTE is a calculation based on total hours worked. Tr. 1371.

[32] Complaint counsel disputed respondents' assertion that Ukiah Valley has saved $1.89 million in salaries and benefits in the 16 months following the acquisition. CAB at 66; CRB at 35-37. Complaint Counsel argued that respondents' personnel costs per unit of output in 1991 were exactly the same as the combined costs for Ukiah General and Ukiah Adventist prior to the acquisition, adjusted for inflation. CAB at 66-67. Complaint counsel further argued that staffing per patient, another measure of output, had remained virtually unchanged following the acquisition. *Id.* at 66-67. The analysis on which complaint counsel's economies of scale challenge is based is suspect. The input data is somewhat inflated in that it includes additional personnel recruited by Ukiah Valley for previously non-existing health care services. The reduction of duplicative FTEs must result in economies of scale and any dispute over the precise dollar amount does not negate this ongoing cost saving efficiency.

[33] Respondents claim to have saved $3.1 million on malpractice insurance in just the 16 months following the acquisition.

[34] For example, following the acquisition, Ukiah Valley has purchased a SPECT camera, an expensive device which neither hospital could afford prior to the acquisition. Tr. 1073; RX 34-G; RX 59-C; RX 59-G. Other recent purchases include an MRI unit, a laparoscope, and a hysteroscope. Tr. 110; 1085-86; RX 59-C. CT scans are now provided in-house, rather than available through a costly non-hospital unit. RX 34-B; RX 59-C.

[35] *See generally* Tr. 386, 415, 429, 434, 1077-78, 1381-82, 1420; RX 4-C; RX 5-Z; RX 41-A-B.

of these significant cost-saving measures, it is therefore difficult to see how Ukiah could justify a price increase to large third-party payors.

In sum, the weak evidence for complaint counsel's geographic market, the impact of the Santa Rosa hospitals, the absence of significant third-party payor objections to this acquisition, and the likelihood that price increases would be resisted by buyers in the face of any cost savings resulting from the consolidation, all lead to the conclusion that the evidence of competitive effects is weak, if not non-existent. Consequently, we concur in the ALJ's dismissal of the complaint.

III. CONCLUSION

AHS/West's acquisition of the assets of Ukiah General Hospital has not substantially lessened competition in the Ukiah area acute care hospital services market in violation of Section 7 of the Clayton Act. We concur in the decision of the Commission to dismiss the complaint in this matter in all respects.

FINAL ORDER

This matter having been heard by the Commission on the appeal of complaint counsel from the initial decision and on briefs and oral arguments in support of and in opposition to the appeal, for the reasons stated in the accompanying opinion, the Commission affirms the decision of the Administrative Law Judge.

Accordingly, *It is ordered*, That the complaint be and it hereby is dismissed.