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**EVANSTON’S LEGACY: A PRESCRIPTION FOR  
ADDRESSING TWO-STAGE COMPETITION IN HOSPITAL  
MERGER ANTITRUST ANALYSIS**

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#### INTRODUCTION

On August 6, 2007, the Federal Trade Commission handed down its Final Decision in the matter of *Evanston Northwestern Healthcare Corporation*.<sup>1</sup> *Evanston* was remarkable for two reasons: the complaint was filed post-acquisition, and the government won. The first reason is notable because although not unheard of, post-merger challenges are generally rare, particularly with regard to hospital mergers.<sup>2</sup> The second reason is significant because prior to *Evanston*, the government had not successfully challenged a hospital merger on antitrust grounds in over a decade.<sup>3</sup> Since the Final Decision, no

<sup>1</sup> *In re Evanston Nw. Healthcare Corp.*, F.T.C. No. 9315, at 5 (Aug. 6, 2007) [hereinafter *Evanston Final Decision*], available at <http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf>.

<sup>2</sup> Tom Campbell, *Defending Hospital Mergers After the FTC's Unorthodox Challenge to the Evanston Northwestern – Highland Park Transaction*, 16 ANNALS HEALTH L. 213, 218 (2007) (“The HSR Act has had the effect of making most merger challenges *prospective*.” (citations omitted)). *But see, e.g., In re Adventist Health Sys./W.*, 117 F.T.C. 224, 231 (1994) (discussing the acquisition, which was completed prior to the filing of the complaint).

<sup>3</sup> The last case the government had won in court was in 1991. *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1226 (11th Cir. 1991) (granting a preliminary injunction to block the acquisition). Since *Evanston*, the FTC has successfully challenged another healthcare transaction post-acquisition, albeit not a hospital merger. In 2009, the FTC initiated administrative action against Carilion Clinic, a large hospital system in Virginia, alleging that its purchase of two outpatient clinics in 2008 led to decreased competition and higher prices for outpatient imaging services and outpatient surgical services. Press Release, Fed. Trade Comm’n, Commission Order Restores Competition Eliminated by Carilion Clinic’s Acquisition of Two Outpatient Clinics (Oct. 7, 2009), available at <http://www.ftc.gov/opa/2009/10/carilion.shtm>. Carilion agreed to settle and divest from both clinics. *Id.* Although it was a post-acquisition challenge, it is distinguished from *Evanston* because the value of the Carilion transactions fell below the Hart-Scott-Rodino threshold and thus were not reported to the government before consummation. *FTC Challenges 2008 Acquisition of Outpatient Medical Clinics*, JUNE-JULY 2009 ANTITRUST UPDATE (Davis Polk & Wardwell LLP, New York, N.Y.), available at [http://www.davispolk.com/files/Publication/e6b744f4-5d21-451b-82e7-31557c238b58/Presentation/PublicationAttachment/599fc228-70f6-409e-b676-322790810517/antitrust\\_20090824.htm](http://www.davispolk.com/files/Publication/e6b744f4-5d21-451b-82e7-31557c238b58/Presentation/PublicationAttachment/599fc228-70f6-409e-b676-322790810517/antitrust_20090824.htm). As such, the FTC had no opportunity to block the sales before they were completed and its only recourse was to unwind the sale post-acquisition.

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court has had the occasion to evaluate a hospital merger for potential antitrust violations, leading to much speculation about what effect, if any, *Evanston* will have on hospital merger antitrust jurisprudence.

Many commentators have been critical of the *Evanston* decision.<sup>4</sup> They believe the decision is flawed because the analysis veers from past precedent and will thus leave no lasting impression on courts' future hospital merger analysis.<sup>5</sup> This Note takes a different view: the *Evanston* decision follows a relatively traditional analysis in line with Federal Horizontal Merger Guidelines, but focuses on first-stage competition, the level where hospitals compete to be included in managed care organizations' networks, rather than second-stage competition, the level where hospitals compete for patients. *Evanston*'s legacy can, and should, be a readjustment of hospital merger analysis to explicitly focus on first-stage, rather than second-stage competition. If courts continue to ignore the role that third-party payors, particularly managed care organizations, play in the complex landscape of health care delivery and consumption in this country, hospital merger analysis will never be able to evaluate the true potential anticompetitive effects of hospital mergers accurately.

This Note suggests several ways to accomplish this refocusing. Adjudicative bodies evaluating hospital mergers should: 1) narrow the relevant product market definition to include only general acute inpatient care sold to managed care organizations ("MCOs"); 2) give more credence to testimony from MCO representatives at all steps of the analysis; 3) cease relying on the Elzinga-Hogarty test and patient flow data to establish geographic market definitions; and 4) reconsider the anchor hospital theory.

Part I of this Note presents an overview of horizontal merger antitrust enforcement. Part II delves more deeply into how agencies and courts have applied the Federal Trade Commission and the Department of Justice's joint Horizontal Merger Guidelines ("Merger Guidelines") to evaluate hospital mergers for antitrust purposes. Part III examines the *Evanston* decision in detail. Part IV explores the role MCOs have played in past hospital merger analyses and discusses how that role can and should be enhanced in the future.

#### I. HORIZONTAL MERGER ANTITRUST ENFORCEMENT OVERVIEW

The Federal Trade Commission and the Department of Justice ("Agencies") are jointly responsible for the enforcement of federal antitrust statutes.<sup>6</sup> With

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<sup>4</sup> See, e.g., Campbell, *supra* note 2, at 213; Barry C. Harris & David A. Argue, FTC v. *Evanston Northwestern: A Change from Traditional Hospital Merger Analysis?*, ANTITRUST, Spring 2006, at 34, 35 ("[N]either the parties to the merger nor the ALJ applied the appropriate tests with regard to post-merger prices.").

<sup>5</sup> Harris & Argue, *supra* note 4, at 35.

<sup>6</sup> Barry E. Hawk & Laraine L. Laudati, *Antitrust Federalism in the United States and Decentralization of Competition Law Enforcement in the European Union: A Comparison*, 20 FORDHAM INT'L L.J. 18, 23 (1996). State attorneys general also have the power to bring

respect to mergers, the Agencies' antitrust work generally occurs before a merger is consummated.<sup>7</sup> Under the Hart-Scott-Rodino Antitrust Improvement Act, firms of sufficient size wishing to merge must notify the Agencies of their intentions and cannot complete the merger until thirty days after notification.<sup>8</sup> During those thirty days, the Agencies will decide whether to challenge the merger as anticompetitive.<sup>9</sup> In 1992, the Agencies issued Horizontal Merger Guidelines to serve as "an analytical road map for the evaluation of mergers."<sup>10</sup> The Merger Guidelines provide a glimpse into the process by which the Agencies decide whether to bring a pre-merger challenge.

If the Agencies determine, according to the Merger Guidelines, that the merger would lead to anticompetitive effects, they can go to a federal court and request a preliminary injunction.<sup>11</sup> Often the threat of a preliminary injunction will cause the parties to abandon the proposed merger before becoming entangled in litigation.<sup>12</sup> Cases that proceed to litigation are usually resolved by the court's decision. If the court grants the injunction, the parties usually abandon the merger plans; if the court does not grant the injunction, the merger usually goes through.<sup>13</sup>

The Agencies have subsequently furnished more specific guidance to the health care industry regarding antitrust enforcement policies. Issued in 1996, the Statements of Antitrust Enforcement Policy in Health Care ("Health Care Guidelines") address various potential areas of antitrust scrutiny in the industry, including hospital mergers.<sup>14</sup> Notably, the Health Care Guidelines

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suit under antitrust statutes as *parens patriae* on behalf of their citizens. *See, e.g.*, *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1066 (N.D. Cal. 2000).

<sup>7</sup> For an explanation of the required pre-merger notification and the thirty-day waiting period during which the Agencies determine whether the proposed merger poses a competitive threat, see PHILLIP AREEDA ET AL., *ANTITRUST ANALYSIS: PROBLEMS, TEXT, AND CASES* 684-87 (6th ed. 2004).

<sup>8</sup> 15 U.S.C. § 18a(a)-(e) (2006).

<sup>9</sup> *See* AREEDA ET AL., *supra* note 7, at 686. If the Agencies need more information, they can extend the waiting period and request more information about the firms. *Id.* After receiving additional information, the Agencies will decide whether to attempt to block the merger or allow the merger to go through. *Id.*

<sup>10</sup> U.S. Dep't of Justice & Fed. Trade Comm'n, 1992 Horizontal Merger Guidelines (revised April 8, 1997), 4 Fed. Trade Reg. Rep. (CCH) ¶ 13,104, at 20,569 [hereinafter *Horizontal Merger Guidelines*].

<sup>11</sup> *See* AREEDA ET AL., *supra* note 7, at 686.

<sup>12</sup> *Id.*

<sup>13</sup> *But see, e.g.*, *FTC v. Whole Foods Mkt., Inc.*, 548 F.3d 1028, 1033 (D.C. Cir. 2008) (explaining that "the court denied the preliminary injunction" and "the FTC filed an emergency motion for an injunction pending appeal"). This case has yet to be resolved and raises interesting questions because, in the interim, the merger was completed.

<sup>14</sup> U.S. Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy in Health Care*, 4 Fed. Trade Reg. Rep. (CCH) ¶ 13,153, at 20,799 (1996) ("In these

defined a “safety zone” for acute care hospital mergers that will generally not be challenged under antitrust laws.<sup>15</sup> The safety zone applies if one of the hospitals involved in the merger has an average of fewer than one hundred beds and fewer than forty inpatients at a time over the past three years.<sup>16</sup> The safety zone does not apply if that hospital is less than five years old.<sup>17</sup>

If a merger falls outside the safety zone, it will be evaluated under the five analytical steps in the Merger Guidelines, which are applicable to all industries.<sup>18</sup> The five steps are: 1) market definition, measurement and concentration; 2) the potential adverse competitive effects of mergers; 3) entry analysis; 4) efficiencies; and 5) failure and exiting assets.<sup>19</sup> Although the Merger Guidelines are not binding, courts frequently turn to them for guidance when addressing antitrust issues.<sup>20</sup>

## II. ANALYSIS OF THE ANTICOMPETITIVE EFFECTS OF HOSPITAL MERGERS

### A. *Market Definition*

A merger violates antitrust laws if it will have anticompetitive effects in a defined geographic area and within a specific product market. Therefore, the first step of analysis necessitates a finding of the proper market definitions. This first step is critical because the court's geographic and market definitions can drastically affect the resolution of the case.<sup>21</sup> As such, the boundaries of both the product market and the geographic market are often in dispute.

Under the Merger Guidelines, the central inquiry is what effect a “small but significant and nontransitory” increase in price” (“SSNIP”) will have on consumer behavior.<sup>22</sup> If consumers would shift their consumption to other products in reaction to a small price increase, the product market definition is too narrow.<sup>23</sup> Likewise, if a small price increase would cause consumers to travel outside the geographic market, therefore making the price increase unsustainable, the geographic market definition is too narrow.<sup>24</sup>

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revised statements, the Agencies . . . analyze all types of health care provider networks under general antitrust principles.”).

<sup>15</sup> *Id.* at 20,801.

<sup>16</sup> *Id.*

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> Horizontal Merger Guidelines, *supra* note 10, at 20,571-74.

<sup>20</sup> See *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1068-69 (N.D. Cal. 2000).

<sup>21</sup> See Jonathan B. Baker, *Market Definition: An Analytical Overview*, 74 ANTITRUST L. J. 129, 129 (2007); Robert Pitofsky, *New Definitions of Relevant Market and the Assault on Antitrust*, 90 COLUM. L. REV. 1805, 1807 (1990).

<sup>22</sup> Horizontal Merger Guidelines, *supra* note 10, § 1.11, at 20,571.

<sup>23</sup> *Id.* § 1.11, at 20,572.

<sup>24</sup> *Id.* § 1.21, at 20,573.

### 1. Hospital Product Market

Initially, defining a relevant product market for merging hospitals appears challenging.<sup>25</sup> In practice, however, parties to hospital merger antitrust enforcement actions do not often disagree about what the product market definition should be. Accordingly, courts generally accept the broad product market definitions presented by the parties.<sup>26</sup> When there is a disagreement about the relevant product market, courts tend to adhere to a traditional product market definition such as general acute inpatient care.<sup>27</sup> For example, in *FTC v. Butterworth Health Corp.*, defendant hospitals argued that the relevant product market should be expanded to include outpatient services.<sup>28</sup> The court rejected the argument, holding that patients would not substitute outpatient care for inpatient care in response to a small increase in the price of inpatient services.<sup>29</sup> According to the court, the choice between outpatient and inpatient care is “generally the product of medical judgment” rather than a decision made based on cost.<sup>30</sup> As such, the court adopted the government’s proposed product market of general acute care inpatient hospital services.<sup>31</sup>

#### a. *The Anchor Hospital Theory*

The anchor hospital theory proffers that certain prominent hospitals must be considered in a product market of their own.<sup>32</sup> Much like anchor tenants in shopping malls, anchor hospitals are “must have” facilities in managed care networks.<sup>33</sup> In *United States v. Long Island Jewish Medical Center*, a notable exception to the general observation that the product market is usually agreed upon by both parties, the government unsuccessfully argued for a narrowed

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<sup>25</sup> Consider, for instance, whether outpatient services are substitutes for inpatient care, or how to account for the fact that some hospitals provide tertiary care in addition to primary and secondary care, while others do not.

<sup>26</sup> See, e.g., *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1052 (8th Cir. 1999) (accepting the product market as “the delivery of primary and secondary inpatient hospital care services”); *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995).

<sup>27</sup> See *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 139 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1291 (W.D. Mich. 1996).

<sup>28</sup> *Butterworth*, 946 F. Supp. at 1290 (“Defendants argue . . . that outpatient services can be substituted for many inpatient services . . . thereby justifying a broader product market including outpatient care . . .”).

<sup>29</sup> *Id.*

<sup>30</sup> *Id.* at 1291.

<sup>31</sup> *Id.*

<sup>32</sup> See *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 137 (arguing that “anchor hospitals” have “prestigious reputations, broad ranging and highly sophisticated services, and high quality medical staffs” and are not interchangeable with community hospitals (citation omitted)).

<sup>33</sup> See *id.*

product market on the basis of the anchor hospital theory.<sup>34</sup> Swiftly rejected by the court, the theory has since been all but abandoned.<sup>35</sup>

*Long Island* addressed the proposed merger of two Long Island hospitals – North Shore Manhasset (“NSM”) and Long Island Jewish Medical Center (“LIJ”).<sup>36</sup> The government framed the product market as “the bundle of acute inpatient services provided by anchor hospitals to managed care plans” and defined anchor hospitals as those with “prestigious reputations, broad ranging and highly sophisticated services, and high quality medical staffs.”<sup>37</sup> According to the government, anchor hospitals had to be considered in a market of their own despite the presence of other hospitals that provided similar acute care services.<sup>38</sup> The claim was that other area hospitals simply could not compete with the “cachet” of NSM and LIJ.<sup>39</sup> The court was not persuaded and chose to define the product market as “general acute care inpatient hospital services,” as was advocated by the hospitals.<sup>40</sup> Perhaps because of the reluctance of courts to take this more nuanced view of product market definition, the government has not attempted to advance the “anchor hospital” theory since.<sup>41</sup>

## 2. Hospital Geographic Market

The geographic market for hospital services is no easier to define and more often in dispute than the product market. It is a particularly difficult question because patients do not make an entirely independent choice about where to access care.<sup>42</sup> A managed care organization may limit a patient’s options to go to specific hospitals, which may or may not be the most convenient for the patient. Furthermore, patients are just as likely to take into account nonprice

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<sup>34</sup> See *id.* at 138.

<sup>35</sup> See Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 616 (2002).

<sup>36</sup> *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 125.

<sup>37</sup> *Id.* at 137 (citation omitted).

<sup>38</sup> *Id.*

<sup>39</sup> See *id.* at 130 n.4, 137 (defining “cachet” as prestige or high status). For a more detailed discussion of the government’s case, see *infra* Part IV.A.2 (discussing *Long Island Jewish Med. Ctr.* and the anchor hospital theory).

<sup>40</sup> *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 140.

<sup>41</sup> Hammer & Sage, *supra* note 35, at 616 (“[C]ourts have not been receptive to arguments by federal enforcement agencies that merging hospitals may be able to exercise market power *because* their high quality puts them in a separate economic market for antitrust purposes.”).

<sup>42</sup> See Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, HEALTH AFF., Mar.-Apr. 2002, at 185, 187 (identifying as a flaw in courts’ geographic market analysis “a propensity to overlook the importance of agency relationships in determining consumers’ responses”).

factors as they are price when choosing a hospital.<sup>43</sup> Evaluating these nonprice factors is complex and raises difficult questions. For example, how far is a patient willing to travel for acute inpatient hospital services? If the patient's treating physician only has staff privileges at a distant hospital, will the patient be willing to travel in order to have his preferred doctor provide the necessary care? Or are patients willing to switch doctors in order to get care at a more convenient hospital? To add to the complexity, these questions are highly personal and each individual will have a different answer based on his own idiosyncratic values. The fact that some consumers may be willing to travel for care does not imply that every patient would do so.<sup>44</sup>

When tackling this difficult task, the Agencies and courts first consider the current makeup of the hospitals' patients. Courts often turn to the Elzinga-Hogarty test as a starting point.<sup>45</sup> The test uses patient flow data to determine the geographic range from which the hospitals currently draw patients to establish a "service area."<sup>46</sup> From that data, two measurements are derived: "Little In From Outside" ("LIFO") and "Little Out From Inside" ("LOFI").<sup>47</sup> LIFO measures the percentage of the hospital's patients living within the service area.<sup>48</sup> LOFI measures the percentage of hospital patients living in the service area who choose to get care at area hospitals rather than go elsewhere.<sup>49</sup> If the LIFO and LOFI numbers are high, the service area chosen

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<sup>43</sup> For a discussion of various nonprice factors that should be considered when evaluating hospital competition, see Jennifer R. Conners, *A Critical Misdiagnosis: How Courts Underestimate the Anticompetitive Implications of Hospital Mergers*, 91 CAL. L. REV. 543, 570 (2003). "Patients are likely to consider nonprice factors such as reputation, quality of care, physical appearance of the hospital, and other bonuses like private rooms or outpatient clinics." *Id.*

<sup>44</sup> See Greaney, *supra* note 42, at 187 (arguing that the courts' conclusion that "patients on the fringe of the market, willing to travel to more distant locales for hospital services, suggests the willingness of others to do so in response to higher prices" ignores "the fact that a myriad of factors other than price . . . shape purchasing decisions for highly differentiated services" (citation omitted)). For a more in-depth discussion of the so-called "silent majority" problem, see *infra* Part III.B.2.

<sup>45</sup> See, e.g., *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1069 (N.D. Cal. 2000). For an in-depth explanation of the Elzinga-Hogarty test, see generally Kenneth G. Elzinga & Thomas F. Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 ANTITRUST BULL. 45 (1973); Kenneth G. Elzinga & Thomas F. Hogarty, *The Problem of Geographic Market Delineation Revisited: The Case of Coal*, 23 ANTITRUST BULL. 1 (1978).

<sup>46</sup> See *Sutter Health Sys.*, 84 F. Supp. 2d at 1069.

<sup>47</sup> See *id.*

<sup>48</sup> See *id.* For example, if the LIFO is 100%, then all hospital admitees in the test market reside in that test market. *Id.*

<sup>49</sup> See *id.* For example, if the LOFI is 100%, then all hospital patients who reside in the test market are admitted to hospitals in that test market. *Id.*



is likely the proper geographic market for antitrust purposes.<sup>50</sup> Under the Elzinga-Hogarty test, ninety percent LIFO and LOFI measurements show a “strong indication of a market.”<sup>51</sup>

The Elzinga-Hogarty test is useful in determining the hospitals' current market, but the inquiry does not end there. The more difficult part of establishing a proper geographic market definition is determining what might happen in the future if the merger is in fact consummated. The overall analysis must be a dynamic one that looks not only at current market conditions, but also “at possible competitive responses from other hospitals, third party payers and consumers.”<sup>52</sup> The range of possible competitive responses is so wide and speculative that it is easy to see why geographic market definitions are so difficult to establish and so often in dispute. In *United States v. Mercy Health Services*, the government was defeated, in part, because it “rel[ied] too heavily on past conditions” and “assumptions and conclusions that are not supported by the evidence.”<sup>53</sup>

Defining the proper geographic market is not an exact science. It is highly fact-specific, and courts' conclusions are often unpredictable. Further, the use of patient-flow data as the basis for determining the geographic market has been criticized because patients usually do not pay for care directly.<sup>54</sup> Because geographic market is so often the deciding factor, it is vital that courts adopt a sensible, predictable method for establishing the proper geographic market definition in antitrust analyses.

#### B. *Market Concentration*

According to the Merger Guidelines, “market concentration affects the likelihood that one firm, or a small group of firms, could successfully exercise market power.”<sup>55</sup> Thus, the next step in the analysis is to determine the concentration of the above-defined market.<sup>56</sup> The Merger Guidelines direct the Agencies to use the Herfindahl-Hirschman Index (“HHI”) as the proper indicator of market concentration.<sup>57</sup> When evaluating the potential

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<sup>50</sup> *See id.*

<sup>51</sup> *Id.*

<sup>52</sup> *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 978 (N.D. Iowa 1995).

<sup>53</sup> *Id.*

<sup>54</sup> *See, e.g., Gregory S. Vistnes, Defining Geographic Markets for Hospital Mergers, ANTITRUST*, Spring 1999, at 28, 31 (“Patient flow data inappropriately focuses on patients, not the immediate purchaser.”); *see also infra* Part III.B.2 (discussing the payor problem with using the Elzinga-Hogarty Test).

<sup>55</sup> Horizontal Merger Guidelines, *supra* note 10, § 2.0, at 20,573-6.

<sup>56</sup> *See id.* § 1.5, at 20,573-5 to -6 (discussing the Agency's consideration of market concentration in horizontal mergers).

<sup>57</sup> *Id.* § 1.5, at 20,573-5. The HHI is an index used to quantify market concentration. It is calculated by “summing the squares of the individual market shares of all the participants.” *Id.*

anticompetitive effects of a merger, the Agencies determine what the HHI would be post-merger and proceed accordingly. Highly concentrated markets and markets that will become significantly more concentrated as a result of the proposed merger garner further scrutiny from the Agencies.<sup>58</sup>

The difficulty with respect to hospital mergers lies in how to determine market share, the variable used to calculate HHI.<sup>59</sup> Recognizing the challenge, the court in *United States v. Rockford Memorial Corp.* ran three different HHI calculations using three different bases for market share: number of beds, number of admissions, and number of patient days.<sup>60</sup> Although the court did not elaborate on why it chose those three bases specifically, this example illustrates the difficulty in determining the actual market share a hospital controls at any given time. Beyond *Rockford*, there is little case law available that reveals how courts define hospital market shares.<sup>61</sup> When courts do discuss market concentration, they often do not elaborate on how each hospital's market share is determined.<sup>62</sup>

### C. *Rebutting the Presumption of Anticompetitive Effects*

Any merger causing an HHI increase of more than one hundred points in a moderately concentrated market or more than fifty points in a highly concentrated market is evaluated further using the factors outlined in Sections Two through Five of the Merger Guidelines.<sup>63</sup> Section Two outlines the potential effects that the Agencies should consider when evaluating a merger that is suspect, but not quite at the concentration level at which it is presumed anticompetitive.<sup>64</sup> A merger in a highly concentrated market that causes an HHI increase of more than one hundred points is presumed anticompetitive.<sup>65</sup> Sections Three through Five present possible ways firms can rebut this

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<sup>58</sup> *Id.* § 1.5, at 20,573-5 to -6 (discussing the Agencies' reactions to various HHI values). A highly concentrated market has an HHI of 1800 or above; an increase of 100 HHI points or more is considered significant. *Id.* § 1.5, at 20,573-6.

<sup>59</sup> See Matthew Reiffer, Note, *Antitrust Implications in Nonprofit Hospital Mergers*, 27 J. LEGIS. 187, 205 (2001).

<sup>60</sup> *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1280 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990).

<sup>61</sup> This is in part because courts often dismiss these cases at the geographic market stage of analysis if they find that the government has failed to establish a relevant geographic market, and therefore many cases never get to the market concentration step. See, e.g., *FTC v. Freeman Hosp.*, 69 F.3d 260, 272 (8th Cir. 1995).

<sup>62</sup> See, e.g., *FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1211 (11th Cir. 1991) (revealing University Health's post-merger market share to be forty-three percent without explaining how that number was calculated); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1294 (W.D. Mich. 1996) (accepting expert's market share calculations).

<sup>63</sup> Horizontal Merger Guidelines, *supra* note 10, § 1.5, at 20,573-5 to -6.

<sup>64</sup> *Id.* § 2, at 20,573-6

<sup>65</sup> *Id.* § 1.51(c), at 20,573-6.

presumption, including ease of entry, efficiencies, and the failing firm defense.<sup>66</sup>

### 1. Entry

Section Three discusses ease of entry.<sup>67</sup> If entry into a given market is very easy, the merged firms would not be able to maintain supracompetitive prices post-merger, even in a highly concentrated market.<sup>68</sup> Thus, the Agencies rarely challenge mergers taking place under conditions that make entry relatively easy because the merger likely would not lead to anticompetitive effects.<sup>69</sup>

Due to state certificate of need (“CON”) laws and other state-mandated barriers to entry, ease of entry is not often cited by hospitals as a defense to potential anticompetitive effects of a merger.<sup>70</sup> Although the federal CON statute was repealed in 1974, thirty-six states still have CON laws on the books.<sup>71</sup> And the fourteen states with no CON legislation still maintain other forms of regulation and barriers to entry for health care providers.<sup>72</sup>

### 2. Efficiencies

A merger is not anticompetitive if it exploits efficiencies and passes the benefits on to consumers.<sup>73</sup> However, the Agencies only consider merger-specific efficiencies, those resulting from the merger that would not have been achieved otherwise.<sup>74</sup> The potential efficiencies in hospital mergers can be found in all areas of hospital operations, including laboratory services, staffing, food services, purchasing, laundry, information services, administration, and capital costs.<sup>75</sup> Over time, courts have become more willing to accept hospitals' claims that savings and efficiencies will lead to benefits for consumers that will far outweigh any anticompetitive effects of a merger. Additionally, courts have started to accept that such efficiencies are in fact merger-specific.

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<sup>66</sup> *Id.* §§ 3-5, at 20,573-9 to 20,574.

<sup>67</sup> *Id.* § 3, at 20,573-9 to -11.

<sup>68</sup> *Id.* § 3, at 20,573-9.

<sup>69</sup> *Id.* § 3, at 20,573-10.

<sup>70</sup> In some jurisdictions, the government must determine that there is need for a new health care facility before it will permit the facility's construction. National Conference of State Legislatures, Certificate of Need: State Health Laws and Programs (Apr. 30, 2009), <http://www.ncsl.org/programs/health/cert-need.htm>. Such approval is known as a “certificate of need.” *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> See Horizontal Merger Guidelines, *supra* note 10, § 4, at 20,573-13.

<sup>74</sup> *Id.*

<sup>75</sup> Reiffer, *supra* note 59, at 208.

In the past, courts were wary of defenses based on merger-specific efficiencies. In 1989, the Northern District of Illinois was suspicious of defendant hospitals' efficiencies defense and granted an injunction to the government because it was not persuaded that the alleged efficiencies would ever come to fruition.<sup>76</sup> Similarly, in 1995 the Northern District of Iowa held that defendant hospitals had not carried their burden of proving that the alleged efficiencies were sufficient to overcome the potential anticompetitive effects of the merger.<sup>77</sup> Again, the court found that the purported efficiencies were highly speculative and that many of the stated efficiencies were achievable without the merger.<sup>78</sup> However, courts seem to have moved toward considering and accepting efficiency defenses. In the same year the Iowa court refused to accept an efficiencies defense, the Western District of Missouri embraced a similar defense.<sup>79</sup> The Missouri court denied the injunction despite finding a suspect increase in concentration, citing potential efficiencies such as reduced overhead and administrative costs, which would outweigh potential anticompetitive effects.<sup>80</sup> Since then, efficiencies defenses have been hugely successful for hospitals, allowing them to realize a seven-case winning streak against the government in hospital merger antitrust enforcement actions.<sup>81</sup>

### 3. Failing Firm Defense

According to the Merger Guidelines, a finding that one of the firms involved in the merger is on the brink of failure can rebut the presumption that the merger is anticompetitive.<sup>82</sup> However, to prove that a firm is indeed failing, the defendant must show that: 1) the firm is "unable to meet its financial obligations in the near future;" 2) reorganization under Chapter 11 of the Bankruptcy Act is impossible; 3) the firm made a good-faith effort to find another buyer whose acquisition of the firm's assets would produce fewer

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<sup>76</sup> *United States v. Rockford Mem'l Corp.*, 717 F. Supp. 1251, 1289, 1292 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990).

<sup>77</sup> *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 987 (N.D. Iowa 1995).

<sup>78</sup> *Id.*

<sup>79</sup> *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1224 (W.D. Mo. 1995) ("The consolidation may also make possible the creation of significant economic efficiencies through less overhead expenses and less administrative duplication.").

<sup>80</sup> *Id.*

<sup>81</sup> *See, e.g.*, *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999) (criticizing the district court's rejection of defendant hospital's efficiencies defense); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 122 (E.D.N.Y. 1997) (finding the merger would promote the achievement of efficiencies); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285, 1301 (W.D. Mich. 1996) (stating that "the Court is persuaded that the proposed merger would result in significant efficiencies"); *see also* Greaney, *supra* note 42, at 186 (discussing the government's 7-0 track record for hospital merger antitrust objections from 1995 to 2002).

<sup>82</sup> Horizontal Merger Guidelines, *supra* note 10, § 5, at 20,574.

anticompetitive effects than the merger in question; and 4) without the merger, the firm would fail.<sup>83</sup>

Generally, if one of the hospitals involved in a potential merger is on the brink of failure, the government will not challenge the merger, so there is little case law on the subject. However, in *California v. Sutter Health System*, the government did pursue a challenge to the proposed merger between Sutter Health System and Summit Medical Center, despite the fact that Summit was in dire financial straits.<sup>84</sup> The hospitals presented a “failing company” defense, arguing that Summit’s financial position met all the requirements of the defense, as set forth in case law and the Merger Guidelines.<sup>85</sup> The court agreed, finding that Summit was close enough to insolvency to show it would likely face failure in the near future, that Chapter 11 reorganization was not a viable option, and that there were no other buyers willing to purchase Summit.<sup>86</sup> Although the court’s primary reason for ruling against the government was its failure to meet the burden of showing that the merger would in fact have anticompetitive effects, the failing company defense certainly strengthened the hospitals’ position.<sup>87</sup>

### III. *IN RE EVANSTON NORTHWESTERN HEALTHCARE CORPORATION*

In February 2004, the FTC filed an administrative complaint against Evanston Northwestern Healthcare Corporation (“ENH”) alleging Clayton Act violations stemming from its acquisition of Highland Park Hospital.<sup>88</sup> What made this complaint unique was the fact that the merger had been consummated four years prior, in January of 2000.<sup>89</sup> The action was a direct result of a change in the FTC’s hospital merger antitrust enforcement strategy that Commissioner Timothy Muris revealed in 2002.<sup>90</sup> After seven straight losses, the FTC decided to evaluate the actual effects of hospital mergers

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<sup>83</sup> *Id.* § 5.1, at 20,574.

<sup>84</sup> *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1081 (N.D. Cal. 2000).

<sup>85</sup> *Id.*

<sup>86</sup> *Id.* at 1085.

<sup>87</sup> *Id.* at 1085-86.

<sup>88</sup> Complaint at 1, *In re Evanston Nw. Healthcare Corp.*, F.T.C. No. 9315 (Feb. 10, 2004), available at <http://www.ftc.gov/os/caselist/0110234/040210emhcomplaint.pdf>.

<sup>89</sup> The government did not challenge the transaction pre-merger. See Evanston Final Decision, F.T.C. No. 9315, at 4 (Aug. 6, 2007), available at <http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf>.

<sup>90</sup> Timothy J. Muris, Chairman, Fed. Trade Comm’n, Everything Old Is New Again: Health Care and Competition in the 21st Century (Nov. 7, 2002) (transcript available at <http://ftc.gov/speeches/muris/murishhealthcarespeech0211.pdf>) (declaring the creation of a “new merger litigation task force” established to “screen targets, select the best cases, and develop new strategies for trying them”).

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retrospectively; if it found anticompetitive effects, the Commission would consider administrative action.<sup>91</sup>

The new strategy was a success. In 2005, an administrative law judge (“ALJ”) found that the merger did lead to anticompetitive effects in violation of Section 7 of the Clayton Act and ordered Evanston to divest Highland Park.<sup>92</sup> Evanston appealed the decision, but in 2007 the full Commission upheld the ALJ’s findings.<sup>93</sup> The Commission did, however, revise the remedy after determining that divestiture seven years after completion of the merger would be difficult and disruptive.<sup>94</sup> But the losing streak had been broken. Over a decade after its last victory, the government finally emerged triumphant in challenging a hospital merger on antitrust grounds.

On its face, the ALJ conducted a traditional antitrust analysis of the merger in line with the Merger Guidelines. However, due to the retrospective nature of the case, the ALJ had considerably more tangible evidence regarding the direct anticompetitive effects of the merger than is traditionally available, a factor that is highly speculative in prospective challenges. As a result, the Initial Decision and the subsequent Final Decision depart from past hospital merger case law in two important ways. The first is the abandonment of the Elzinga-Hogarty test as a measure for defining the relevant geographic market. The second is the ALJ’s reliance on evidence from market participants – testimony of MCO representatives and information from internal hospital documents – when evaluating the adverse competitive consequences of the merger.

#### A. *Background*

Evanston Northwestern Healthcare Corporation (“ENH”) is the surviving entity of a 2000 merger between ENH and Lakeland Health Services.<sup>95</sup> Prior to the merger, ENH owned two hospitals – Evanston Hospital and Glenbrook Hospital; Lakeland Health Services owned one – Highland Park Hospital.<sup>96</sup> Evanston Hospital, located in Evanston, Illinois, is a 400-bed facility providing primary, secondary, and tertiary care.<sup>97</sup> Glenbrook Hospital, located in Glenview, Illinois approximately 12.6 miles west of Evanston, is a 125-bed

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<sup>91</sup> *Id.*

<sup>92</sup> *In re* Evanston Nw. Healthcare Corp., F.T.C. No. 9315 at 2 (Oct. 20, 2005) [hereinafter Evanston Initial Decision], available at <http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf>.

<sup>93</sup> Evanston Final Decision, F.T.C. No. 9315, at 5.

<sup>94</sup> In lieu of divestiture, the Commission settled on a “conduct” remedy and ordered the hospitals to establish “separate and independent” teams to negotiate reimbursement rates with MCOs. *Id.* at 88-91.

<sup>95</sup> Evanston Initial Decision, F.T.C. No. 9315 at 14.

<sup>96</sup> *Id.* at 5, 7.

<sup>97</sup> *Id.* at 5-6.

facility providing primary and secondary care.<sup>98</sup> Highland Park Hospital, located in Highland Park, Illinois about 13.7 miles north of Evanston, has approximately 150 to 200 beds.<sup>99</sup> Before the merger, Highland Park offered only primary and secondary care services.<sup>100</sup>

Although they retained separate physical facilities, after the merger the three hospitals effectively became one entity.<sup>101</sup> All corporate offices for the entire ENH system moved to Evanston, and ENH instituted an integrated billing system for all its affiliates and held a single Medicare identification number for all three hospitals.<sup>102</sup> Medical staff privileges granted at one hospital became transferrable to the other two.<sup>103</sup> ENH negotiated with MCOs on behalf of all three hospitals jointly and insisted that either all or none were a part of an MCO's network.<sup>104</sup>

## B. *Relevant Market*

### 1. Product Market

The government advocated for a product market definition limited to "general acute care inpatient services sold to managed care organizations."<sup>105</sup> ENH argued for the inclusion of outpatient services in the definition, contending that MCOs negotiate and pay for both outpatient and inpatient services on behalf of their subscribers.<sup>106</sup> The ALJ, following precedent, agreed with the government and included primary, secondary, and tertiary care in the product market definition.<sup>107</sup> Outpatient services were excluded because "there is an inherent inability to substitute outpatient services for inpatient services."<sup>108</sup> ENH did not dispute that it set inpatient prices independent of outpatient prices and without concern that patients would switch to outpatient care in response to a price increase.<sup>109</sup> The ALJ cited this recognition as further evidence that outpatient services are not substitutes for inpatient services.<sup>110</sup>

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<sup>98</sup> *Id.* at 6.

<sup>99</sup> *Id.* at 7.

<sup>100</sup> *Id.*

<sup>101</sup> *Id.* at 14.

<sup>102</sup> *Id.*

<sup>103</sup> *Id.* at 15.

<sup>104</sup> *See id.* at 14.

<sup>105</sup> *Id.* at 131.

<sup>106</sup> *Id.* at 131-32.

<sup>107</sup> *Id.* at 133-34.

<sup>108</sup> *Id.* at 133.

<sup>109</sup> *Id.*

<sup>110</sup> *Id.*

## 2. Geographic Market

In defining the relevant geographic market, the ALJ departed from traditional antitrust merger analysis by rejecting the Elzinga-Hogarty Test.<sup>111</sup> The test was created to analyze mergers in the beer and coal industries, which, according to the ALJ, made it unsuitable for the health care industry.<sup>112</sup> The test “is premised on the assumption that patient flow data affects market prices,” an assumption the ALJ rejected.<sup>113</sup> Had the ALJ used traditional geographic market determination methods as advocated in the past, the resulting geographic market would have been excessively broad.<sup>114</sup> Professor Elzinga himself testified at the hearing that the test was not an appropriate way of determining market concentration for hospital services.<sup>115</sup>

The ALJ identified two factors that make the test inapplicable to hospitals: the “payor problem” and the “silent majority” problem.<sup>116</sup> The “payor problem” refers to the fact that the party who utilizes hospital services is different from the party who pays for the services.<sup>117</sup> MCOs, or other third-party payors, such as the government, usually pay for hospital services while the patient benefits from the care. The ALJ held that because of this disconnect, patients do not really set the price for services, and that their willingness to travel for care tells us nothing about the effect of price changes at hospitals.<sup>118</sup> Further, the ALJ held that although some patients would travel to distant hospitals in response to a price increase, there is a “silent majority” who would not, and would instead be subject to anticompetitive price increases.<sup>119</sup>

The government attempted to define the market as exclusive to the three merged hospitals.<sup>120</sup> In support, it offered testimony of MCO representatives stating the impossibility of creating a viable network without the ENH hospitals.<sup>121</sup> It also pointed to the fact that ENH did not experience a loss of patients, despite post-merger price increases, because MCOs could not drop the hospitals from their networks without losing a large number of subscribers.<sup>122</sup> ENH advocated for a more expansive geographic market

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<sup>111</sup> *Id.* at 30.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> *Id.* at 138.

<sup>116</sup> *Id.* at 139.

<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

<sup>119</sup> *Id.*

<sup>120</sup> *Id.* at 137.

<sup>121</sup> *See id.* (“[M]anaged care organizations found that they had to accept ENH’s price increases because they could not satisfy their customers, employers, without ENH in their networks.”).

<sup>122</sup> *Id.*



definition.<sup>123</sup> The ENH definition included the three merged hospitals plus, at a minimum, six additional area facilities.<sup>124</sup> It also suggested that the court consider four other hospitals that might have an effect on competition.<sup>125</sup>

Past hospital merger cases tended to use larger geographic market definitions, and while the ALJ considered precedent, other factors also weighed heavily in its analysis.<sup>126</sup> The “key issue” was “identifying which hospitals managed care organizations need to have in their hospital networks in order to establish viable, competitive networks.”<sup>127</sup> As such, testimony from MCOs and other “market participants” was highly influential to the ALJ’s ultimate geographic market definition.<sup>128</sup> Various MCO representatives testified from their personal experience as to which hospitals directly competed with Evanston, Glenbrook, and Highland Park.<sup>129</sup> Representatives of ENH and Highland Park also expressed their opinions about which hospitals they competed with pre-merger.<sup>130</sup> The ALJ, who believed that people generally seek care at local hospitals, also considered driving times in his geographic market analysis.<sup>131</sup> From these factors, the ALJ came up with a list of hospitals included in the geographic market, rather than delineating a set geographic area by county, zip code, or distance from one of the merged hospitals.<sup>132</sup> Choosing a middle ground between ENH’s expansive nine-hospital market and the government’s narrow three-hospital view, the ALJ determined that the relevant geographic market included a total of seven hospitals – the three ENH hospitals plus four others, all of which were located within ten miles of one of the ENH facilities.<sup>133</sup>

### C. *Effect of the Merger on Competition*

#### 1. Market Concentration

A merger in a market with an HHI above 1800 (a “highly concentrated” market) and/or a change in HHI of over one hundred is “likely to create or

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<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> *Id.*

<sup>126</sup> *Id.* at 137-38.

<sup>127</sup> *Id.* at 139.

<sup>128</sup> *Id.* at 140.

<sup>129</sup> *Id.* at 140-41.

<sup>130</sup> *Id.* at 141.

<sup>131</sup> *Id.* at 147-48 (examining the driving times, among other factors, from Evanston Hospital to various potential competitors).

<sup>132</sup> *Id.* at 144-46.

<sup>133</sup> *Id.* Some of the hospitals were specifically excluded from the geographic market because they were not “significant competitor[s]” of ENH. *Id.* at 146-48. Several other hospitals were listed as possible competitors because they were mentioned by one or more of the MCO representatives as alternatives to the ENH hospitals. *Id.* at 144-46.

enhance market power or facilitate its exercise” and is presumed anticompetitive.<sup>134</sup> Again rejecting both ENH and the government’s HHI numbers, the ALJ calculated its own HHI figures using the established seven-hospital geographic market.<sup>135</sup> Using ENH’s market share estimates, the ALJ calculated the post-merger HHI to be 2739, a 384 point increase over the pre-merger concentration.<sup>136</sup> As the ALJ pointed out, this was well above the Merger Guidelines’ threshold of HHI of 1800 or a one hundred point increase for a highly concentrated market, and therefore attracts the attention of antitrust enforcers due to potential anticompetitive effects caused by the merger.<sup>137</sup>

## 2. Contemporaneous and Post-Merger Evidence

In the traditional pre-merger context, a court evaluating a hospital merger with similarly high HHI figures would speculate as to whether the merger would lead to anticompetitive behavior or if other factors rebut the anticompetitive effects presumption. The Merger Guidelines provide some guidance, but any methodology that evaluates what will happen in the future is by its nature an imperfect science. The *Evanston* case, however, provided a unique opportunity because it was a post-merger enforcement action and therefore the effects of the merger on competition were readily observable. Although the government did not need to “provide evidence of actual anticompetitive post-merger effects, only evidence that anticompetitive effects are probable,” the ALJ took full advantage of the chance for a rare glimpse into actual effects of a merger on competition and considered several varieties of “contemporaneous and post-acquisition” evidence.<sup>138</sup>

Both parties presented post-merger evidence, but the ALJ found the government’s to be more credible.<sup>139</sup> After reviewing all the post-merger evidence, the ALJ found that 1) ENH charged higher prices post-merger; 2) ENH’s prices rose faster than other comparable hospitals; and 3) the price increases could not be explained by factors other than the merger.<sup>140</sup> Therefore, the ALJ concluded that “the relative price increases were the result of ENH’s enhanced market power, achieved through elimination of a competitor as a consequence of the merger.”<sup>141</sup>

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<sup>134</sup> Horizontal Merger Guidelines, *supra* note 10, § 1.51, at 20,573-5.

<sup>135</sup> *Evanston* Initial Decision, F.T.C. No. 9315 at 151 (Oct. 20, 2005), available at <http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf>.

<sup>136</sup> *Id.*

<sup>137</sup> *Id.*

<sup>138</sup> *Id.* at 153.

<sup>139</sup> *Id.* at 154. The government’s expert relied on four different data sources while ENH’s looked only at data provided by MCOs. *Id.*

<sup>140</sup> *Id.* at 155.

<sup>141</sup> *Id.*

The evidence considered included ENH and Highland Park's internal pre- and post-merger documents and testimony from MCO representatives.<sup>142</sup> Significantly, the hospitals' own documents admitted that two primary motivations for the merger were to eliminate a competitor and to increase clout in negotiations with MCOs.<sup>143</sup> Post-merger documents confirmed that the hoped-for price increases had been achieved, lauding these increases as a significant accomplishment related to the merger.<sup>144</sup> Additionally, several MCO's verified the post-merger price increases and discussed their perceived loss of negotiating power when facing the post-merger ENH.<sup>145</sup>

### 3. Empirical Studies

Although it was clearly established and undisputed that ENH raised prices after the merger, ENH's behavior was only illegal if it was a direct result of its increased market power.<sup>146</sup> If higher prices can be attributed to another cause such as some overall marketplace change, then the price increases cannot be considered an anticompetitive effect of the merger. An empirical study conducted by the government showed that ENH's prices rose more than prices at other hospitals in three separate control groups.<sup>147</sup> The government also ran regressions controlling for ENH's post-merger changes in customer mix, patient mix, and teaching intensity to see if any of those factors explained the price increase and found that they did not.<sup>148</sup> Thus, the study concluded that the price increases could be directly attributed to ENH's improved market position and not "to changes in the marketplace that would affect all hospitals equally."<sup>149</sup> It appears that as a result of the merger, ENH was able to raise prices at a rate of eleven to eighteen percent higher than other hospitals.<sup>150</sup> ENH's own expert's calculations were not far off, estimating ENH's post-merger price increases to be approximately nine percent higher than other

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<sup>142</sup> *Id.* at 153.

<sup>143</sup> *Id.* at 156. The ALJ acknowledged, however, that there were other incentives for the merger cited by the hospitals. *Id.* at 155.

<sup>144</sup> *Id.* at 164. Through various methods, ENH realized as much as an eighteen million dollar increase in annualized economic value. *Id.* at 158.

<sup>145</sup> *Id.* at 160-64.

<sup>146</sup> *See id.* at 169.

<sup>147</sup> *Id.* at 166-68. Although ENH did not increase prices for Blue Cross Blue Shield, the ALJ did not find this Blue Cross anomaly a sufficient inconsistency to disregard the overall findings of the study. *Id.* at 168. Blue Cross is the largest MCO in Chicago, so it is not surprising that it was able to effectively bargain with ENH. That does not make it any less relevant that other MCOs could not. *Id.* at 167-68.

<sup>148</sup> *Id.* at 168.

<sup>149</sup> *Id.* at 166-67.

<sup>150</sup> *Id.* at 168.

hospitals.<sup>151</sup> After examining the available empirical data, the ALJ concluded that “enhanced market power is the only plausible, economically sound, and factually well-founded explanation for ENH’s post-merger relative price increases.”<sup>152</sup>

#### D. *Defenses*

The ALJ ruled that the government proved its prima facie case that the ENH/Highland Park merger led to Clayton Act violations and then gave ENH an opportunity to rebut the presumption.<sup>153</sup> To rebut this presumption, ENH presented procompetitive justifications, arguing that the benefits of the merger outweighed any potential anticompetitive effects,<sup>154</sup> but the ALJ rejected them all.<sup>155</sup>

##### 1. Learning About Demand

ENH contended that some price increases were the result of learning, by reviewing Highland Park’s billing practices, that pre-merger ENH was billing at a below-market rate for some services.<sup>156</sup> In light of this new information, they argued, ENH merely raised its prices to bring them in line with what it now knew the market would bear.<sup>157</sup> A review of the evidence left the ALJ unconvinced, finding that the foundations for the theory were unsupported, that contemporaneous actions by ENH were inconsistent with the theory, and that there was empirical evidence refuting the theory.<sup>158</sup>

##### 2. Quality Improvements

While not denying that prices increased after the acquisition, ENH argued that the higher prices charged to MCOs post-merger were reasonable in light of quality care improvements at Highland Park.<sup>159</sup> ENH presented this argument as a procompetitive justification rather than an efficiencies defense, but the ALJ retained some elements of the analysis used to evaluate a traditional efficiencies defense.<sup>160</sup> Therefore, the ALJ determined, the improvements had

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<sup>151</sup> *Id.* Because ENH’s calculations were done with pricing data from only four MCOs, the ALJ chose to accept the government’s estimates. *Id.*

<sup>152</sup> *Id.* at 169.

<sup>153</sup> *Id.* at 169-70.

<sup>154</sup> *Id.* at 169-97.

<sup>155</sup> *Id.* at 197.

<sup>156</sup> *Id.* at 170.

<sup>157</sup> *Id.*

<sup>158</sup> *Id.* at 170-72 (finding that the price increases were a result of “newly created market conditions” effectuated by the merger and not ENH’s discovery of new information).

<sup>159</sup> *Id.* at 175.

<sup>160</sup> *Id.*

to be both verifiable and merger-specific.<sup>161</sup> In support of its contention, ENH pointed to a litany of post-merger improvements including the building of a new ambulatory care center and other physical renovations, the installation of a full-time OB/GYN chairperson and other personnel changes, the establishment of a quality improvement program that identified and implemented best practices in all areas of patient care, and the implementation of an electronic medical records system.<sup>162</sup> The ALJ rejected all of ENH's quality improvement assertions, concluding that many of the alleged improvements had little factual support, others were not merger-specific, and those that could be identified as merger-specific were not significant enough to outweigh the anticompetitive effects of the merger.<sup>163</sup>

### 3. Nonprofit Status

The ALJ quickly dispensed with ENH's argument that its nonprofit status lowered the probability of anticompetitive effects.<sup>164</sup> Although some courts have considered nonprofit status in evaluating whether a hospital will raise prices to anticompetitive levels after a merger, all were pre-merger cases in which the court had to "speculate about the potential effects of a proposed merger."<sup>165</sup> The ALJ found that the relevance of those cases was limited when evaluating a consummated merger in which "there is substantial evidence of actual price increases post-merger."<sup>166</sup>

### 4. Entry

Ease of entry is not often cited in hospital merger cases because building a new hospital is a long, highly-regulated process.<sup>167</sup> Indeed, Illinois's Certificate of Need law requires approval for all new acute hospital inpatient services.<sup>168</sup> For this reason, ENH's argument did not focus on the ease of entry of new hospitals, but rather on the ease of existing hospitals' ability to

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<sup>161</sup> *Id.* at 182. Interestingly, it should be noted that the ALJ was hesitant to address the quality improvement argument because "[t]he precise role of quality of care in the antitrust context has yet to be determined." *Id.* at 175.

<sup>162</sup> *Id.* at 183-91.

<sup>163</sup> *Id.* at 183, 191-92. Under the Merger Guidelines, any efficiencies have to be verifiable and merger-specific. See Horizontal Merger Guidelines, *supra* note 10, § 4, at 20,573-13.

<sup>164</sup> Evanston Initial Decision, F.T.C. No. 9315 at 192-94.

<sup>165</sup> *Id.* at 193.

<sup>166</sup> *Id.* (emphasis added).

<sup>167</sup> See *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 986 (N.D. Iowa 1995) ("Most hospital cases have stated the inability to build new hospitals as a strong barrier to entry."), *quoted in* Evanston Initial Decision, F.T.C. No. 9315 at 194; *supra* Part II.C.1 (discussing how ease of entry can rebut the presumption of anticompetitive effects).

<sup>168</sup> Evanston Initial Decision, F.T.C. No. 9315 at 194 (Oct. 20, 2005).

reposition by expanding their services and/or capacity.<sup>169</sup> The ALJ found no evidence that this was true, and further found that any change in other hospitals' functions would not have had an effect on ENH's ability to raise prices above competitive levels.<sup>170</sup>

#### 5. Failing Firm

ENH's final defense was that Highland Park was in a dire financial condition before the merger.<sup>171</sup> The government contended that Highland Park's financial situation was not so serious, but that even if it was, the hospital had other available remedies that would not raise antitrust concerns.<sup>172</sup> Finding that Highland Park's pre-merger financial situation was "essentially sound," the ALJ sided with the government and rejected the defense.<sup>173</sup>

### IV. THE ROLE OF MANAGED CARE AND TWO-STAGE COMPETITION IN HOSPITAL MERGER ANTITRUST ANALYSIS

There has long been a debate over whether nonprofit hospitals will take advantage of market power by raising prices.<sup>174</sup> Several courts have emphasized a hospital's nonprofit status in holding that a proposed merger would not lead to anticompetitive effects,<sup>175</sup> and many commentators have criticized such rulings.<sup>176</sup> In light of the finding in *Evanston* that the merged hospitals did in fact exploit their newly achieved market positions despite their nonprofit statuses, this argument should be put to rest.<sup>177</sup> That is not to say that all nonprofit hospitals that merge will achieve sufficient market power to enable the new entity to raise prices above competitive levels, or that every

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<sup>169</sup> *Id.* at 194.

<sup>170</sup> *Id.* at 195.

<sup>171</sup> *Id.*

<sup>172</sup> *Id.*

<sup>173</sup> *Id.* at 196. For a discussion of the "failing firm" defense, see *supra* Part II.C.3.

<sup>174</sup> For a discussion of both sides of the debate, see generally Thomas L. Greaney, *Antitrust and Hospital Mergers: Does the Nonprofit Form Affect Competitive Substance?*, 31 J. HEALTH POL. POL'Y & L. 511 (2006).

<sup>175</sup> See *id.* at 517-18 (citing *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121 (E.D.N.Y. 1997); *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996); *United States v. Carilion Health Sys.*, 707 F. Supp. 840 (W.D. Va. 1989)).

<sup>176</sup> See, e.g., Martin Gaynor, *Why Don't Courts Treat Hospitals Like Tanks for Liquefied Gases? Some Reflections on Health Care Antitrust Enforcement*, 31 J. HEALTH POL. POL'Y & L. 497, 504 (2006) (arguing that nonprofits have a "direct incentive to exploit market power" and that most research indicates that nonprofits do in fact exploit market power); Hammer & Sage, *supra* note 35, at 615.

<sup>177</sup> See Jeff Miles & Ober Kaler, *Observations and Lessons from the FTC's Evanston Northwestern Healthcare Hospital-Merger Decision*, 20 HEALTH LAW. 24, 29 (2007) ("The 'nonprofit-status' defense is a non-starter.").

newly merged facility will exploit its new market power.<sup>178</sup> Rather, courts have to evaluate each proposed merger on a case-by-case basis because “[t]hough certainly it appears true that nonprofit hospitals *may* exercise market power when they acquire it, there is sufficient uncertainty about the conditions under which – and the extent to which – individual hospitals would do so.”<sup>179</sup> The challenge then, is to develop a method for teasing out which hospital mergers, regardless of nonprofit status, will have anticompetitive effects. The *Evanston* decision’s “more nuanced investigation into the issue” provides some insight into how hospital merger antitrust analysis can effectively do so in the future.<sup>180</sup>

One important aspect of the *Evanston* case is the ALJ’s understanding of the role managed care plays in hospital competition.<sup>181</sup> Conversely, a review of the government’s string of pre-*Evanston* losses reveals a “confusion [on the part of courts] over the implications of the interplay of managed care organizations (MCOs), employers, and insured persons in selecting hospitals.”<sup>182</sup> When faced with a hospital merger challenge, courts consistently “fail[] to incorporate the subtleties of agency relationships in the purchasing of hospital services.”<sup>183</sup> Very few patients directly pay for their own care, yet only a small number of courts have explicitly accepted that MCOs are the “true consumer[s] of . . . inpatient services.”<sup>184</sup> The failure of courts to give much credence to MCO testimony reflects their misunderstanding of how competition is structured in the health care sector.

Hospital competition takes place in two stages: first-stage competition refers to hospitals competing to be included in an MCO’s network, while second-stage competition refers to hospitals competing to attract individual patients.<sup>185</sup> At the first stage, health plans are the consumers, while at the second stage, patients are the consumers.<sup>186</sup> In antitrust litigation, the government has tended to focus on first-stage competition while defendant hospitals have based their

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<sup>178</sup> See Greaney, *supra* note 174, at 524.

<sup>179</sup> *Id.*

<sup>180</sup> *Id.* at 525.

<sup>181</sup> *Evanston* Initial Decision, F.T.C. No. 9315 at 17 (Oct. 20, 2005), available at <http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf> (“The ‘customer’ in the sale of inpatient hospital services is the managed care organization.”).

<sup>182</sup> Greaney, *supra* note 42, at 187.

<sup>183</sup> Thomas L. Greaney, *Chicago’s Procrustean Bed: Applying Antitrust Law in Health Care*, 71 ANTITRUST L.J. 857, 877 (2004).

<sup>184</sup> *California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1078 (N.D. Cal. 2000) (citing *FTC v. Universal Health, Inc.*, 938 F.2d 1206, 1213 n.13 (11th Cir. 1991)); accord *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 134 (E.D.N.Y. 1997) (recognizing MCOs as one of five distinct groups of relevant consumers).

<sup>185</sup> Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L.J. 671, 672 (2000).

<sup>186</sup> *Id.*

arguments on second-stage competition.<sup>187</sup> This has led to a disconnect in how the two parties argue their positions, and the courts have not clarified which stage should be the focus. Courts generally have not differentiated between the two phases of competition, and thus have consistently failed to explain the grounds for their findings regarding the potential anticompetitive effects of hospital mergers.<sup>188</sup>

In contrast, the ALJ in *Evanston* explicitly differentiated between the two stages of competition, identifying the “relationship between hospital[] and managed care organizations” as “first stage competition” and the “relationship between patients and hospitals” as “second stage competition.”<sup>189</sup> Importantly, the ALJ recognized that competition at the second stage is not based on price because prices are set at the first stage when hospitals contract with MCOs.<sup>190</sup> Thus, hospitals compete to attract patients through other nonprice factors. Because the underlying question in any antitrust merger analysis is whether the merged entity will be able to exploit market power to raise prices above the competitive level, the ALJ rightly determined that the “critical concern” was the merger’s effects on first stage competition.<sup>191</sup>

The problem with ignoring the complexity of hospital competition is that antitrust analysis differs depending on which stage of competition the analysis is based.<sup>192</sup> For example, “both product and geographic markets may differ between the first and second stages of competition . . . , and the effect of a hospital merger, may differ across the two stages.”<sup>193</sup> Clearly, which stage is used can greatly affect the outcome. A reduction in competition at one stage does not necessarily imply a reduction at the other.<sup>194</sup> Going forward, courts should clearly explain who the relevant consumer is and at which stage potential anticompetitive effects are being evaluated.<sup>195</sup>

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<sup>187</sup> *See id.*

<sup>188</sup> Greaney, *supra* note 42, at 187.

<sup>189</sup> *Evanston* Initial Decision, F.T.C. No. 9315 at 16, 18 (Oct. 20, 2005), available at <http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf> (internal quotation marks omitted).

<sup>190</sup> *See id.* at 18 (“Hospitals compete, although not on price, to attract patients who are covered by the [MCOs] with which the hospital has contracts.”).

<sup>191</sup> *Id.* at 136.

<sup>192</sup> Vistnes, *supra* note 185, at 672.

<sup>193</sup> *Id.*

<sup>194</sup> *Id.*

<sup>195</sup> *See* William M. Sage & Peter J. Hammer, *Competing on Quality of Care: The Need to Develop a Competition Policy for Health Care Markets*, 32 U. MICH. J.L. REFORM 1069, 1093 (1999) (discussing the problems caused by the courts’ failure to clearly identify the relevant consumer in hospital-merger antitrust cases).



A considered evaluation of the phases of competition in the health sector reveals that the first stage should be the focus for antitrust purposes.<sup>196</sup> Thus, “the appropriate empirical tests would assess the combination of market power and health insurance.”<sup>197</sup> In the absence of, or in addition to, such empirical tests, testimony from MCO representatives and other market players can provide important additional insights into the strength and dynamics of competition at the first stage.<sup>198</sup> Particularly when determining the relevant markets for antitrust purposes, “the opinions of knowledgeable market participants . . . can supply a workable gauge of future demand responses necessary to delineate antitrust markets.”<sup>199</sup> Rather than “inexplicably reject[ing] such testimony,” courts assessing the impact of a hospital merger in the future should follow the *Evanston* example and allow MCO testimony to play an integral role in determining the relevant antitrust markets, and ultimately in evaluating the potential anticompetitive effects of the proposed merger.<sup>200</sup>

With few exceptions,<sup>201</sup> courts prior to *Evanston* did not give much thought to the role third-party payors play in hospital competition and thus little weight or credence was given to MCO testimony. Occasionally the government was allowed to present such evidence, but this information rarely played a central role in the final disposition of the case. Further, when such evidence was considered, it was often in the context of evaluating the effect of the merger on second-stage competition. As discussed above, evaluating the effects of a merger on second-stage competition is not the appropriate measure of whether a merger will have anticompetitive effects, and thus the acceptance of MCO testimony in these cases does not truly address the disconnect between courts' perception of competition in the hospital industry and the reality.

In contrast, the opinions of MCO representatives are pervasive throughout the *Evanston* decision and are explicitly considered in order to evaluate the effects of the merger on first-stage competition.<sup>202</sup> Importantly, these voices

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<sup>196</sup> See Vistnes, *supra* note 185, at 672 (“[E]ven if a merger has little effect on second-stage competition, a reduction in first-stage competition is sufficient to conclude a hospital merger is anticompetitive.”).

<sup>197</sup> Barak D. Richman, *The Corrosive Combination of Nonprofit Monopolies and U.S.-Style Health Insurance: Implications for Antitrust and Merger Policy*, 69 LAW & CONTEMP. PROBS. 139, 152-53 (2006).

<sup>198</sup> See Vistnes, *supra* note 54, at 30.

<sup>199</sup> Greaney, *supra* note 42, at 194.

<sup>200</sup> See *id.*

<sup>201</sup> See, e.g., *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 144 (E.D.N.Y. 1997) (considering the testimony of a representative from one MCO who thought the merger was a “good idea”); *In re Adventist Health Sys./W.*, 117 F.T.C. 224, 310 (1994) (crediting testimony that post-merger, the health plans were still able to “negotiate[] favorable rates”).

<sup>202</sup> *Evanston* Initial Decision, F.T.C. No. 9315 at 136 (Oct. 20, 2005), available at <http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf>.

are found at all steps of the merger analysis as outlined in the Merger Guidelines. The ALJ relied heavily on the testimony of market players, for example, in defining both the product and geographic markets and evaluating the anticompetitive effects. In a pre-merger challenge, this testimony becomes even more vital because the inquiry is “necessarily forward-looking, predictive, and hypothetical.”<sup>203</sup> Going forward, courts must address the role that managed care plays in hospital competition. In order to do so, market participant testimony should play a central role in hospital merger antitrust jurisprudence, particularly at the market definition and anticompetitive effects steps of the analysis.

A. *Product Market Definition*

The role of MCOs can come into play in two distinct ways when defining the product market. As in *Evanston*, the product market definition can be framed in a way specifically designating managed care organizations as the relevant consumers. Additionally, courts can use the testimony of MCOs and other market participants such as the hospitals themselves to narrow the product market. Doing so recognizes the heterogeneity of hospital care by qualifying the acute inpatient care product market as care provided only by anchor hospitals or some other subset of hospitals, rather than care provided by all hospitals.

1. The Product Market in *Evanston* – General Acute Inpatient Care Services Sold to Managed Care Organizations

The opposing parties in a hospital merger challenge rarely dispute the product market definition.<sup>204</sup> But redefining the product market is an important first step in redirecting courts’ attention to first-stage competition and acknowledging the role third-party payors play in hospital competition. By narrowing the product market definition to general acute inpatient care services *sold to managed care organizations*, the ALJ in *Evanston* implicitly recognized that the first stage of competition is the relevant one when evaluating the potential adverse competitive effects of a hospital merger.<sup>205</sup> Defining the product market in this manner is a small but important step courts can take to show their understanding that MCOs are the relevant consumers in hospital merger antitrust analyses.

2. Anchor Hospital Theory Revisited

The anchor hospital theory, championed by the government in *Long Island Jewish Medical Center* but ultimately rejected by the court, deserves a second look after *Evanston*. Although the ALJ did not explicitly accept the anchor

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<sup>203</sup> Greaney, *supra* note 183, at 878.

<sup>204</sup> See *supra*, Part II.A.1.

<sup>205</sup> See *Evanston* Initial Decision, F.T.C. No. 9315 at 27.

hospital theory, the *Evanston* decision reopens the door by recognizing that hospitals are not homogeneous.<sup>206</sup> “The hospital industry is composed of a diverse group of facilities” including research-oriented hospitals affiliated with universities, hospitals run by religious groups who emphasize charitable care, and specialty hospitals.<sup>207</sup> In general, courts ignore the differentiated nature of the industry and oversimplify the product market definition to the detriment of a proper antitrust analysis.<sup>208</sup> Reconsideration of the anchor hospital theory would be a step in the right direction.

Anchor hospitals are those that provide such high-quality care and have such superior reputations that MCO subscribers will always demand access to at least one of these facilities.<sup>209</sup> When courts properly define the consumers, for antitrust purposes, as MCOs, the anchor hospital theory begins to make sense. The product provided by certain hospitals is so unique that “no health plan will be successful if it fails to offer access” to at least one.<sup>210</sup>

Understanding these nuances, the government in *Long Island Jewish Medical Center* attempted to define the product market as “acute inpatient services provided by anchor hospitals to managed care plans.”<sup>211</sup> To prove its case, the government presented numerous witnesses who testified as to the “must have” quality of the two merging facilities.<sup>212</sup> The witnesses, representatives of health insurers and other third-party payors, were nearly unanimous in their belief that excluding both NSM and LIJ (the merging hospitals) from a health plan’s network would preclude a plan from being able to attract customers.<sup>213</sup> The overwhelming evidence was that no hospital in the area could match the two merging hospitals’ reputations.<sup>214</sup> As such, if the two hospitals merged they would face no competition to be included in an MCO’s network because a plan needed to include at least one of them in order to survive.<sup>215</sup>

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<sup>206</sup> See *id.* at 143 (recognizing the difference between hospitals in defining the geographic market).

<sup>207</sup> Conners, *supra* note 43, at 563.

<sup>208</sup> *Id.*

<sup>209</sup> Greaney, *supra* note 183, at 880.

<sup>210</sup> Conners, *supra* note 43, at 570.

<sup>211</sup> *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 137 (E.D.N.Y. 1997) (defining anchor hospitals as those with “prestigious reputations, broad ranging and highly sophisticated services, and high quality medical staffs” (citation omitted)).

<sup>212</sup> *Id.* at 130-33.

<sup>213</sup> *Id.* at 130 (quoting witnesses making statements such as “[I] could not conceive [an] . . . arrangement without those two hospitals” and that it was impossible to “build a marketable network on Long Island” without the merging hospitals (citations omitted) (alterations in original)).

<sup>214</sup> *Id.*

<sup>215</sup> See *id.*

Despite the evidence, the court refused to accept the “anchor hospital” qualification and retained the traditional broad product market definition.<sup>216</sup> In doing so, the court held that the government had not proved that the care provided by these hospitals was in fact unique.<sup>217</sup> However, this finding does not directly address the real issue: that MCOs believed that the merging hospitals’ reputations made them “indispensable” in creating a viable network of hospitals necessary to attract subscribers to their health plans.<sup>218</sup> Further, “[t]he court’s refusal to credit testimony of market participants . . . is particularly striking because of the absence of conventional evidentiary findings to discredit or rebut such proofs.”<sup>219</sup> Accepting *arguendo* that first-stage competition is what is relevant, MCOs are a good source of information when trying to determine whether a merger will lessen competition between hospitals competing to be included in an MCO’s network.

Further, establishing the product market as a subset of a larger market is nothing new.<sup>220</sup> For example, in *FTC v. Staples*, the court limited the product market to office supplies sold at “office supply superstores” in spite of the “functional interchangeability” of office supplies.<sup>221</sup> The court found that although identical office supplies were sold at many different types of retail outlets such as Wal-Mart and wholesale clubs, Staples customers would only go to other “office superstores” in response to an increase in Staples’s prices.<sup>222</sup> Likewise, all hospitals may provide nearly identical care, but if an MCO is not willing to drop certain hospitals from its network due to some distinguishing characteristic, such as reputation, those facilities should be considered in their own product market. In light of the *Staples* ruling, several commentators have found the *Long Island* result surprising.<sup>223</sup>

Also of note, the *Staples* court gave considerable weight to the views of market participants regarding the relevant product market.<sup>224</sup> The court credited the testimony of other sellers of office supplies, including representatives from Wal-Mart and BJ’s, a wholesale club, as well as internal

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<sup>216</sup> *Id.* at 140.

<sup>217</sup> *See id.*

<sup>218</sup> Greaney, *supra* note 183, at 881.

<sup>219</sup> *Id.* at 881-82.

<sup>220</sup> *See, e.g.,* *FTC v. Staples*, 970 F. Supp. 1066, 1075 (D.D.C. 1997) (recognizing that just because two firms are competitors in the general sense of the term, they are not necessarily competitors for antitrust purposes).

<sup>221</sup> *Id.* at 1074. Functional interchangeability is defined as “[w]hether there are other products available to consumers which are similar in character or use to the products in question.” *Id.*

<sup>222</sup> *Id.* at 1077.

<sup>223</sup> *See, e.g.,* Monica Noether, *Overview: Economic Issues in Hospital Merger Policy*, ANTITRUST, Spring 1999, at 6, 9 n.4; William H. Rooney, *Consumer Injury in Antitrust Litigation: Necessary, but by What Standard?*, 75 ST. JOHN’S L. REV. 561, 582 (2001).

<sup>224</sup> *Staples*, 970 F. Supp. at 1077.

documents from the office superstores.<sup>225</sup> The testimony from other office supply retailers showed that they did not consider themselves in competition with office superstores, while evidence from the three office superstores showed that each only considered the other two superstores to be direct competitors.<sup>226</sup> On balance, the court found this evidence persuasive enough to determine that the relevant product market was actually a submarket, and thus focused its analysis directly on products sold at office supply superstores. Courts evaluating hospital mergers should accept a similar analysis and should consider whether perhaps the proper market is actually a subset of acute care provided by all hospitals. In doing so, market participant views, including testimony from MCO representatives and internal hospital documents, can provide a solid ground from which courts can make a proper and complete product market definition determination.

#### B. *Geographic Market Definition*

The ALJ took the most remarkable departure from traditional hospital merger analysis when defining the geographic market in *Evanston*. By rejecting patient flow data as a basis for defining the geographic market and instead allowing MCO testimony to play a central role in the process, the ALJ was able to more accurately define the geographic market in a way that accounted for the complex relationship between hospitals, patients, and third-party payors.

Defining the relevant geographic market is almost always a contentious issue in hospital merger antitrust litigation and often the deciding factor.<sup>227</sup> Unfortunately, the basis for the chosen geographic market is often unsound, and thus courts' methods for defining hospital geographic markets have been heavily criticized.<sup>228</sup> One underlying theme in these critiques is the courts' tendency to "overlook the confounding role of imperfect agency relationships in purchasing decisions" and, as a result, to rely too heavily on patient flow data.<sup>229</sup> Also, because "simple patient flow calculations . . . fail to distinguish between [the two stages of competition]," patient flow data is a flawed method for determining the proper geographic market definition.<sup>230</sup>

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<sup>225</sup> *Id.*

<sup>226</sup> *Id.*

<sup>227</sup> See Vistnes, *supra* note 54, at 28.

<sup>228</sup> For an overview of the various criticisms of courts' methods of defining hospital geographic markets, see Greaney, *supra* note 183, at 869-79.

<sup>229</sup> See *id.* at 869. But see, e.g., *In re Adventist Health Sys./W.*, 117 F.T.C. 224, 290 (1994) ("The likely response of health insurance plans and their patients to a price increase is important in evaluating the bounds of the geographic market.").

<sup>230</sup> See Greaney, *supra* note 183, at 877.

Under the Merger Guidelines, the way to determine market definition is to evaluate the effect of an SSNIP.<sup>231</sup> Assuming a narrow product market where MCOs are the purchasers, the question is what effect an SSNIP would have on insurers, not on individual patients.<sup>232</sup> The relevant question is: If a hospital raises charges to an insurer, can an MCO effectively steer enough of its members away from the high-cost facility?<sup>233</sup> Patient flow data cannot possibly provide a satisfactory answer.

While patient flow data can be useful in determining whether a plan would be able to implement a diversionary strategy without surrendering subscribers, it does not give a full picture of how an MCO would react to an SSNIP because it “inappropriately focuses on patients, not the immediate purchaser.”<sup>234</sup> Further, formalistic evaluations such as the Elzinga-Hogarty test are not able to account for how patients choose a health plan. A patient does not know the full range of health care services she might require while covered by an insurance plan, and because of this uncertainty she may, at the time of insurance selection, want more hospitals to be included in the plan’s network than she will ever realistically require.<sup>235</sup> Finally, in the absence of a very specific product market such as care provided by anchor hospitals, patient flow data inappropriately focuses on where patients live to the exclusion of other, non-geographic reasons patients choose a hospital.<sup>236</sup>

By narrowing the product market to care sold to MCOs, *Evanston* set the foundation for rejecting the traditional geographic market definition analysis that focused on second-stage competition.<sup>237</sup> Indeed, the ALJ explicitly rejects patient flow data because it is “relevant to second stage competition for patients, but provides no useful information about first stage competition for managed care contracts.”<sup>238</sup> This is perhaps the most radical position in the entire decision. As one commentator explains, the “lack of emphasis on patient-flow data in delineating relevant geographic markets may be the most important facet of the [*Evanston*] opinion, because of the emphasis federal courts have placed on patient-flow data for delineating relevant geographic

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<sup>231</sup> Horizontal Merger Guidelines, *supra* note 10, § 1.11, at 20,572-73; *see also supra* Part II.A.

<sup>232</sup> *See Vistnes, supra* note 54, at 28.

<sup>233</sup> *Id.*

<sup>234</sup> *Id.* at 31-32 (“Whether or not a plan actually adopts a particular patient diversion strategy depends on how that strategy would be received by the employers to whom the plans must market themselves.”).

<sup>235</sup> *Id.* at 32-33 (criticizing patient flow analysis in determining geographic markets for hospitals because patient flow focuses on ex post hospital decision while ignoring ex ante concerns).

<sup>236</sup> *Id.* at 33.

<sup>237</sup> Michael R. Bissegger, *The Evanston Initial Decision: Is There a Future for Patient Flow Analysis?*, 39 J. HEALTH L. 143, 147 (2006).

<sup>238</sup> *Evanston Initial Decision*, F.T.C. No. 9315 at 139 (Oct. 20, 2005), *available at* <http://www.ftc.gov/os/adjpro/d9315/051021idtextversion.pdf>.

markets in previous healthcare antitrust cases.”<sup>239</sup> This begs the question: If not through patient flow data, how will courts determine the relevant geographic market in the future?<sup>240</sup>

The *Evanston* decision may provide a glimpse into the future of geographic market definition. In *Evanston*, the ALJ relied on “market participant views, geographic proximity, travel times, and physician admitting patterns” in defining the relevant geographic market.<sup>241</sup> Although not dispositive, market participant views and particularly MCO testimony played a prominent role.<sup>242</sup> The ultimate seven-hospital market was developed because “market participants’ views . . . clearly demonstrate[d] that managed care organizations cannot develop a viable managed care plan in this market without” those particular facilities.<sup>243</sup>

The ALJ’s openness to accepting the opinions of MCOs as at least a partial basis for determining the geographic market is particularly remarkable given that past courts gave little weight to such evidence.<sup>244</sup> Hopefully courts going forward will see the error of their past ways and, following *Evanston*, consider the testimony of market participants. As one commentator has observed:

[T]he rejection of market participant testimony is particularly problematic given the nature of the geographic inquiry in a merger case. The question at hand . . . is necessarily forward-looking, predictive, and hypothetical. It is difficult to imagine a setting in which participants’ opinion and statements of intention of future conduct would be of more probative value.<sup>245</sup>

### C. Anticompetitive Effects

The use of MCO testimony in evaluating the potential anticompetitive effects of a hospital merger is not a new concept, although before *Evanston* it had fallen out of favor.<sup>246</sup> In an early case that came before the FTC, an ALJ recognized the role MCOs play in hospital competition and specifically chose to address it in the adverse competitive effects stage of the analysis.<sup>247</sup> In *In re Adventist Health System/West*, the ALJ observed that because the merged

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<sup>239</sup> Miles & Kaler, *supra* note 177, at 28.

<sup>240</sup> *Id.*

<sup>241</sup> *Evanston* Initial Decision, F.T.C. No. 9315 at 140.

<sup>242</sup> *Id.*

<sup>243</sup> *Id.* at 142.

<sup>244</sup> See, e.g., *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir. 1999); *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1127 (N.D. Cal 2001).

<sup>245</sup> Greaney, *supra* note 183, at 878.

<sup>246</sup> *But see* *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 144 (E.D.N.Y. 1997) (crediting the testimony of an MCO representative who stated his belief that the merger was a “good idea” and prices charged to MCOs would actually decrease as a result of the merger).

<sup>247</sup> *In re Adventist Health Sys./W.*, 117 F.T.C. 224, 281 (1994).

hospitals “would face considerable opposition from third-party payors if [they] attempted to gouge their subscribers,” anticompetitive effects resulting from the merger were unlikely.<sup>248</sup> A concurring opinion also discussed the role of MCOs under the “Competitive Effects” step of the analysis, though in a slightly different fashion.<sup>249</sup> It found persuasive the fact that no third-party payors had objected to the merger.<sup>250</sup> The concurring commissioners gave this evidence significant weight because “[t]hird-party payors are most knowledgeable about market conditions.”<sup>251</sup> Although in general courts have been dismissive of MCO testimony, a few did follow the FTC’s lead by noting the absence of MCO testimony, finding no likely anticompetitive effects in part because no third-party payors objected to the pending transaction.<sup>252</sup>

MCO testimony played the biggest role in the *Evanston* decision when the ALJ evaluated the direct competitive effects of the merger.<sup>253</sup> Specifically, health plan representatives testified that there were in fact price increases post-merger and also testified as to their perceived inability to bargain with the merged hospitals. Post-merger, an MCO faced with rate increases was forced to grapple with a difficult decision: either include both merged hospitals and accept their rate hikes or drop both from its network. Because at least one of the hospitals was needed in order to create a viable network, the MCOs could not credibly threaten to drop the hospitals from their networks, putting them in a severely diminished bargaining position.<sup>254</sup> Without a credible threat, MCOs were at the mercy of the hospitals, forced to accept whatever rates the hospitals proposed.

Of course, the *Evanston* case is unique in that it was a post-merger challenge, and as such, the MCOs could testify about the actual anticompetitive effects they had already experienced. But market participants’ views can be just as useful in evaluating potential adverse competitive effects in a prospective challenge to a hospital merger. In order to keep the focus on the first stage of competition, MCO testimony must play into what is already a speculative analysis. MCO representatives should be able to express their opinion as to whether a hospital would be able to raise prices above

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<sup>248</sup> *Id.*

<sup>249</sup> *Id.* at 308.

<sup>250</sup> *Id.*

<sup>251</sup> *Id.* at 311. Further, because this was a retrospective challenge there was testimony from the insurers that even post-merger they were able to “negotiat[e] favorable rates.” *Id.* at 310.

<sup>252</sup> *FTC v. Freeman Hosp.*, 911 F. Supp. 1213, 1227 (W.D. Mo. 1995); *see also California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1079 n.8, 1085 (N.D. Cal. 2000) (noting that not all MCO representatives who testified were opposed to the merger and denying the government’s preliminary injunction request).

<sup>253</sup> *See supra* Part II.C.2 (discussing MCO testimony on the merger’s effect on prices). Because the *Evanston* case was post-merger, direct competitive effects were observable.

<sup>254</sup> *See Vistnes, supra* note 185, at 677-78.



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competitive levels post-merger, and courts would be wise to at least consider the testimony. Conversely, courts can use the absence of objections from MCOs as a signal that a merger is unlikely to have anticompetitive effects at the first stage of competition.

Inevitably, courts will question the reliability and credibility of market participants' opinions. After all, the outcome of a hospital merger case will likely directly affect an MCO's ability to do business, instilling in the witness a natural bias. But it is precisely the close relationship between the witness and the subject matter of the case that makes them uniquely qualified to provide useful insight. Furthermore, credibility concerns may be overblown.<sup>255</sup> Thus, MCO testimony is vital to refocusing hospital merger analyses on the first stage of competition, and courts must develop methods to elicit credible information from market participant witnesses.<sup>256</sup>

#### CONCLUSION

The *Evanston* case was unique in many ways. Due to its retrospective nature, directly observable adverse consequences on competition were available as evidence, whereas in a prospective challenge, parties can only speculate about such effects. But the focus on first-stage competition is a change that can and should be used by the Agencies and courts in their future antitrust analyses of hospital mergers. Ignoring the role that managed care plays in hospital competition leads to an incomplete evaluation of the potential anticompetitive effects caused by a hospital merger.

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<sup>255</sup> For a discussion of the reliability of market participants' testimony, see Greaney, *supra* note 183, at 878.

<sup>256</sup> *See id.* at 879. For example, courts could rely on cross-examination as a way of impeaching a biased witness. *Id.*