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MEMBER BRIEFING

HOSPITALS AND HEALTH SYSTEMS PRACTICE GROUP

THE FTC'S ROUND ONE VICTORY IN ITS CHALLENGE TO THE EVANSTON NORTHWESTERN HOSPITAL MERGER: WHAT DID THE ALJ FIND, AND WHAT ARE THE IMPLICATIONS?

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I. INTRODUCTION AND OVERVIEW

Antitrust scrutiny of hospital mergers returned to center stage last month when the Federal Trade Commission (FTC) won the first round in a challenge to the merger of three hospitals in the northern Chicago area. In a decision dated October 20, 2005, FTC Administrative Law Judge (ALJ) Stephen J. McGuire concluded that the January 2000 merger of Evanston Hospital (Evanston) and Glenbrook Hospital with Highland Park Hospital (Highland) to form Evanston Northwestern Healthcare Corporation (ENH) violated § 7 of the Clayton Act.[1] In particular, he found that the probable effect of the merger was to lessen competition in the market of "general acute inpatient services sold to managed care organizations" in a relevant geographic market encompassing the three merging hospitals, as well as four additional nearby hospitals. To remedy this

violation, ALJ McGuire ordered ENH to divest itself fully of Highland within 180 days from the time that his Order becomes final.

The case is widely viewed as an attempt by the FTC to reinvigorate hospital merger antitrust enforcement after a string of losses in federal court in the 1990s. Indeed, this is the first challenge since 1998 to a hospital merger by either the FTC or the Department of Justice. The ALJ's decision, of course, is only the first round – the hospitals already have filed a Notice of Appeal to seek review of the decision before the full Commission, and if unsuccessful there, they will almost certainly appeal the decision to the Seventh Circuit Court of Appeals, a process that likely will take a year or two. But ALJ McGuire's 225-page opinion is significant because it generally adopts (with some important exceptions) the framework urged by the FTC staff for analyzing hospital mergers and the decision highlights the battleground on which the appeals will be fought.

In this article, we address some of the key issues raised by the opinion, including its approach to product and geographic market definition, the analytical framework for evaluating competitive effects, the analysis of post-merger price effects, the hospitals' explanations of those effects (including quality improvements and their "learning about demand" arguments), and the divestiture remedy. We conclude with a discussion of some of the broader implications that arise from the decision.

II. BACKGROUND FOR THE LITIGATION AND INITIAL DECISION

From the mid-1990s through 2001, federal and state enforcers challenged seven hospital mergers in five different states.[2] Litigated prospectively, as most Clayton Act § 7 challenges are, the government sought preliminary injunctions in each of the cases in

order to prevent the proposed transactions from occurring. The basis on which the government sought to enjoin the combinations – generally among not-for-profit hospitals – was that they would result in a substantial lessening of competition for hospital inpatient services. None of the seven challenges was successful, largely because the courts refused to adopt the government's proposed geographic market definition, instead finding somewhat broader markets with larger numbers of competitors.[3]

After suffering four of the seven losses, the FTC announced plans in August 2002 to study – on a retrospective basis – consummated hospital mergers in a number of different markets around the country. According to then-FTC Chairman Timothy Muris, the purpose of studying hospital mergers on a looking-back basis was to determine – using "real-world information" – whether the selected transactions were anticompetitive and to "update prior assumptions about the consequences of particular transactions and the nature of competitive forces in health care."[4] The FTC established a Merger Litigation Task Force to conduct the retrospective hospital studies with an aim toward "reinvigorating the Commission's hospital merger program."[5] Chairman Muris announced that to the extent the studies conducted by the Task Force revealed that a hospital merger was anticompetitive, the FTC would consider the propriety of seeking a remedy through administrative litigation.[6]

It was within the context of their retrospective studies that the FTC sought and announced that it had found evidence that prices rose substantially at three Chicago-area hospitals located on the North Shore of Lake Michigan in Cook County, Illinois after their merger in January 2000. Specifically, the FTC investigated the merger of Evanston and Glenbrook with Highland. Evanston – a 114-year old acute care hospital

with 400 beds – is located in Evanston, Illinois, a few miles north of Chicago.[7] It offers primary, secondary, and tertiary care services and is affiliated with Northwestern Feinberg School of Medicine.[8] Glenbrook is a community hospital with 125-150 beds that was developed and opened by Evanston in 1977; it is located in Glenview, Illinois, which is immediately northwest of Evanston.[9] Highland, which is situated north of Evanston and northeast of Glenbrook in Highland Park, Illinois, is an eighty-seven-year old hospital with between 150-200 beds.[10] Prior to and after the merger, all hospitals operated as not-for-profit entities.[11]

Alleging that ENH raised its prices as a result of market power gained through merger, the FTC sued ENH on February 10, 2004 through the Commission's administrative litigation process and sought complete divestiture of Highland.[12] In its complaint, the FTC alleged that the merger of the three hospitals substantially lessened competition in the relevant market in violation of § 7 of the Clayton Act (Count I).[13] In Count II, the FTC asserted that the merger enabled ENH to raise prices to private payors above the prices it otherwise would have been able to achieve absent the merger.[14] Although this count alleges a violation of Clayton Act § 7, it is somewhat novel in that the allegations are based entirely on competitive effects and do not include any proposed product or geographic markets. In Count III, the FTC brought a price fixing claim, unrelated to the merger, against ENH Medical Group, alleging illegal joint negotiations on the part of physicians who were affiliated with the medical group.[15] ENH Medical Group subsequently entered a consent agreement with the FTC and, thus, the ALJ did not consider Count III in his Initial Decision.[16]

In contesting Counts I and II, ENH did not dispute that prices had increased. Instead it argued that the increases occurred for competitively benign reasons, and in any event, the price levels achieved were not supracompetitive when assessed against comparable hospitals and taking into account overall trends in price increases during the period after the merger. Although ALJ McGuire did not accept all of the FTC's arguments on key elements of the FTC's Clayton Act case – including geographic market – he ultimately sided with the FTC, concluding that the merger was anticompetitive and that divestiture of Highland is warranted. In his decision, however, ALJ McGuire found for Complaint Counsel only with respect to Count I (which included explicit market definition allegations). The ALJ dismissed Court II (which was based solely on competitive effects evidence), as moot, but opined that if it had been necessary to reach Count II, he would have dismissed the allegations because Complaint Counsel is obligated to at least define the "rough contours" of a relevant market, which they expressly did not do.[17]

Both sides have filed appeals to the Commission, with the hospitals appealing the entire decision, and Complaint Counsel appealing the ALJ's decision with respect to Count II and certain aspects of the Order.

III. THE STRUCTURAL CASE

The ALJ's structural market analysis is relatively traditional, beginning with an evaluation of the evidence on product and geographic market definition, identification of providers to include in the relevant market as competitors, and measurement of shares and concentration.[18] However, in a departure from other hospital merger cases, ALJ McGuire rejected patient flow data[19] in assessing geographic market definition, primarily

on the grounds that these data are not predictive or useful for assessing the viable alternatives to the merging parties for managed care organizations (MCOs), who are identified as the customers at issue.[20]

While rejecting these traditional empirical analyses, which are critiqued in the Initial Decision as tending to find markets that are overly broad, the ALJ, nonetheless, concluded that the relevant geographic market is broader than that claimed by Complaint Counsel (which was limited to only the three merging hospitals), but narrower than the geographic market proposed by the Respondents. He identified the relevant competitors as general acute care hospitals within a certain driving distance of the merging hospitals and hospitals that are identified (in some, but not all circumstances) as viable alternatives for MCOs and their enrollees.[21] The ALJ concluded that in this seven-hospital market, the Herfindal Hirsch Index (HHI)[22] would be about 2700 (with an increase of over 350 points) and the merged firms' share increased from about 35% to about 40%. It appears from statements in the Initial Decision that, if the market were to include two additional hospitals (advanced by the Respondents as part of a "minimum" or conservative market and evaluated by the ALJ but rejected for inclusion in the market), the HHI would have been approximately 1900 with a change of 222.[23]

A number of methodological points are central to the ALJ's conclusions and worthy of some note, both with regard to product market and especially geographic market.

A. Product market definition – services and customers

The central product market issue before the ALJ was whether to include outpatient services in the relevant product market. While noting that there has been a

trend toward greater migration of services from inpatient to outpatient, the ALJ observed that because a number of services can be provided on an inpatient basis only, it is reasonable to exclude outpatient services from the relevant product market.[24]

The product market definition findings are consistent with prior litigated cases, where courts have typically limited the relevant product market to general acute care inpatient services. The Initial Decision departs from these prior cases, however, in its conclusion that the only customers on which the analyses should focus are the MCOs. This contrasts with the majority of other litigated hospital merger cases that have either expressly included other customers (*e.g.*, individual consumers, employers, or other entities) or have focused on the fact that MCOs are negotiating on behalf of a broad set of consumers.[25] Moreover, such cases have noted that the underlying patterns of usage of a broad base of customers are relevant to market definition.[26] While the distinction appears to be a subtlety, it affects directly the ALJ's assessment of which evidence and actions are relevant for purposes of geographic market definition and competitive effects analyses.

B. Geographic market

The ALJ reached his findings with regard to geographic market definition after a lengthy summary of the methodological and evidentiary findings raised by both parties. In assessing geographic market, the ALJ adopted Complaint Counsel's analyses and expert testimony with regard to patient flow data, critical loss analyses, and the meaning of a hospital as a "viable" alternative. In particular, the ALJ determined that patient flow data, however utilized,[27] are not relevant to the analyses or identification of likely or viable hospital alternatives for the enrollees of managed care plans (or for MCOs in their

pricing) in the event of an actual or threatened price increase. In reaching this conclusion, the ALJ appears to have rejected the utility of patient flow data as it has been applied in other litigated mergers.

Prior cases have found that, while MCOs take into account which hospitals are important to include in order to form attractive and marketable networks,[28] the pricing of hospital services at such in-network hospitals can be constrained by the availability of other in-network hospitals offering comparable services. These other in-network hospitals are deemed to exercise a pricing constraint if a sufficient number of patients that otherwise would be using the merged hospitals would utilize one or more of these alternatives. As a result, estimating empirically the sufficiency of the patient volumes that would be shifted (or that could be threatened to be shifted) has been a focal point of analyses in these other litigated cases. Patient flow data, physician data, utilization data, and evidence of actions taken by MCOs or employers in the marketplace have been examined to determine whether there was a sufficient number of patients that would make use of alternatives.[29]

In contrast, in the sections of the decision addressing product market and background on contracting, the ALJ decided that only the "first stage" of competition – formation of *marketable* networks by MCOs – is relevant to hospital merger analysis and to assessment of the relevant geographic market. He expressly rejected any relevance of "second stage" competition that focuses on patient or employer willingness actually to use particular hospitals. Having made the finding that only "Stage I" competition is relevant – *e.g.*, which hospitals are required to form a marketable network – the ALJ focused heavily on testimony by the MCOs with regard to the hospital

alternatives and contemporaneous business documents about the competitors in the subsequent section addressing geographic market definition. In addition, the ALJ makes use of some distance analyses.

(1) ***MCO testimony*****.** To support his finding on geographic market, the ALJ relied extensively on MCO testimony. In particular, testimony offered by Aetna, PHCS, Great West, United, and Unicare (but not Blue Cross and Blue Shield of Illinois – the largest MCO in the Chicago area) led the ALJ to find that the MCOs were unable to engage successfully in selective contracting with ENH post-merger[30] – that is, that they could not drop the merging hospitals (or other hospitals in many instances) – and could not offer a viable product to employers without the merged hospitals (Evanston, Glenbrook, Highland Park) and potentially one or more of the other hospitals included in the geographic market – Lake Forest, Advocate Lutheran General, Rush, or St. Francis in their networks.[31] Identification of some of the hospitals for inclusion (or exclusion) in the market was based on MCO testimony that the merging hospitals and these others were close competitors or viable alternatives to each other. The decision is unclear, however, as to whether the basis for including hospitals was a finding that each (or several) testifying MCO could substitute the competing hospital for one of the merged hospitals, or that it was regarded by MCOs in some more general way as "competing" with the merged hospitals.[32] As a result, while the ALJ discussed selective contracting at length in the decision, it is unclear whether his conclusion regarding which hospitals to include in the market is based primarily on selective contracting, overall competitiveness, or some other metric (such as distance, which is addressed below).[33]

The ALJ viewed MCO testimony as credible because the MCOs' post-merger, but pre-lawsuit, actions were consistent with their trial testimony.[34] Interestingly, the significance the ALJ accorded to the MCOs' views on viable networks seemed to outweigh testimonial and documentary evidence offered by both MCOs and ENH reflecting their respective views on which hospitals were *closest* competitors to the merging hospitals, which is generally the evidence used to support a unilateral effects theory[35] of competitive harm and the type of evidence relied upon in other decided cases.[36]

(2) ***Distance analysis*.** In determining which hospitals to include in the market, the ALJ relied on a measure of the convenience of the alternative hospitals to the merging parties, and considered evidence from a travel survey conducted by one of the area hospitals. The survey identified that "convenient" hospitals for emergency services were those within sixteen minutes of the survey respondents and for elective services were those within thirty-five minutes travel time. The ALJ did not set out a rationale for the choice of the emergency-based time (sixteen minutes) as compared to the elective-based time (thirty-five-minutes) as the appropriate standard for inclusion. Based on this metric, two area hospitals and the greater Chicago-area hospitals were excluded.[37] Interestingly, the ALJ did not appear to have evaluated the extent to which ENH and Highland Park were *close* competitors based on the same metric – *e.g.*, driving time.

C. Market share and concentration

The ALJ's market included four other hospitals that were found based on MCO testimony as close alternatives for the merged hospitals and as such could presumably

be substituted for them in a network. The market definition accepted by the ALJ, thus, appears to reject Complaint Counsel's theory that MCOs had no alternatives for the merged hospitals in network formation and that the market should be limited to just the three merged hospitals.[38] The ALJ concluded that the competing hospitals in the market have a collective market share of about 60%. However, he did not indicate whether, absent direct evidence on anticompetitive price increases, these share and concentration measures would, in and of themselves, suggest that there were sufficient alternatives for the MCOs to constrain a price increase. The ALJ ultimately concluded that there is a (weak) structural case, but that the conclusion about the effects of the merger is supported by the pricing evidence. [39]

IV. COMPETITIVE EFFECTS

The majority of the Initial Decision is focused on an evaluation of testimony and evidence concerning the competitive effects of the consummated merger – and particularly on whether ENH was able to achieve anticompetitive price increases post-merger.

A. Price levels vs. price increases

In examining competitive effects evidence, the ALJ concluded that *relative price changes*, not *relative price levels*, were the appropriate standard for evaluating the anticompetitive effect.[40] In this regard, the ALJ stated that one need only show that the price *changes* of the merged hospitals exceeded those of other hospitals and that "Complaint Counsel need not make a definitive showing that prices *rose* to an anticompetitive level in order to find Respondent in violation of Section 7."[41]

The ALJ reached his conclusion about the relevance of price levels to hospital merger analysis based on a finding that it is not possible to conduct a meaningful price *level* (*e.g.* rate for a specific service or set of services) comparison across hospitals – either at a particular point in time or across time. In reaching this conclusion, the ALJ cited the testimony by FTC expert Dr. Deborah Haas-Wilson with regard to the validity of levels versus prices and the nature of the product at issue.[42] As a starting point, the ALJ concluded that meaningful comparisons cannot be made of rates across hospitals because the services they offer are differentiated products. The ALJ also opined that price comparisons are difficult to do in other industries involving differentiated products and not just in healthcare. It is unclear from the decision whether the ALJ concluded that MCOs and other market participants could not themselves conduct such price level or rate comparisons.

The choice of rates of change vs. levels as the pertinent standard was central to the finding of anticompetitive effect because the ALJ concluded that the evidence "indicates but does not conclusively establish that Respondent's prices were supracompetitive."[43] While competitive effects and the empirical analyses of price increases are clearly the most significant part of the Initial Decision – largely forming the basis for Count I and the rationale for divestiture – it is difficult to discern the precise methodologies and evidence presented by the FTC or the Respondents even from a thorough reading of the Initial Decision. Much of the evidence is *in camera*, and it is particularly difficult to discern the key economic findings that support the assessment of anticompetitive price increases. For example, there is some ambiguity regarding whether differences among hospitals in 1999 (*e.g.,* in terms of contract timing or starting

levels) were taken into account in the price increase analysis. Similarly, it appears that the price level analyses were inconclusive and that possibly the FTC witnesses did not sponsor any testimony on levels.[44]

B. Evidence of anticompetitive effects

In setting out conclusions with regard to anticompetitive effects, the ALJ focused on testimony of the effects on certain MCOs as measured by the relative changes in prices experienced with ENH as compared to other similar hospitals and the empirical studies presented by experts for both sides.

(1) ***Price Increase Analyses:*** The ALJ reviewed the empirical analyses of relative price changes by the experts (Haas-Wilson for Complaint Counsel and Dr. Jonathan Baker for the Respondents) both with regard to the cohort groups and methodologies used. While there are some important differences between the analyses, the ALJ concluded that both analyses find statistically significant price increases, with the Baker analyses yielding about half of the price increases of the Haas-Wilson analyses.[45] Of note with respect to differentiated products analyses, the ALJ concluded that the cohort analyses[46] and empirical analyses (*e.g.*, regression analyses) should be adjusted to reflect differences among hospitals (such as case mix).

In accepting the "differences of differences" analyses[47] and the findings with regard to relative price increases, the ALJ also seems to have accepted that the initial pricing of each hospital in the cohort group is at an "equilibrium" or appropriate starting point.[48] He thus rejected, in part, claims by the Respondents that ENH's prices were not at equilibrium or market levels prior to the transaction.[49]

(2) ***MCO testimony and mechanisms for price increases:*** The ALJ focused on the price increases experienced by certain MCOs, while noting that not all MCOs appear to have been subject to comparable price increases. However, he did not spell out the mechanism by which some of these MCOs were able to avoid substantial increases or the relevance of this for the overall price increase or competitive effects analyses.[50]

By concluding that ENH was able to raise its prices at a greater rate than other hospitals, the ALJ appears to have focused on a unilateral effects theory as the basis for the competitive harm. A unilateral effects theory posits that the merging parties are the *closest* competitors to each other and that other competitors are sufficiently distant in product and/or geographic space that they cannot profitably divert enough customers from the merged parties to discipline the merging parties' prices after the merger. A unilateral effects theory, therefore, could posit that the merged hospitals alone achieved non-competitive price increases. As noted above, the ALJ found that other hospitals were regarded as close competitors and as a result were included in the relevant market. The ALJ determined that these competing hospitals collectively had a 60% share and ENH had a 40% share. These higher shares of the competing hospitals and their inclusion as competitors, would seem, however – absent additional analyses or facts that indicate that these hospitals are not able to attract or serve additional patients – to be inconsistent with a unilateral effects theory. While the ALJ does not expressly state it, the focus on the greater price increases achieved by ENH relative to other area hospitals, suggests that the ALJ rejected a coordinated effects theory as the basis for the competitive harm. A coordinated effects theory of harm would entail concern that the

merger had resulted in increased ability of in-market hospitals tacitly to coordinate their price, and collectively achieve non-competitive price increases after the merger.

(3) ***Documents and testimony:*** In reaching his conclusions regarding ENH's use of market power to achieve post-merger price increases, the ALJ used contemporaneous and post-merger ENH documents to confirm the "predictive assessments made in the structural analysis."[51] In particular, he relied primarily on ENH documents, including internal memoranda, documents prepared by consultants, strategic plans and meeting minutes, and to a lesser extent on MCO testimony, to find that (1) the primary motivation for the merger between Evanston and Highland was economic and a quest for market power,[52] (2) price increases occurred post-merger,[53] and (3) ENH attributed substantial price increases obtained from MCOs to the merger.[54] That ENH's own documents revealed that ENH was able to obtain price increases post-merger and directly attributed such achievements to the merger confirmed for the ALJ that ENH exercised market power and obtained post-merger price increases substantially above its pre-merger prices.[55] It is unclear, however, what weight would be accorded to such "bad documents" in the absence of the structural findings.

C. Ruling out "benign" explanations for the higher price increases

The ALJ's conclusion that ENH's relative price increases support a finding of market power rested on his determination that all other explanations for these increases were ruled out.[56] Respondents had essentially offered three "benign" explanations for why their prices may have been higher than the various peer groups to which they had been compared.

(1) ***Differences in hospitals' experiences*****.** There are many reasons that could help explain why a hospital increases its prices, and as the FTC's economic expert Haas-Wilson acknowledged, it is important to rule out the possibility that ENH's experience was different with respect to these possible explanations from the hospitals in her comparison groups. Dr. Haas-Wilson suggested that there were eight potential explanations for price increases, and that she could directly rule out five of them (cost increases; changes in regulations; changes in consumer demand; changes in quality; and declines in outpatient prices) as possible explanations for relatively higher price increases at ENH. She found, at least initially, that for three factors (changes in patient mix, changes in customer mix, and changes in teaching intensity), ENH's experience differed from that of the other hospitals, and therefore it was not possible to rule out these factors as possible causes for the relatively higher price increase at ENH. At this point, however, the decision suggests that Haas-Wilson performed regression analyses that showed that the post-merger price increases at ENH were greater than the average price increases at comparison hospitals "even taking into account variations in patient mix, customer mix, and teaching intensity."[57] Unfortunately, the public record sheds little light on these regression analyses, and whether controlling for these other variables substantially reduced the extent of the unexplained relative price increase or whether taking these factors into account at the initial stage of the analyses (*e.g.*, in determining whether these differences affected comparisons of the initial pricing) would have affected the empirical results.[58]

The decision suggests that the hospitals were unable to provide substantial affirmative evidence to suggest that these possible explanations for the relative price

changes were more plausible than an increase in market power, and no more discussion of this issue is provided in the opinion. Instead, the ALJ focused on two other areas that the Respondents argued could explain the differences in relative price increases: ENH's quality increases and "learning about demand."

(2) ***Differences in quality improvement.*** ENH argued that since the merger, it had substantially improved quality at its hospitals, particularly Highland, and that these improvements significantly exceeded those of comparable hospitals. Thus, even if ENH had increased prices at a higher rate than other providers, such increases might be explained by disproportionate improvements in quality at ENH.

The ALJ rejected this argument essentially on three grounds.[59] First, he concluded that ENH's price increases were not linked to its quality improvements at Highland Park. In reaching this conclusion, the ALJ determined that there was little evidence tying ENH's price increases to its quality improvements. He noted that managed care representatives, as well as ENH's Chief Operating Officer, testified that in negotiations ENH did not attempt to justify higher prices based on quality improvements, that Highland Park was already viewed as a highly desirable hospital pre-merger, and that the price increases were negotiated before the quality improvements were implemented. Second, the ALJ found that ENH had failed to provide sufficient evidence that over the entire ENH system, its quality had improved more relative to other hospitals. Third, the ALJ concluded that most of ENH's quality improvements were not "merger-specific," that is, they could have been undertaken by the hospitals without merging, and therefore were not relevant to his analysis.

It is clear from the focus on quality both at trial and in the briefs and opinion that the role of quality was much more central in this proceeding than it had been in other hospital merger cases. This is not surprising, since it was undisputed that ENH spent millions of dollars on quality enhancements (indeed the ALJ found that ENH had invested $120 million at Highland since 2000). In contrast, in the typical *prospective* review of a hospital merger, both the agencies and courts tend to discount claims of quality enhancements because they generally are much more speculative and less susceptible to verification.

At the outset of the section on quality in his decision, the ALJ observed that "the precise role of quality of care in the antitrust context has yet to be determined."[60] And, indeed, the decision reflects some uncertainty as to how to address quality arguments. For example, it is unclear why quality enhancements that are not merger-specific should be disregarded when assessing whether ENH had greater quality improvements than its peers. Whether or not the improvements could have been undertaken without the merger, the question should be whether the services that ENH provided post-merger had improved disproportionately relative to its peers, and therefore could justify higher prices; thus, it would seem that all quality enhancements should be considered. But as the ALJ acknowledged, measuring the value of these quality enhancements relative to other providers, and on top of that, determining whether these enhancements are valued by payors so as to justify higher prices, is a very difficult undertaking. As a result, what may be determinative is which party has the burden (*i.e.* must the FTC show that *quality-adjusted* price increases are higher at ENH, and therefore it has the burden of showing that the relative quality enhancements were inconsequential; or does ENH

have the burden of showing its quality enhancements not only exceeded those of the comparison facilities, but also were of the sort that warranted the price hikes). By analyzing quality as a defense, the ALJ appears to have placed this very substantial burden on the shoulders of ENH.

(3) ***The "Learning About Demand" defense.*** ENH also argued that a benign explanation for any higher price increases was that in the course of the merger, ENH learned that Evanston's contract rates were lower than those of Highland, even though in ENH's view Evanston warranted higher rates for its services because of its role as a teaching hospital. Thus, its post-merger price increases simply reflected its greater knowledge about its services and the demand for hospital services and brought its rates into line to reflect a competitive market.

Significantly, the ALJ did not reject the "learning about demand" defense as a matter of law. Rather, the decision is based on his view that the evidence was inconsistent with the theory.[61] For example, the ALJ concluded that (1) ENH was not justified in trying to obtain prices for Evanston that were higher than Highland and equivalent to other teaching hospitals; (2) ENH also raised prices at Highland, and those higher prices were not justified by any knowledge or change of status due to the merger; (3) ENH rewarded the Evanston negotiator (who ENH claims had negotiated lower than market rates), but fired the Highland negotiator (who had negotiated superior contracts); and (4) Evanston's rates actually may have been higher than Highland pre-merger.

V. REMEDY

The ALJ, with a few modifications, adopted the remedy sought by FTC Complaint Counsel, which includes the divestiture of Highland within 180 days of the date on which the Order becomes final. ENH had urged that even if the ALJ had found a § 7 violation, divestiture was not necessary since quality improvements made by ENH had cured any possible immediate anticompetitive effects of the merger, and the expected demise of Illinois certificate-of-need laws will soon make the market more competitive. Instead, ENH suggested that the ALJ could fashion a narrowly crafted conduct remedy that would require ENH to give prior notification of any future acquisitions (even if not mandated under the Hart-Scott-Rodino Act), and which would require ENH to negotiate and contract on behalf of its three hospitals separately, if health plans so desired. ALJ Maguire rejected these alternative remedies on the grounds that they would not restore competition.

The insistence on divestiture by the ALJ apparently stems from his finding that the merger had resulted in what in his view was a significant change in market structure, and the strong preference of the antitrust agencies for structural, as opposed to conduct, remedies.[62] One implication of this preference, of course, is that in a hospital merger challenge it is very difficult for the parties to agree on a settlement. Unlike with other mergers, there are no obvious overlapping product lines that might be divested. Moreover, the only hospital merger case in which a settlement has been reached with a federal antitrust enforcer,[63] whereby the hospitals, instead of merging, could jointly produce some of their services and separately sell them, reportedly was very difficult to implement and has not been replicated.

ENH would not be the first instance in recent years in which the antitrust agencies have challenged a consummated merger.[64] But such events are quite rare. Moreover, in some of these matters, the remedy included only a mandatory licensure;[65] in others, where a divestiture was ordered, the parties had allegedly withheld 4(c) documents.[66] In this case, ENH may argue it is unreasonable, several years after the merger, to require ENH, a non-profit organization that has spent considerable sums to improve quality at Highland, to sell Highland, perhaps at fire-sale prices. It also may assert that such a remedy is inappropriate without compelling testimony from purchasers as well as others who will be affected by a divestiture (*e.g.,* that health plans, employers, and patients believe a divestiture – at this point in time – would improve consumer welfare).

VI. SOME CONCLUDING THOUGHTS

It is important to emphasize that this is only Round One, and ultimately it will be the opinion of the full Commission, or the decision of the Seventh Circuit if the FTC upholds the ALJ, that will really define the importance of this matter. Nevertheless, the Initial Decision already has several implications.

First, it will give the government at least a temporary "boost in the arm." It has been a long time since the antitrust enforcers have mounted a successful hospital merger challenge, and this may embolden them to subject hospital mergers to much closer scrutiny in the future. But such scrutiny is likely to be undertaken primarily with respect to prospective mergers before they are consummated – just as is the case typically with mergers in other sectors of the economy.

In such cases, the likely impact of the decision is uncertain. The evidence that the ALJ relied on for defining the relevant markets is the same type of evidence – largely views of the managed care plans and contemporaneous documents – that the government has relied on in past merger challenges, with a distinct lack of success. The new argument that the agencies will make, if the ALJ decision is upheld, is that notwithstanding assertions that health plans can shift patients to hospitals that are not in the very immediate vicinity of the merging parties so as to constrain anticompetitive price increases, in fact that may not be the case – as they would claim is evident from the Evanston experience. That experience, the agencies may argue, shows that even hospitals that have only a 40% market share may successfully raise prices in an anticompetitive fashion. This argument, however, does not provide an ability to distinguish or predict which transactions resulting in a 40% share are likely to raise substantial competitive issues.

If this is the argument, the FTC will be urged to release all of the results of its hospital merger retrospective study. It has been rumored that the FTC looked closely at about ten hospitals in the course of the study. When FTC Chairman Muris launched the hospital retrospective, he promised that the "agency will announce the results of these studies regardless of the outcome."[67] This has not happened, and at least one FTC Commissioner has indicated will not likely occur while the agency has a case in litigation.[68] But if the agencies will assert that a retrospective review of Evanston supports challenges in other markets, it will be important to see whether that conclusion is supported by experiences with other hospital mergers in the retrospective study. This is especially important because more insight is needed to inform both agency staff and

the courts regarding what evidence on a *prospective* basis will suggest that a merger is likely to be anticompetitive. In other words, unless the agencies wish to use Evanston to assert that any merger resulting in hospital market shares of 40% should be challenged (which would be a far more stringent standard than has been applied in recent years), it will be important to identify what additional factors suggest – before any evidence of pricing changes is available – that a hospital merger is likely to be anticompetitive.

The Initial Decision, if it is upheld, also may cause hospitals in concentrated markets to modify their conduct somewhat even if their initial mergers survive scrutiny. While post-merger challenges are likely to continue to be rare, the possibility cannot be entirely discounted. Accordingly, hospitals may be somewhat more cautious in seeking price increases in the period immediately after they consolidate. They also may be more skittish about fully integrating their operations and investing in substantial quality improvements if they believe that price increases to finance such improvements will be viewed as evidence of market power. To help provide more certainty to the hospital community, it will be important that the FTC, and the Seventh Circuit if it reviews the matter, fully explain the competitive theory underlying hospital merger analysis so that providers can obtained informed guidance regarding when a hospital merger is likely to undergo a serious antitrust challenge.

Endnotes

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[1] *In the Matter of Evanston Northwestern Healthcare Corporation,* Dkt. No. 9315, Initial Decision (Oct. 20, 2005) (Init. Dec.). Case documents and pleadings are available at www.ftc.gov/os/adjpro/d9315/index.htm.

[2] *See In re Adventist Health Sys*., 117 F.T.C. 224 (1994); *FTC v. Freeman Hosp*., 911 F. Supp. 1213 (W.D. Mo. 1998), *aff'd*, 69 F.3d 260 (8th Cir. 1995); *United States v. Mercy Health Servs*., 902 F. Supp. 968 (N.D. Iowa 1995); *FTC v. Butterworth Health Corp*., 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd,* 121 F.3d 708 (6th Cir. 1997); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121 (E.D.N.Y. 1997); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045 (8th Cir. 1999); *California v. Sutter Health Sys*., 130 F. Supp. 2d 1109 (N.D. Cal. 2001).

[3] One exception involves the merger in Grand Rapids, Michigan in which the court accepted the FTC's proposed market definition, but concluded nevertheless that the merger would not harm consumers, in large part because of the non-profit nature of the hospitals. *See Butterworth,* 946 F. Supp. at 1291-94, 1296-97.

[4] Timothy J. Muris, *Everything Old is New Again: Health Care and Competition in the 21st Century*, Prepared Remarks before 7th Annual Competition in Health Care Forum, Chicago, Ill., at 19-20 (Nov. 7, 2002).

[5] Press Release, Federal Trade Commission Announces Formation of Merger Litigation Task Force (Aug. 28, 2002), *available at* www.ftc.gov/opa/2002/08/mergerlitigation.htm; Muris, *Everything Old is New Again*, *supra* note 4, at 20 ("To the extent ex post data reveal a real problem in some of these mergers, that data may bolster the Commission's position the next time it seeks a preliminary injunction against a proposed merger in federal district court."); *see also* Joseph Simons, Report from the Bur. of Competition, Before the 51st Annual ABA Antitrust Section Spring Meeting § II (Apr. 4, 2003) available at www.ftc.gov/speeches/other/030405simonsaba.htm (discussing generally the FTC's renewed emphasis on Part 3 administrative litigation).

[6] *See id;* Muris, *Everything Old is New Again*, *supra* note 4, at 19.

[7] *See* Init. Dec., *supra* note 1, at 5-6; *In the matter of Evanston Northwestern Healthcare Corp.,* Dkt. No. 9315, Respondent's Replies to Complaint Counsel's Proposed Findings of Fact (Vol. 1), 22 (July 1, 2005) (RRFF).

[8] *See id.* at 5-6, 9; RRFF, *supra* note 7, at 19-21.

[9] *See* Init. Dec., *supra* note 1, at 6; RRFF, *supra* note 7, at 23.

[10] *See* Init. Dec., *supra* note 1, at 7; RRFF, *supra* note 7, at 25-26.

[11] *See* Init. Dec., *supra* note 1, at 5, 15.

[12] *See In re Evanston Northwestern Healthcare Corp*., Dkt. No. 9315 (Feb. 10, 2004) (complaint).

[13] *See id.* at ¶¶ 15-27.

[14] *See id*. at ¶¶ 28-32.

[15] *See id*. at ¶¶ 33-45.

[16] *See In the Matter of Evanston Northwestern Healthcare*, Dkt. No. 9315, Agt. containing Consent Order to Cease and Desist (Apr. 5, 2005).

[17] *See* Init. Dec., *supra* note 1, at 200-201.

[18] *See* Init. Dec., *supra* note 1, at 27-40 (for factual and methodological analyses) *and* 131-149 (for conclusions of law with respect to these topics).

[19] Patient flow data provide historical information on hospital usage by residents of a particular area. Patient flow data and critical loss analysis have routinely been used by both plaintiffs and defendants in recent hospital merger cases and have been cited by the courts as providing an empirical basis for hospital usage patterns. *See Sutter*, 130 F. Supp. 2d at 1131-32. Critical loss analysis is a methodology

for assessing the magnitude of patients which, if shifted to competing hospitals, would be sufficient to discipline a price increase. It has been applied in recent litigated hospital merger cases and referenced in the FTC and Department of Justice (DOJ) Report, *Improving Health Care: A Dose of Competition*, as a tool for providing an empirical basis for merger analysis. *See id.* at 1128-32; Report of the FTC and DOJ, *Improving Health Care: A Dose of Competition* (July 2004), *available at* http://www.ftc.gov/reports/index.htm. While a number of articles support its general application, there has been some criticism raised of the technique. *See, e.g.,* David T. Scheffman & Joseph J. Simons, *The State of Critical Loss Analysis*: *Let's Make Sure We Understand the Whole Story,* The Antitrust Source (Nov. 2003), *available at* www.abanet.org/antitrust/source/11-03/scheffman.pdf.

[20] *See* Init. Dec., *supra* note 1, at 30-33.

[21] *See id.* at 35-38 (identifying hospitals included in the market); *id.* at 39-40 (identifying hospitals excluded and rationale for exclusion).

[22] The HHI provides a measure of the concentration of a market. The HHI is derived by summing the squares of the shares of each of the participants in the market and thus takes into account both the number and size distribution of competitors. According to the Merger Guidelines, an HHI of 1800 is regarded as highly concentrated and mergers that cause a change in the HHI of more than fifty are likely to raise concerns. The change in the HHI is measured by multiplying two times the share of one merging firm times the share of the other merging firm. *See* FTC and DOJ, Horizontal Merger Guidelines § 1.5 (Apr. 8, 1997), *available at* http://www.ftc.gov/bc/bcmergacq.htm.

[23] *See* Init. Dec., *supra* note 1, at 42-43.

[24] *See id.* at 27-29, 135.

[25] *See Long Island Jewish*, 983 F. Supp. at 125 ("These burgeoning, multifaceted and diverse managed care plans contract with huge numbers of consumers *en masse*, including large corporate employers and unions. This presents the question of identifying the 'consumers' of medical care; namely, are the consumers in this antitrust context the members of various managed care plans, or are the 'consumers' the managed care plans themselves?"). The court concluded that there were five groups of customers, including patients (self pay or indemnity insurance, physicians and physicians groups who control admissions, managed care plans, employers, and government). *See id.* at 134; *see also Sutter*, 130 F. Supp. 2d at 1131-32 (evaluating both MCO and independent physician associations (IPAs) testimony and examining information on patient flow data).

[26] Sometimes the so-called "Elzinga-Hogarty" test has been applied to patient flow data to define geographic market in hospital merger cases, more typically by plaintiffs than by defense. Competitors for inclusion in the relevant geographic market are identified by using an iterative measure that poses to the data the following empirical question: which are the hospitals, which when combined with the merging hospitals, represent 75% (90%) of the hospitals to which area residents are going and have collectively a 75% (90%) share of the discharges in the area. The 75% test is regarded as a "weak test" (because 25% are using "out-of-market" providers), and 90% represents a "strong test." The terms Elzinga-Hogarty test and patient flow analysis are sometimes used interchangeably although they are distinct concepts – the Elzinga-Hogarty test is a specific methodology for organizing and examining patient flow data, while patient flow analysis covers an array of means of examining and testing empirically the actual usage patterns of hospitals over time by patients of a given area or a given managed care plan. Patient flow data thus can lead to narrow or broad markets, depending on the particular fact pattern.

[27] The ALJ rejected both Elzinga-Hogarty analysis, as well as other uses of patient flow data, to provide predictive information about the alternatives for the merging parties. *See* Init. Dec., *supra* note 1, at 30-34. In this section, the ALJ cited primarily to literature on network formation, and potential biases or drawbacks in patient flow data (*e.g.,* the fact that they do not include prices and are patient rather than payor level data) as the basis for his findings. It does not appear that expert testimony was presented by Complaint Counsel that expressly evaluated the patient flow analyses of the Respondents' expert or provided countering empirical analyses.

[28] This is often referred to as "Stage I" competition – it is the stage of contracting at which the MCO is determining the set of providers (*e.g.,* hospitals, physicians, and other medical facilities) that make it feasible for the MCO to market the resulting provider network to employers.

[29] Utilization, physician admission, and patient flow information – *e.g.,* the actual choices made by consumers – reflect what is often referred to as "Stage II" of competition. Several cases have expressly relied upon patient flow data as useful to the analysis of the relevant market in determining which hospitals are practical alternatives for the merging hospitals and informative as to outcomes of the alternatives to which patients would turn (and to which MCOs could direct sufficient numbers of patients). These generally have not involved Elzinga-Hogarty analyses. *See Long Island Jewish*, 983 F. Supp. at 141-45; *Sutter*, 130 F. Supp. 2d at 1131-32 (concluding that about 30,000 residents of the market were already entering or leaving the area for healthcare).

[30] *See* Init. Dec., *supra* note 1, at 138-40.

[31] *See id.* at 142.

[32] *Compare, e.g., id.* at 40 (discussing the Vista Hospitals and Northwestern Memorial, both of which were excluded from the market but which were identified by Great West as alternatives to ENH), *with id.* at 38 (discussing testimony about St. Francis, which was included in the market and was identified as an alternative to ENH by Great West and PHCS and as a "competitor" by United and Unicare as well).

[33] *See id.* 23-24 (setting forth information on contracting by area MCOs and indicating that those with PPO networks tended to include large numbers of hospitals and typically more hospitals than HMO networks).

[34] *See id.* at 138.

[35] *See* discussion *infra* Section IV.B, at *MCO testimony and mechanisms for price increases* (describing the unilateral effects theory of competitive harm).

[36] *See id.* at 141 (according little weight to testimony of Evanston CEO regarding which hospitals were substantial competitors for Evanston); *id.* at 32-33 (reflecting testimony by representatives of Aetna, PHCS, Great West Unicare and United that Evanston competed more closely with Advocate Lutheran General, Rush North Shore and St. Francis whereas Highland Park's most significant competitors were Lake Forest and Condell). The testimony on this point apparently was not entirely consistent. Some managed care representatives did testify that Evanston and Highland Park were each other's "main competitors" or "primary alternative." *Id.* at 31.

[37] In part, Chicago area hospitals were excluded because they were deemed sufficiently remote that affluent residents of the ENH service area would not be willing to drive such distances due to the value of their time, although this appears based on general literature as opposed to empirical assessment of actual usage patterns of such residents.

[38] This is similar to the court's rejection of a two hospital market in the LIJ – North Shore case. *See id.* at 16-27, 135-142.

[39] Shares and concentration levels have varied in other matters as have the number of hospital competitors. In *Sutter* and *Long Island Jewish*, each involving metropolitan areas, there were numerous alternative hospitals located in the area served by the merging hospitals and regarded as competitors (*e.g.*, thirteen in the Plaintiff's East Bay market) and more than twenty in the market found by the court for primary and secondary services in LIJ. *See Sutter,* 130 F. Supp. 2d at 1112-13; *Long Island Jewish,* 983 F. Supp. at 141-42. In virtually all decided cases, the hospitals' service area was used as the starting point for the geographic market and, accordingly, hospitals located at distances greater than sixteen minutes were included. *See, e.g., Sutter,* 130 F. Supp. 2d at 1123-26, 1131 (concluding that the relevant market for primary and secondary services included hospitals located in the East Bay and areas to the south and east, and that the merging hospitals' service area should be extended across the East Bay). None of the prior cases were decided based on travel distances for emergency care.

[40] *See id.* at 62.

[41] *Id.* at 155. While the ALJ accepted price increases as the only relevant measure of anticompetitive effect, he also evaluated and critiqued the evidence presented by the Respondents' experts on price levels. *See id.* at 155, 173-75. He concluded that one can evaluate price increases over time, and can rule out factors/experiences for price increases other than market power. There appears to have been no expert testimony by Compliant Counsel with regard to price levels.

[42] The ALJ found that hospital services are a differentiated product and that consumers are willing and able to pay higher prices for certain aspects of product differentiation. Because prices can vary in the market for a differentiated service for many different reasons, one may not conclude anything about market power by merely using a cross-sectional analysis of hospital prices at a single point in time. *See* Init. Dec., *supra* note 1, at 62 (citing Haas-Wilson, Tr. 2492-93; Haas-Wilson, Tr. 2495).

[43] Init. Dec., *supra* note 1, at 155. The ALJ observed: "Indeed, Complaint Counsel did not attempt to compare ENH's prices to a competitive level, instead focusing on ENH' s price increases relative to other hospitals' price increases. ENH's expert, Noether, compared ENH's inpatient and outpatient prices to inpatient and outpatient prices charged by other hospitals in connection with supporting the hospitals' "learning about demand" defense, but the extent of such evidence is unclear." *Id.* (citations omitted).

[44] The Post-Trial Briefs of the Respondents and Complaint Counsel do not provide substantial additional clarification on methodology or findings due to the extensive portions that are redacted.

[45] *See id.* at 86-88.

[46] The ALJ critiqued the cohort groups that were used in the price levels analyses on the grounds that they excluded certain comparable hospitals and included non-comparable hospitals.

[47] "Differences in differences" refers to the methodology of examining the rate of change in prices of the merged hospital over the period and the rate of change of the control group, and examining the differences in the relative rates of change. This methodology takes into consideration the fact that all hospitals may have experienced increasing prices and that an anticompetitive rate of change is one that is not only occurring, but is occurring at a faster or higher rate.

[48] A hospital that had substantially lower than average prices in the starting period due perhaps to financial condition, nature of services offered, or other factors may have a substantially higher than average rate of increase in prices but end up at a level that is in line with other hospitals. A key issue is whether that initial rate is an appropriate starting point for the price increase analysis.

[49] *See* Init. Dec., *supra* note 1, at 173.

[50] *See* Init. Dec., *supra* note 1, at 65-82, (noting that some MCOs were able to avoid substantial price increases). In addition, there is no reference in the Initial Decision of the extent to which MCOs could use negotiations on outpatient services that may face greater competition as a mechanism to obtain lower rate increases for inpatient services or other mechanisms.

[51] *Id.* at 153.

[52] *See id.* at 155-56.

[53] *See id.* at 158-64

[54] *See id.* at 164-66.

[55] *See id.* at 153.

[56] *See id*. at 169.

[57] *Id.* at 96.

[58] It is also unclear as to how the ALJ evaluated possible adjustments for comparable factors in the choice of cohort groups.

[59] *See* Init. Dec., *supra* note 1, at 177-78.

[60] *See id.* at 175.

[61] *See id.* at 170-72.

[62] *See, e.g.,* DOJ, *Antitrust Division Policy Guide to Merger Remedies* (October 2004), *available at* www.usdoj.gov/atr/public/guidelines/205108.htm ("Structural remedies are preferred to conduct remedies in merger cases because they are relatively clean and certain, and generally avoid costly government entanglement in the market.").

[63] *See United States v. Morton Plant Health System, Inc. and Trustees of Mease Hospital, Inc.,* Stipulation and Proposed Final Settlement (M.D. Fl. 1994), *available at* www.usdoj.gov/atr/cases/f5000/5057.htm.

[64] *See*, *e.g.*, *In the Matter of Chicago Bridge & Iron, Co.*, Dkt. No. 9300, *available at* www.ftc.gov/05/adjpro/d9300/index.htm (challenging consummated merger between two leading producers of large, field-erected industrial and water storage tanks and other specialized steel-plate structures); *In the Matter of MSC.Software Corp.*, Dkt. No. 9299, *available at* www.ftc.gov/os/adjpro/d9299/index.htm (challenging consummated merger between two suppliers of advanced computer-aided engineering software); *In the Matter of Ceridian Corp*., Dkt. No. C-3933, *available at* www.ftc.gov/os/caselist/c3933.htm (challenging consummated merger in the "fleet" card market).

[65] *See, e.g.*, *MSC.Software*, *supra* note 64 (ordering divestiture through royalty-free, perpetual, non-exclusive licensure to one or two acquirers); *Ceridian*, *supra* note 65 (ordering ten-year unrestricted, non-exclusive, royalty-free licenses).

[66] *See, e.g.*, *FTC v. The Hearst Trust*, Civ. Action No. 1:01CV00734 (D.D.C. 2001), *available at* www.ftc.gov/os/caselist/ca101cv00734ddc.htm (acquirer failed to include in its Hart-Scott-Rodino filing several high-level corporate documents prepared to evaluate the acquisition and its competitive effects).

[67] Muris, *Everything Old is New Again*, *supra* note 4, at 19 ("If the studies find efficiencies associated with some or all of the mergers, the staff will say so. If, on the other hand, the studies indicate that the mergers are anticompetitive, then the Commission will carefully consider whether administrative litigation is appropriate.").

[68] *See Interview with FTC Commissioner Tom Leary,* Antitrust Health Care Chronicle (ABA/Sec. of Antitrust Law, Washington, D.C.), Oct. 2005, at 4, *available at* www.meetings.abanet.org/webupload/commupload/AT301000/newsletterpubs/vol19-3.pdf.